Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Adult Day Services**		
Statutory Service	**Case Management**		
Statutory Service	**Homemaker**		
Statutory Service	**Personal Support Services**		
Statutory Service	**Respite**		
Extended State Plan Service	**Home Health Aide**		
Extended State Plan Service	**Skilled Nursing**		
Other Service	**Assisted Living Facility Services**		
Other Service	**Assistive Technology**		
Other Service	**Companion Services**		
Other Service	**Environmental Modification**		
Other Service	**Home-Delivered Meals**		
Other Service	**Non-Medical Transportation**		
Other Service	**Transition Intensive Case Management**		
Other Service	**Transition Setup**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04060 adult day services (social model)
Category 2:	**Sub-Category 2:**
04 Day Services	04050 adult day health
Category 3:	**Sub-Category 3:**

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

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 person-centered service plan.

Transportation is a component of adult day services and is included in the rate to providers. Adult day services do not include and do not replace or supplant the physical, occupational, and/or speech/language therapies available through the state plan.

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

Services are authorized based on the participant's assessed needs. Adult day services are limited to 40 hours per week. Adult day services may not be provided virtually.

Non-medical transportation services cannot be provided at the same time as adult day services.

Meals provided as part of these services shall not constitute a full nutritional regimen.

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 to provide Adult Day Services
Agency	Senior Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Services

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Services

Provider Category:

Agency

Provider Type:

Agency certified to provide Adult Day Services

Provider Qualifications

License *(specify):*

If the agency is an Adult Day Care Facility, it shall be fully licensed by the Wyoming Department of Health, Division of Aging pursuant to W.S. 35-2-901(a)(xxiii).

Certificate *(specify):*

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

Other Standard *(specify):*

A provider of this service shall meet the requirements as established in Wyoming Medicaid Rule. In addition providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in sub-regulatory guidance and the Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Services

Provider Category:

Agency

Provider Type:

Senior Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Case management is a required service that assists participants in gaining access to needed waiver and other state plan services, as well as medical, social, educational and other services, regardless of the funding source.

Case manager duties include:

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

(2) Facilitation and oversight of the development (and periodic revision) of a person-centered service plan in accordance with DHCF polices and procedures.

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

(4) Conduct monthly activities as described below:

(i) Maintain direct contact with the participant and/or legal representative (if applicable), which must include a monthly in-person visit to the participant's place of residence. Additional service observations, and virtual or in-person interactions may also be required;

(ii) Review service utilization and documentation of traditional and participant-directed services to assure the amount, frequency, and duration of services is appropriate;

(iii) 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;

(iv) When a participant chooses the participant-directed service delivery model, use the FMS portal to review service delivery information, determine budget usage, provide ongoing monitoring of the participant's budget, and report improper budget usage to the assigned DHCF staff member.

(5) Service plan implementation, monitoring, and follow-up activities, including activities and contacts that are necessary to ensure that the service plan is effectively implemented and adequately addresses the needs of the participant. Contacts may be with the participant, legal representative, as appropriate, family members, service providers, or other entities or individuals and are conducted at minimum monthly but more often as necessary in order to:

(i) Ensure services are being furnished in accordance with the participant's service plan;

(ii) Evaluate the effectiveness of the service plan in meeting the participant's needs;

(iii) Identify any changes in the participant's condition or circumstances;

(iv) Screen for any potential risks or concerns;

(v) Assess the participant's satisfaction with services and supports;

(vi) Make any necessary adjustments in the service plan and service arrangements with providers; and

(vii) Report and follow-up on all critical and non-critical incidents in accordance with DHCF polices.

(viii) Monitor for compliance with HCBS settings criteria.

(6) Information and assistance in support of participant direction as necessary:

(i) Inform participants of participant direction opportunities;

(ii) Ensure participants who express an interest in participant direction are informed of the potential benefits, liabilities, risks, and responsibilities associated with each service delivery option;

(iv) Assist the participant/designated employer in obtaining and completing required documents as determined by the Department;

(v) Coordinate with the Department to verify the participant’s budget allocation in accordance with the Department’s methodology;

(vi) Coordinate with the Financial Management Services (FMS) agency; and

(vii) Monitor participant-directed service effectiveness, quality, and expenditures against the monthly budget allocation.

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

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

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

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.

Other Standard *(specify):*

An independent case manager must meet the requirements in Chapter 34 of Wyoming Medicaid Rules. 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:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case Management Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be a County Public Health Nursing Agency designated by the Wyoming Department of Health, Public Health Division; or corporation, Limited Liability Company (LLC), non-profit organization, or sole proprietorship.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

Homemaker

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Homemaker services consist of chore-type activities and routine household care that is not covered by personal support services, and is considered a non-direct service. Homemaker is an indirect service as providers do not prompt or assist the participant in the completion of a task, and the participant is not required to be present when the service occurs.

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

As homemaker is an indirect service, this service can be provided at the same time that direct services are being provided to the participant by a different provider or provider staff.

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

A maximum of three (3) hours per week per household (624 units per year) is allowed.

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

Transportation costs are not associated with the provision homemaker services

If homemaker is added to a participant's person-centered service plan, the case manager must identify if personal support services (PSS) or home health aide are also included. If homemaker and PSS or home health aide are listed on the participant's plan, the case manager must indicate how homemaker services will be different from the chore services associated with PSS or home health aide. The case management information system will trigger a Quality Improvement Review (QIR) at a higher rate when homemaker is added to a plan with PSS or home health aide to be reviewed by a Benefits and Eligibility Specialist (BES). The BES will review the information included in the person-centered service plan, and work with the case manager if additional clarification is needed or concerns are noted.

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

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

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

A participant's spouse can be hired as an employee if there is evidence that demonstrates the spouse is not authorized to make financial decisions on behalf of the participant. For a spouse to be hired to provide this service the participant must require care that exceeds the range of activities that a spouse would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization.

The employer of record, with assistance as needed from the case manager, shall verify that, prior to working alone with the participant, the individual being hired has received training on the participant's person-centered service plan and has received training on the following Division requirements:

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

Employees who are hired to provide Personal Support Services through the participant-directed service delivery option are required to take the following trainings every two years. These trainings are developed by the State and available on the Home and Community-Based Services Section website:
Identifying and Reporting Abuse, Neglect, and Exploitation
Roles and Responsibilities in Participant Direction
Infection Control, Health, and Safety

All employees must receive training on the participant's specific needs, and how the participant wants to be supported. This training is conducted by the employer of record, and must be completed annually, or whenever a change is made to the person-centered plan of care that would change service delivery expectations. at a minimum.

The Financial Management Services (FMS) Agency collects all required training documentation for participant-directed employees, and ensures that employees continue to meet training requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

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

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Agency Provider

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

A provider of this service shall meet the requirements as established in Wyoming Medicaid Rule. In addition providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in sub-regulatory guidance and the Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Support Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

Personal support services may also consist of general household tasks when those tasks are incidental to the personal support service being provided during the visit, when the participant is unable to manage the home and care for themselves, and the individual regularly responsible for these activities is temporarily absent or unable to conduct these activities. However, incidental homemaker and chore service tasks shall not comprise the entirety of this service.

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

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

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

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

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

If personal support services and homemaker are listed on the participant's plan, the case manager must indicate how the chore services associated with personal support services will be different from homemaker services. If homemaker and personal support services are added to a service plan, the case management information system will trigger a Quality Improvement Review (QIR) of the person-centered service plan at a higher rate that will be completed by a Benefits and Eligibility Specialist (BES). The BES will review the information included in the person-centered service plan, and work with the case manager if additional clarification is needed or concerns are noted.

Personal support services and home health aide services may be included on the same service plan, but the services cannot be billed for 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	Participant-directed employee hired under the participant-direction service delivery option
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Support Services

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

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

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

A participant’s spouse can be hired as an employee if there is evidence that demonstrates the spouse is not authorized to make financial decisions on behalf of the participant. For a spouse to be hired to provide this service the participant must require care that exceeds the range of activities that a spouse would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the

participant and avoid institutionalization.

The employer of record, with assistance as needed from the case manager, shall verify that, prior to working alone with the participant, the individual being hired has received training on the participant's service plan and has received training on the following Division requirements:

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

Employees who are hired to provide personal support services through the participant-directed service delivery option are required to take the following trainings, which are developed by the State and available on the Home and Community-Based Services Section Training website:
- Identifying and Reporting Abuse, Neglect, and Exploitation
- Roles and Responsibilities in Participant Direction
- Infection Control, Health, and Safety

These trainings are required every two years. Additionally, all employees must receive training on the participant's specific needs, and how the participant want to be supported. This training is conducted by the employer of record, and must be completed annually, at a minimum.

The Financial Management Services (FMS) Agency collects all required training documentation for participant-directed employees, and ensures that these employee continue to meet training requirements.

The State offers a comprehensive provider list accessible, providing participants with access. Additionally the State can deliver the Provider list to the Participant upon request via mail or email.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

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

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Support Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Licensed by the Wyoming Department of Health, Division of Aging pursuant to W.S. 35-2-901(a)(xi). The individual

providing the service must meet the training requirements established by the Aging Division's Rules and Regulations for Home Health Agency Administration.

Certificate *(specify):*

Other Standard *(specify):*

Certified providers will meet all Division required training and ensure that employees meet training standards identified by the Division.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

○ **Service is included in approved waiver. There is no change in service specifications.**

◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

Respite services may be delivered in the participant's home or in the community when the participant requires assistance with activities of daily living in order to participate in community activities or to access other services in the community.

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

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

Services are authorized by a case manager based on the participant's assessed need and are limited to the prorated equivalent of thirty (30) days per service plan year.

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

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

☒ **Provider managed**

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

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 Provider

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

A provider of this service shall meet the requirements as established in Wyoming Medicaid Rule. In addition providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in sub-regulatory guidance and the Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

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

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

A participant’s spouse can be hired as an employee if there is evidence that demonstrates the spouse is not authorized to make financial decisions on behalf of the participant. For a spouse to be hired to provide this service the participant must require care that exceeds the range of activities that a spouse would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization.

The employer of record, with assistance as needed from the case manager, shall verify that, prior to working alone with the participant, the individual being hired has received training on the participant’s person-centered service plan and has

received training on the following Division requirements:

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

Employees who are hired to provide Respite through the participant-directed service delivery option are required to take the following trainings every two years. These trainings are developed by the State and available on the Home and Community-Based Services Section website:
-Identifying and Reporting Abuse, Neglect, and Exploitation
-Roles and Responsibilities in Participant Direction
-Infection Control, Health, and Safety

All employees must receive training on the participant's specific needs, and how the participant wants to be supported. This training is conducted by the employer of record, and must be completed annually, or whenever a change is made to the person-centered plan of care that would change service delivery expectations. at a minimum.

The Financial Management Services (FMS) Agency collects all required training documentation for participant-directed employees, and ensures that employees continue to meet training requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

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

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Home Health Aide

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

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

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

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

Home health aide services do not include companionship or other services which are diversional or recreational in nature.

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

Medically necessary home health aide services for individuals under the age of 21 are provided under the state plan in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage requirements.

If home health aide and homemaker are listed on the participant's plan, the case manager must indicate how the chore services associated with home health aide will be different from homemaker services. If homemaker and home health aide are added to a service plan, the case management information system will trigger a will trigger a Quality Improvement Review (QIR) of the person-centered service plan at a higher rate to be reviewed by a Benefits and Eligibility Specialist (BES). The BES will review the information included in the person-centered service plan, and work with the case manager if additional clarification is needed or concerns are noted.

Home health aide services and personal support services may be included on the same service plan, but the services cannot be billed for 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
Agency	Home Health Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

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

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

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

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

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

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

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

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assisted Living Facility Services

HCBS Taxonomy:

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

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

Assisted living facility services do not include services which are available through the state plan. Participant transportation costs are included in the rate for the assisted living facility services.

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

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

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Providers must be able to support a participant in accordance with a participant's person-centered service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:

Assistive Technology

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

○ **Service is included in approved waiver. There is no change in service specifications.**

◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Assistive technology includes electronic devices that are programmed to signal a response center once a help button is activated and enables the waiver participant to secure help in an emergency. Personal Emergency Response Systems (PERS) are limited to participants who demonstrate need based on their person-centered service plan.

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

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

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

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

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

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

☒ **Provider managed**

☐ **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	Personal Emergency Response System Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Personal Emergency Response System Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Companion Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08040 companion
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

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 with 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 19 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.

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
Agency	Agency certified by DHCF to provide service
Individual	Participant-directed employee hired under the participant-direction service delivery option
Individual	Independent Provider

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):*

Other Standard *(specify):*

A provider of this service shall meet the requirements as established in Wyoming Medicaid Rule. In addition providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in sub-regulatory guidance and the Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, 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: Companion Services

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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 will 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 will 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):*

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 34 of Wyoming Medicaid Rules. Requirements for providers include, but are not limited to:
-Successful criminal history background screening; and
-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 34 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 Home and Community Based Service (HCBS). A participant must have a 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:

Wyoming Department of Health, 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:

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Environmental modification services include the installation of functionally necessary physical adaptations to the private residence of the participant or the participant's family, as outlined in the person-centered service plan, that are necessary to ensure the health, welfare, and safety of the participant in order for them to remain in their home instead of an institutional setting or to transition from an institutional setting. If transition from an institutional setting, this service may be authorized up to 180 calendar days in advance of the transition date. Adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

If this service is provided to a participant transitioning into the community from an institutional setting, the modification will not be considered complete and cannot be billed until the individual leaves the institution and is accepted onto the waiver.

An occupational or physical therapy assessment in the amount established in the Medicaid State Plan may be included in the service if the individual is transitioning to the community from an institution; assessments for participants who are currently living in the community must be paid through the Medicaid State Plan and are not allowable charges under this service.

All services shall be provided in accordance with applicable state and local building codes

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

A lifetime cap of $20,000 per family applies to this service.

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve the entrance or egress of a residence or to configure a bathroom to accommodate a wheelchair). Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant are excluded.

Modifications of rented or leased homes shall be extraordinary alterations that are uniquely needed by the individual, and for which the property owner would not ordinarily be responsible.

Adaptations that are covered by the Medicaid State Plan, a state independent living center, or Division of Vocational Rehabilitation are excluded. Case managers are required to contact Wyoming Medicaid to determine if the requested modification is covered under the Medicaid State Plan. The provider must then sign a third party verification form indicating that the Community Choices Waiver is the payer of last resort. Environmental modifications shall not be furnished to modify settings that are owned or leased by providers of waiver services.

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

The Division may use a third party to conduct an on-site visit to assess the proposed modification and need for the modification to ensure cost effectiveness.

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

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

☒ **Provider managed**

☐ **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 provider certified by the Division to provide the service
Individual	Individual provider certified by the Division to provide the service

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modification

Provider Category:

Agency

Provider Type:

Agency provider certified by the Division to provide the service

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modification

Provider Category:

Individual

Provider Type:

Individual provider certified by the Division to provide the service

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

A provider must obtain and maintain general liability insurance commensurate with the service. In addition, providers shall

adhere to the standards and requirements of all applicable Wyoming Medicaid Rules, and requirements specified in the CCW Provider Manual and Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home-Delivered Meals

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

Americans Act.

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

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

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

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

☒ **Provider managed**

☐ **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	Commercial Food Service Operator
Agency	Older Americans Act Nutritional Services Provider

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Commercial Food Service Operator

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Older Americans Act Nutritional Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

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

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

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **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	Participant-directed employee hired under the participant-direction service delivery option
Agency	Contract Motor Carrier
Agency	Senior Center
Agency	Public Transit Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

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

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

A participant’s spouse can be hired as an employee if there is evidence that demonstrates the spouse is not authorized to make financial decisions on behalf of the participant. For a spouse to be hired to provide this service the participant must require care that exceeds the range of activities that a spouse would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization.

The employer of record, with assistance as needed from the case manager, shall verify that, prior to working alone with the participant, the individual being hired has received training on the participant’s person-centered service plan and has received training on the following Division requirements:

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

Employees who are hired to provide Respite through the participant-directed service delivery option are required to take the following trainings every two years. These trainings are developed by the State and available on the Home and Community-Based Services Section website:
Identifying and Reporting Abuse, Neglect, and Exploitation
Roles and Responsibilities in Participant Direction
Infection Control, Health, and Safety

All employees must receive training on the participant’s specific needs, and how the participant wants to be supported. This training is conducted by the employer of record, and must be completed annually, or whenever a change is made to the person-centered plan of care that would change service delivery expectations. at a minimum.

The Financial Management Services (FMS) Agency collects all required training documentation for participant-directed employees, and ensures that employees continue to meet training requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

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

The contracted FMS agency maintains a directory of individuals who are interested in additional employment opportunities

under the participant-directed service delivery option.

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Contract Motor Carrier

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Senior Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Public Transit Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transition Intensive Case Management

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

The payment for this service is only payable upon the participant's discharge from an institution and their proper enrollment in the CCW program.

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

This service is only available to participants during their transition to the community from an extended nursing facility stay, which is defined as ninety (90) or more consecutive calendar days. It is available to a participant once during their lifetime. Case managers may assist individuals with their community transition for no more than 180 consecutive calendar days while the individual is still residing in a nursing home.

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

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	Case Management Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Case Management Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transition Setup

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Transition setup expenses are one-time, non-recurring expenses necessary for a participant to establish a basic household, and support the participant to transition to a community living arrangement from an extended nursing facility placement, which is defined as ninety (90) or more consecutive calendar days.

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

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

Transition setup services are available to individuals up to 180 consecutive calendar days in advance of the transition date and are to be billed after an individual transitions into the community and is enrolled in the CCW program.

Transition setup services are to be furnished only to the extent they are reasonable and necessary as determined through the service plan development process. The service plan must clearly identify the need for the service by identifying that the person is unable to meet such an expense and the service cannot be obtained through other sources.

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

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

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

Community transition services are to be furnished only to the extent they are reasonable and necessary as determined through the service plan development process. The service plan must clearly identify the need for the service by identifying that the person is unable to meet such an expense and the service cannot be obtained through other sources.

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

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

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Setup

Provider Category:

Agency

Provider Type:

Case Management Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Wyoming Department of Health, Division of Healthcare Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under 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):

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

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

The screening must confirm that the individual has not been excluded from federally-funded healthcare programs and has not been convicted 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).

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

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

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

DHCF requires a full subsequent background screening every 5 years. Providers must, on a routine basis, ensure that employees are not included on the OIG List of Excluded Individuals/Entities. Additionally, the FMS must, on a routine basis, ensure that employers of record and participant-directed employees are not included on the OIG List of Excluded Individuals/Entities.

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):

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

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

- Adult Day Services
- Assisted Living Facility Services
- Case Management
- Home Health Aide
- Homemaker
- Personal Support Services
- Respite
- Skilled Nursing
- Transition Intensive Case Management
- Companion Services

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

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

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

Appendix C: Participant Services

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

Note: Required information from this page 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.*

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.*

A relative or spouse of a participant may be reimbursed for Personal Support Services, Adult Day Services, Respite, and Non-Medical Transportation delivered under the participant-directed service delivery option. The relative or spouse must meet all qualifications specified in Appendix C1/C3 and may not be a legal guardian or designated employer of record for the participant. A participant's spouse can be hired as an employee if there is evidence that demonstrates the spouse is not authorized to make financial decisions on behalf of the participant.

In accordance with the provisions of the 21st Century Cures Act, Electronic Visit Verification (EVV) is required for personal support services to ensure payments are made only for services rendered. The employee and participant/designated employer of record must sign an attestation affirming the veracity of the information included on the timesheet and that the timesheet is an accurate representation of services rendered. Misrepresentation or false statements may result in disciplinary actions up to or including involuntary termination from the participant-directed service delivery option and criminal prosecution.

Services are provided in accordance with the plan of care and receive prior authorization. EVV captures all log in and log out times for services provided during the time when services are provided.

Safeguards for participant direction follow the same safeguards outlined in appendix E. The participants case manager is required to do monthly checks to ensure the health and safety of the participant.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

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

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.**

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

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

Responsible Party for data	**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:
C.a1.1 Number and Percent of providers that initially met licensing and/or certification standards prior to delivering services. Numerator: Number of providers that initially met licensing and/or certification standards prior to delivering services. Denominator: Total number of providers that require a licensure and/or certification.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

All Community Choices 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, Companion Services, Homemaker, Personal Support Services, Home Health Aide, Skilled Nursing, and Assisted Living Facility Services.

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 person-centered plan of care. 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 Community Choices 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 Community Choices Waiver program.

Case managers review participant satisfaction each month, and conduct service observations along with monthly in-person meetings to ensure services are delivered in alignment with the participant's person-centered plan of care, are non-institutional in nature, and are consistent with the requirements and objectives of the HCBS Settings Rule. Monthly monitoring and in-person visits include both provider owned or controlled settings as well as those individually owned where services are provided. 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 34 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 person-centered plan of care, 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).***