Health, Department of

Medicaid

Chapter 45: Waiver Provider Certification and Sanctions

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CHAPTER 45

DD WAIVER PROVIDER STANDARDS, CERTIFICATION AND SANCTIONS

Section 1. **Authority.**

This Chapter is promulgated by the Department of Health pursuant to Wyo. Stat. Ann. § 9-2-102, the Medical Assistance and Services Act at Wyo. Stat. Ann. §§ 42-4-104 through -120, 2013 Wyo. Sess. Laws 322-25, and the Wyoming Administrative Procedure Act at Wyo. Stat. Ann. §§ 16-3-101 through -115.

Section 2. Purpose and Applicability.

(a) This Chapter was adopted to govern certification of providers under the Wyoming Medicaid Supports Waiver, Comprehensive Waiver, and Acquired Brain Injury Waiver (herein collectively referred to as the "DD Waivers").

(b) This Chapter, in addition to Medicaid Chapters 43. 44 and 46, shall govern services and provider requirements of the DD Waivers.

(c) The Behavioral Health Division, hereafter referred to as the "Division," may issue Provider Manuals, Provider Bulletins, or both, to providers or other affected parties to interpret the provisions of this Chapter. Such Provider Manuals and Provider Bulletins shall be consistent with and reflect the rule provision's policies, as revised in this Chapter. The provisions contained in Provider Manuals or Provider Bulletins shall be subordinate to the provisions of this Chapter.

Section 3. General Provisions.

(a) Terminology. Unless otherwise specified or as defined in Chapter 1, the terminology used in this Chapter is the standard terminology and has the standard meaning used in accounting, health care, Medicaid, and Medicare.

(b) Definitions.

(i) "Case Manager" means an individual who provides case management services as defined in Chapter 45, Section 9.

(ii) "Elopement" means the unexpected or unauthorized absence of a participant for more than is approved in the participant's plan of care when that person is receiving waiver services, or the unexpected or unauthorized absence of any duration of a participant whose absence constitutes an immediate danger to themselves or others. This could be an unexpected participant action which may not be intentional and may be due to wandering that is secondary to dementia.

(iii) "Relative" means a participant's biological or adoptive parent(s) or stepparent(s).

(c) Incorporation by reference:

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

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

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

(C) The incorporated code, standard, rule, or regulation is maintained at 6101 Yellowstone Road, Suite 220, Cheyenne, Wyoming 82002 and is available for public inspection and copying at cost at the same location.

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

(A) CMS regulations implementing Title XIX of the Social Security Act. 42 C.F.R. Part 441, Subpart G, found at http://www.ecfr.gov/cgi-bin/text-idx?SID=3a781748bb6036d683e5e774a9df97dl&mc=true&node=sp42.4.441.g&rgn=div6.

(B) Wyoming's Medicaid State Plan found at http://www.health.wyo.gov/healthcarefin/medicaid/spa/.

(C) Wyoming's CMS Comprehensive, Supports, and Acquired Brain Injury Waiver Applications, effective July 1, 2016, found at https://health.wyo.gov/behavioralhealth/dd/waivers/.

Section 4. Rights of Participants Receiving Services.

(a) Each participant receiving services has the same legal rights and responsibilities guaranteed to all other U.S. citizens under the United States and Wyoming constitutions and federal and state laws.

(b) Participant rights may not be modified or suspended except in accordance with state or federal law.

(c) The participant, the participant's legally authorized representative(s), the participant's case manager, and the Division shall be informed in writing of the grounds for the denial or limitation of a right so they may advocate for the participant. Such notice shall include a statement that the participant may choose an alternative provider, if the participant or legally authorized representative disagrees with the denial or limitation. If the Division denies a restriction in a plan of care, this decision will apply to any provider offering services to the participant. Rights restrictions shall constitute a material change to the plan of care, requiring pre-approval by the Division. The following participant rights may not be denied or limited, except for the purpose of

an identified health or safety need, which must be included in the participant's individualized plan of care:

(i) The right to privacy, dignity, and respect;

(ii) The right to freedom from coercion or restraint;

(iii) Privacy in their sleeping or living quarters;

(iv) Sleeping and living quarters have entrance doors lockable by the individual, with only appropriate staff having keys to doors;

(v) Individuals sharing quarters have a choice of roommates in that setting;

(vi) Freedom to furnish and decorate their sleeping or living quarters within the lease or other agreement;

(vii) Freedom and support to control their own schedules and activities;

(viii) Freedom and support to have access to food at any time;

(ix) The ability to have visitors of their choosing at any time;

(x) The ability to communicate with people of their choosing;

(xi) Access to their personal possessions and property;

(xii) Control over how they spend their personal resources;

(xiii) All settings must be physically accessible to the individual;

(xiv) The right to make and receive telephone calls. No person may limit a participant's right to make calls to Protection & Advocacy, or state and federal oversight or protection agencies as protected by 42 U.S.C. 10841(1)(M), such as the Division or Department of Family Services;

(d) A participant's right to be free from physical, mechanical, and chemical restraints may not be denied or limited unless a court, the participant, or the participant's legally authorized representative authorizes the denial or limitation in writing, accompanied by the written order of a physician or other licensed medical professional who prescribes medication. Such denial or limitation shall be included in the participant's plan of care, which must address how other less restrictive interventions will be used prior to a restraint, and detail the manner in which a restraint may be used pursuant to Section 18. The authorizing document shall be made part of the participant's individual plan of care.

(e) Procedural requirements regarding rights. A provider that provides direct services shall have and implement policies and procedures that ensure:

(i) Except as identified in this section, participants have the opportunity to maximize their rights and responsibilities;

(ii) All participants have the right to refuse services and may not be disciplined or charged with a monetary fee for refusing Home and Community Based Waiver services;

(iii) Each participant served, parent of a minor, or legally authorized representative(s) is informed of the participant's rights and responsibilities;

(A) The information must be given at the time of entry to direct care and case management services, annually thereafter, and when significant changes occur; and

(B) The information must be provided in a manner that is easily understood, given verbally and in writing, in the native language of the participant or legally authorized representative(s), or through other modes of communication necessary for understanding.

(iv) Participants receiving services from the provider are supported in exercising their rights;

(v) Rights may not be treated as privileges or things that should be earned; and

(vi) Retaliation against participants' services and supports due to the participant, family members, or legal representatives advocating on behalf of the participant, is prohibited. This includes initiating a complaint with outside agencies.

(f) Providers may not request or require participants to waive or limit their rights as a condition of receiving service.

(g) Providers may not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual who exercises any right established by, or for participation in any process provided in, these rules or the Wyoming Medical Assistance and Services Act.

(h) When rights restrictions are deemed necessary, the individual plan of care shall include a rights restriction protocol that must include the following:

(i) The reasons for the rights restriction(s), including the legal document, court order, or guardianship papers, or medical order, that allows a person other than the participant to authorize a restriction to be imposed.

(ii) For any rights restriction imposed, the following items must be addressed and documented in the individual plan of care as follows:

(A) Identify the specific and individualized assessed need;

(B) Document the positive interventions and supports used prior to any modifications to the person-centered service plan;

(C) Document less intrusive methods of meeting the need that have been tried but did not work;

(D) Include a clear description of the condition that is directly proportionate to the specific assessed need;

(E) Include regular collection and review of data to measure the ongoing effectiveness of the modification;

(F) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;

(G) Include the informed consent of the individual; and

(H) Include an assurance that interventions and supports will cause no harm to the individual.

(iii) In addition to the items mentioned above, a rights restriction must have a restoration plan that addresses the following:

(A) Minimize the effect of the restriction;

(B) Assist the participant with exercising their rights more fully;

(C) Ensure that a participants rights are not completely removed;

(D) Identify what part of the right is restricted;

(E) Set goals for restoration of rights (participant training); and

(F) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

Section 5. Provider Qualifications for Each Waiver Service.

(a) All individual waiver providers and provider employees shall complete and maintain the following requirements unless otherwise specified in this section:

(i) Be eighteen (18) years or older; and

(ii) Maintain current CPR and First Aid Certification, which includes hands-on training from a trainer certified with a curriculum consistent with training standards set forth by the American Heart Association or the American Red Cross.

(b) A provider shall also meet the following specific requirements for the service in which they want to receive and maintain certification:

(i) Adult Day Services. A provider of Adult Day Services shall be either:

(A) Certified to provide Adult Day Services; or

(B) An agency licensed as an Adult Day Care as provided by the Wyoming Department of Health, Office of Healthcare Licensing and Surveys, and certified as a waiver provider with the Division.

(ii) Behavioral Support Services. A provider of Behavioral Support Services shall have either:

(A) A Master's Degree and be a Board Certified Behavior Analyst, or

(B) A current license to practice from the Wyoming Board of Psychology.

(iii) Case Management.

(A) After the effective date of this rule, all providers of case management services must have one (1) of the following:

(I) A Master's degree from an accredited college or university in one (1) of the following related human service fields:

(1.) Counseling;

(2.) Education;

(3.) Gerontology;

(4.) Human Services;

(5.) Nursing;

(6.) Psychology;

(7.) Rehabilitation;

(8.) Social Work;

(9.) Sociology; or

(10.) A related degree, as approved by the Division.

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

(III) An Associate's degree in a related field from an accredited college, and four (4) years of work experience as a case manager or in a related human services field;

(B) A case manager employed by an agency or certified prior to the effective date of this rule may continue to provide case management services, without meeting the criteria in subsection (b)(iii)(A), as long as the case manager demonstrates reasonable and ongoing efforts to obtain the required qualifications during a transition period that expires on June 30, 2017.

(I) The Division shall accept 60 credit hours with at least 24 credit hours in a related field, and five (5) years of work experience as a case manager on any of the Wyoming waivers as an exception for not meeting the required education requirements in (b)(iii)(A) of this section.

(II) Persons seeking to qualify as a case manager under this section shall obtain the additional education requirements prior to June 30, 2017.

(III) The Division shall terminate the certification of a case manager who fails to obtain the required education.

(C) A case manager shall obtain and maintain his or her own National Provider Identifier (NPI) number for case management services through the Medicaid enrollment process.

(D) A case manager shall obtain and provide evidence of eight (8) hours of continued education relating to the delivery of case management services during each year of certification.

(E) A provider agency certified to provide case management services shall:

(I) Have policies and procedures for backup case management for each person's caseload, which include a process for notification of when the backup case manager should be the primary contact. Case managers must meet with their designated backup to review all participant cases on a quarterly basis. The review must be documented in case notes.

(II) Document on the plan of care that they have no conflict of interest with the participant or family.

(III) Meet the following conflict free requirements:

(1.) The case management agency and any managing employee may not own, operate, be employed by, or have a financial interest in or financial relationship with any other person or entity providing services to a participant;

(2.) The case management agency may be certified in other waiver services, but shall not provide case management services to any participant to whom they are providing any other waiver services, including self-directed services;

(3.) The owner, operator, or managing employee of a case management agency may not be related by blood or marriage to the owner, operator, or managing employee of any other waiver service provider on the participant's plan of care;

(4.) Any employee of a guardianship agency may not provide case management to any participant who is receiving any services from the guardianship agency; and

(5.) The case management agency may not:

a. Employ case managers that are related to the participant, the participant's guardian, or a legal representative served by the agency. If the case management agency is a sole proprietor, the case manager may not be related to the participant, the participant's guardian, or a legal representative served by the agency;

b. Make financial or health-related decisions on behalf of the participant receiving services from that agency, including but not limited to a guardian, representative payee, power of attorney, or conservator; or

c. Provide case management services to, or live in the same residence of, any provider on a participant's plan in which they provide case management service.

(IV) If a rural area of the State does not have a case manager without a conflict of interest for a participant, the participant or legally authorized representative may request to have a case manager with a conflict. If the Division confirms that there are no other case managers available in the region or a nearby region to provide case management, then the conflicted case manager may be approved on an annual basis.

(1.) A third party entity without a conflict shall be involved in the participant's team to mediate, advocate for the participant as needed, and address unresolved grievances for any conflicts that are approved.

(2.) This approval shall be subject to notice to and approval by the Centers for Medicare and Medicaid Services.

(V) All case managers shall notify the provider of a participant or guardian's decision to discontinue services within three (3) business days.

(iv) Child Habilitation. A Child Habilitation provider, if operating a day care

while also providing child habilitation services, shall follow the Department of Family Services licensing rules in addition to meeting the Medicaid waiver provider rules.

(v) Cognitive Retraining. A Cognitive Retraining provider shall:

(A) Be certified in Cognitive Retraining from an accredited institution of higher learning;

(B) Be a certified Brain Injury Specialist through the Brain Injury Association of America; or

(C) Be a licensed professional with one year of acquired brain injury training or Bachelor's degree in related field and three (3) years of experience in working with acquired brain injuries.

(vi) Dietician. A Dietician provider or provider staff shall have a license to provide dietician services by the Wyoming Dietetics Board and a National Provider Identifier (NPI).

(vii) Environmental Modification. Environmental Modification providers shall have all applicable building, construction, and engineer license and certifications that may be required to work as a contractor in the location where services will be provided. Employees do not have to be certified in CPR or First aid, complete a background check, or have participant specific training. The provider must report critical incidents as defined in Section 20.

(viii) Employment Discovery and Customization. Within one (1) year of becoming certified in employment services, the Employment Discovery and Customization provider shall have one (1) employee certified in a Division approved supported employment curriculum for every ten (10) participants served.

(ix) Independent Support Broker. An Independent Support Broker shall complete a required training and pass a competency based test from the Division prior to providing the service and have either:

(A) One (1) year of experience in the field of ID/DD or ABI and a Bachelor's degree, Master's degree or Doctoral degree, or

(B) Two (2) years or 48 credit hours of college and two (2) years of experience.

(x) Individual Habilitation Training. Within one (1) year of being certified in this service, and annually thereafter, the provider or staff providing the service shall successfully complete at least eight (8) hours of continued education in any of the following areas: specific disabilities or diagnosed conditions relating to the population served, writing measurable objectives, gathering and using data to develop better training programs, or training modules posted by the Division.

(xi) Homemaker. A provider of Homemaker services must be at least eighteen (18) years old but does not have to be certified in CPR and First Aid.

(xii) Occupational Therapy. An Occupational Therapy provider or provider staff shall have a current license to practice occupational therapy by the Wyoming Board of Occupational Therapy and a National Provider Identifier (NPI).

(xiii) Physical Therapy. A Physical Therapy provider or provider staff shall have a current license to practice physical therapy by the Wyoming Board of Physical Therapy and a National Provider Identifier (NPI).

(xiv) Prevocational. Within one (1) year of certification in prevocational services, a provider shall have one (1) staff person in this service setting certified in a nationally recognized supported employment curriculum and demonstrate that a portion of their time each month is spent training other direct care staff on exploring employment interests, working on job readiness skills, or other employment-related activities with participants.

(xv) Skilled Nursing. A skilled nursing provider or provider staff shall be licensed to practice nursing by the Wyoming Board of Nursing, and have a current National Provider Identifier.

(xvi) Special Family Habilitation Home. A Special Family Habilitation Home provider shall be at least 21 years of age.

(xvii) Specialized Equipment. A Specialized Equipment provider shall have the applicable license or certification for the type of equipment purchased, and does not have to be certified in CPR or First Aid.

(xviii) Speech, Hearing, and Language Services. A Speech, Hearing, and Language Service provider or provider staff shall have a current license to practice Speech, Hearing and Language Services by the Wyoming Board of Speech Pathology and Audiology.

(xix) Supported Employment and Supported Employment Follow Along. A Supported Employment provider shall, within one (1) year of becoming certified in employment services, have one (1) employee that is certified in a nationally recognized supported employment curriculum for every ten (10) participants served in this service.

(xx) Transportation. A Transportation provider shall have a current, valid driver's license; automobile insurance; and additional liability insurance for transporting people for business purposes.

Section 6. Standards for all Providers.

(a) Consistent with the provisions of this chapter, providers shall:

(i) Protect participants from abuse, neglect, mistreatment, intimidation, and exploitation;

(ii) Treat participants with consideration, respect, and dignity;

(iii) Honor participants' preferences, interests, and goals;

(iv) Provide participants with daily opportunities to make choices and participate in decision making;

(v) Provide and access activities that are meaningful and functional for each participant;

(vi) Direct services toward maximizing the growth and development of each participant for maximum community participation and citizenship;

(vii) Provide services in the most appropriate, least restrictive, most integrated environment;

(viii) Encourage participants to express their wishes, desires, and needs;

(ix) Protect and promote the health, safety, and well-being of each participant;

(x) Design services to meet the needs of all participants served by their agency; and

(xi) Establish and implement written policies and procedures that are:

(A) Available to staff, participants, and the general public;

(B) Updated or revised as needed by rule or policy changes;

(C) Reviewed at least annually with employees; and

(D) Describe the provider's operation and how systems are set up to meet participants' needs.

(b) Providers shall establish and implement a quality assurance process for ongoing proactive internal review of the quality and individualization of services. Participants served and their families shall be involved in the quality assurance process.

(c) Before providing services to a participant, the provider shall gather and review referral information regarding the participant so, to the greatest extent possible, the provider is aware of the participant's preferences, strengths, and needs. The provider shall use this information to:

(i) Make a determination as to whether their agency is capable of providing services to meet the participant's needs;

(ii) Consider the safety of all participants who the provider serves in the decision to accept new participants to service or the location for the services; and

(iii) Consider whether the provider has the capacity, commitment, and resources necessary to provide supports to the participant served.

(iv) The provider may not serve a participant if the provider cannot reasonably assure the participant, legally authorized representative, and case manager that it has the ability to meet the participant's needs.

(d) The provider shall orient, train, and manage staff with the skills necessary to meet the needs of participants in their services, and be able to respond to emergencies.

(e) The provider shall facilitate opportunities for all participants to receive services consistent with the needs and preferences of the participant.

(f) The provider shall develop a process for detecting and preventing abuse, neglect, exploitation, and intimidation, and handling allegations of abuse, neglect, exploitation and intimidation in accordance with state and federal statutes and rules.

(g) The provider shall, at all times, maintain documentation to demonstrate sufficient staff provide services, supports, and supervision to meet the needs of each participant per the participant's plan of care.

(h) The provider shall implement reasonable and appropriate policies and procedures to comply with the standards, specifications, and requirements of this chapter. Compliance with this provision does not permit or excuse a violation of any standard, specification, or requirement of this chapter. A provider may change its policies or procedures at any time, provided that the changes are documented, implemented, and maintained in accordance with the standards, specifications, and requirements of these rules.

Section 7. Provider Recordkeeping and Data Collection.

(a) The provider shall collect and maintain data, records, and information as necessary to provide services.

(b) The provider shall develop and maintain a record keeping system that includes a separate record for each participant served.

(c) The provider shall develop and implement a systematic organization of records to ensure permanency, accuracy, completeness, and easy retrieval of information.

(d) The provider shall develop a process relating to retention, safe storage, and safe destruction of the participant's records to ensure retention of necessary information and to protect confidentiality of records. The provider shall retain all records relating to the participant and the

provision of services for at least six (6) years after the end of the fiscal year during which services were provided.

(e) If there are changes in ownership of the provider agency, complete and accurate copies of all participant records must be transferred to the participant's newly chosen provider. Before dissolution of any provider agency, the provider shall follow Medicaid disenrollment procedures and notify the Division in writing of the location and secure storage of any remaining participant records.

(f) The provider shall establish and implement policies that govern access to, duplication, dissemination, and release of information from the participant's record, which are consistent with applicable state and federal laws.

(g) Except as otherwise provided by law, the provider shall obtain a written authorization from the participant or the participant's legally authorized representative for the release of participant information that identifies or can readily be associated with the identity of a participant. The authorization must comply with the requirements for hospital records identified in Wyo. Stat. Ann. § 35-2-607.

(h) Providers shall make all records maintained or controlled by the provider available upon request to the Division Staff, representatives from the State or Federal Medicaid programs, or the Medicaid Fraud Control Unit, without prior written authorization, consent, or other form of release.

(i) The provider shall specify the method and frequency for obtaining authorizations for medical treatment and consents.

(j) The provider shall ensure that all record entries are dated, legible, and clearly identify the person making the entry.

Section 8. Documentation Standards.

(a) In addition to the requirements of Chapter 3, Provider Participation, of the Wyoming Medicaid Rules, the following provisions shall apply to the documentation of services, medical and financial records, including information regarding dates of services, diagnoses, services furnished, and claims affected by this Chapter.

(b) A provider shall complete all required documentation, including the required signatures, before or at the time the provider submits a claim.

(i) Documentation prepared or completed after the submission of a claim is prohibited. The Department shall deem the documentation to be insufficient to substantiate the claim and Medicaid funds shall be withheld or recovered.

(ii) Documentation may not be altered in any way once billing is submitted unless the participant or legally authorized representative requests an amendment to the

documentation in accordance with the patient privacy rules in the Health Insurance Portability and Accountability Act of 1996.

(c) A provider shall document services either electronically or in writing.

(d) Electronic documentation shall capture all data required by subsection (e) and include electronic signatures and automatic date stamps pursuant to Wyo. Stat. Ann. § 40-21-107, and must have automated tracking of all attempts to alter or delete information that was previously entered.

(i) Electronic records may not be altered or deleted prior to submission of payment unless incorrect, and the purpose of the correction must be captured in the electronic documentation system.

(ii) If anyone other than the employee who provided the service completes electronic documentation for the purpose of claims submission, the provider of the service shall separately maintain all written or electronic service documentation to support the claim.

(iii) A provider must make a participant's electronic case file, specific to the case manager's caseload, available to a case manager in the electronic record, such as Therap, in order to comply with the required documentation reviews and service unit utilization specified in this Chapter.

(iv) Case management monthly documentation in the electronic Medicaid waiver system, once signed as final and submitted to the Division in the web portal, meets the requirements for an electronic signature and date stamp. These records cannot be altered once the case manager bills for the service provided.

(e) For written documentation, each physical page of documentation must include:

(i) Full legal name of participant;

(ii) Individualized plan of care start date for participant;

(iii) Physical address of the location of services;

(iv) Date of service, including year, month, and day;

(v) Type of service provided and the service name, type, and billing code of service provided;

(vi) Time services begin, and time services end using either AM and PM or military time and documenting per calendar day, even when services are provided over a period longer than one calendar day;

(vii) Printed name of person performing the service;

(viii) At least one legible signature of each person performing a service, and the date of signature. Initials may subsequently be used on any page that bears the staff person's full signature;

(ix) A detailed description of services provided and:

(A) Consist of a personalized list of tasks or activities that describe a typical day, week, or month for a participant, in which the participant and guardian has provided input.

(B) Include specific objectives for habilitation services, support needs, health and safety needs, and approximate number of hours in service.

(f) Documentation for different services must be on separate forms, and must clearly be separated by time in and out, service name, documentation of services provided, signature of staff providing services, and printed name of staff providing the service.

(g) A provider organization may not bill for the provision of more than one direct service for the same participant at the same time unless the participant's approved individualized plan of care identifies the need for more than one (1) direct service to be provided at the same time.

(h) A provider may not round up total service time to the next unit, except as outlined in Chapter 46, Section 7(xxv) – Skilled Nursing.

(i) Documentation of services must be legible, retrieved easily upon request, complete, and unaltered. If hand written, documentation must be completed in permanent ink.

(j) Services must meet the service definitions in these rules and be provided pursuant to a participant's individualized plan of care.

(k) For all direct care waiver services, the participant shall be in attendance in the service in order for the provider to bill for services.

(l) The provider shall make service documentation and unit billing information for services rendered available to the case manager each month by the tenth (10th) business day of the month following the date that the services were rendered so the case manager can monitor budget utilization. If services are not delivered during a month, the provider shall report the zero units used to the case manager by the tenth (10th) business day of the following month.

(i) Failure to make documentation available by the tenth (10th) business day of the month may result in a corrective action plan or sanctioning.

(ii) The case manager shall give written notification of noncompliance to the provider with a copy submitted to the Behavioral Health Division. Chronic failure to make documentation available may result in provider sanctions.

Section 9. Case Management Services.

(a) Case management is a mandatory service to all participants enrolled on the waivers.

(b) Case Managers shall complete all eligibility paperwork within 30 calendar days.

(c) A case manager shall use person-centered planning to understand the needs, preferences, goals, and desired accomplishments of the participant. The case manager shall coordinate and assist the participant in accessing all resources, such as natural, paid, and community support available and needed. The case manager shall develop and monitor the implementation of an individualized plan of care.

(d) It is the case manager's responsibility to maintain the current physical and mailing addresses of the participant's and legally authorized representative(s) at all times, and update the Division and other providers as there are changes.

(e) The case manager shall maintain a participant's file and service documentation:

(i) The case manager shall assure information is disseminated to and received by the participant and appropriate parties involved in the participant's care or as authorized by a signed release of information by the participant or the participant's legally authorized representative(s);

(ii) The case manager shall arrange and coordinate eligibility for applicants, or waiver participants, by providing:

(A) Targeted case management services to an applicant who is in the eligibility process for waiver services or awaiting a funding opportunity; and

(B) Services that include the coordination and gathering of information needed for initial and annual certification, clinical and financial eligibility, and the level of care determination.

(iii) Provide the participant and any legally authorized representative(s) with a list of all providers available in their community in order to allow the participant a choice of providers. To the extent that they are available, participant choice shall include any certified waiver provider, self-directed options, Medicaid state plan services, services offered by other state agencies, as well as community and natural supports.

(A) At least once every six (6) months, the case manager shall provide information to the participant or the legally authorized representative(s) on all available waiver services, including self-direction service delivery options. This may be done more frequently as requested by the participant or legally authorized representative(s).

(B) The case manager shall coordinate transition plans when the participant chooses to change, stop, or add providers to his or her plan of care, or exit the waiver.

(C) If the case manager chooses to discontinue providing services, the case manager shall give thirty (30) days written notice of the change to the participant or legally

authorized representative(s), and to the Division. The case manager shall continue to provide case management services for the thirty (30) days or until a new case manager is approved, whichever is first.

(iv) The case manager shall involve and assist the participant's identified team members with developing a person-centered plan of care in accordance with this Chapter. The case manager shall assist the team with planning, budgeting, and prioritizing services for the participant using all available resources and the assigned individual budget amount.

(v) The case manager shall complete and submit the individualized plan of care, including all required components, for Division approval in the electronic Medicaid waiver system, or its successor, at least thirty (30) days before the intended plan start date.

(vi) If the participant chooses to self-direct services on the waiver, the case manager shall assist the participant in finding a support broker when applicable, modifying the plan of care as needed, and monitoring the services of the Financial Management Service utilized by the participant to self-direct in accordance with the approved waiver.

(vii) The case manager shall ensure all providers on the participant's plan of care sign off on the plan, receive a copy of the plan, receive team meeting notes, and complete participant specific training as required in Section 15(h) of this Chapter.

(viii) The case manager shall monitor and evaluate the implementation of the participant's individualized plan of care including a review of the type, scope, frequency, duration, and effectiveness of services, and the participant's satisfaction with the supports and services on a quarterly basis in the report provided by the Division. After the evaluation, the case manager shall:

(A) Report to the provider any concerns with provider implementation of the individualized plan of care or concerns with the health and safety of a participant. Significant concerns shall be reported to the Division through the incident reporting or complaint processes;

(B) Send the Division and the provider or employer of record written notification of noncompliance with these rules, the health, safety or rights of the participant specified in the plan of care, or when documentation is not received by the tenth (10th) business day of the following month after services were provided;

(C) Securely store and retain all confidential provider documentation received from other providers for a participant's services for a twelve (12) month period from the month services were rendered, even if the participant changes case managers; and

(D) Document all monitoring and evaluation activities, follow-up on concerns and actions completed, and make appropriate changes to the plan of care with team involvement, as needed.

(f) A case manager shall be the second-line monitor for participants receiving medications. Second-line monitoring is conducted to help ensure a participant's medical needs are addressed and medication regimens are delivered in a manner that promotes the health, safety, and well-being of the participant.

(i) The case manager shall provide monitoring and oversight of the delivery of the participant's medication through monthly review of medication assistance records and timely review of medication error reports.

(ii) The case manager shall provide monitoring and oversight of the usage of the participant's over-the-counter and prescription medications through monthly review of medication assistance records and PRN medication usage records.

(iii) The case manager shall provide monitoring and oversight of the usage of the participant's psychotropic medications through monthly review of medication assistance records and PRN medication usage records, and timely review of incident reports. PRN psychotropic medication usage shall be validated by review of related documentation to verify the positive behavior support plan's non-pharmacological interventions were attempted prior to medication administration and medications were utilized as a last resort measure only.

(iv) The case manager shall provide monitoring and oversight of the participant's medical needs through ensuring appropriate and timely communication between provider and health care professionals as identified by need.

(g) The Division may establish caseload limits to ensure the case manager effectively coordinates services with all participants on his or her caseload.

Section 10. Individualized Plan of Care.

(a) A participant's case manager shall convene a participant's plan of care team to develop an individualized plan of care for each participant on his or her caseload, and base the plan on the results of the comprehensive assessment(s) and the person-centered planning process. The team shall include persons who are knowledgeable about the participant, and are qualified to assist in developing an individualized plan of care for that person, including: the participant; any legally authorized representative(s); the case manager; providers chosen by the participant; and any other advocate, family member, or entity chosen by the participant or the participant's legally authorized representative(s).

(b) The plan of care meeting must be timely and occur at times and locations that are convenient for the participant.

(c) The plan of care cannot exceed twelve (12) months and must be developed in accordance with state and federal rules, which includes the submission of the complete plan of care to the Division for approval at least 30 days prior to the plan start date. Corrections to the plan of care required by the Division must be submitted by the case manager within seven (7) business days of being issued.

(d) The plan of care must include the provision of or describe the inability to provide:

(i) Necessary information and support to the participant to ensure that the participant directs the process to the maximum extent possible;

(ii) Services in a setting chosen by the participant from all service options available including non-disability specific settings, including alternate settings that were considered;

(iii) Opportunities for the participant to seek employment and work in competitive integrated settings;

(iv) Opportunities for the participant to engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services;

(v) Cultural and religious considerations;

(vi) Services based on the choices made by the participant regarding supports the participant receives and from whom;

(vii) What is important to the participant and for the participant;

(viii) Services, which will be provided in a manner reflecting personal preferences and ensuring health and welfare;

(ix) Services based on the participant's strengths and preferences;

(x) Any rights or freedoms that are restricted, including why the restriction is imposed, how the restriction is imposed, and the plan to restore the right to fullest extent possible;

(xi) Both clinical and support needs;

(xii) Participant's desired outcomes;

(xiii) Risk factors and plans to minimize them;

(xiv) Individualized backup plans and strategies when needed;

(xv) Individuals important in supporting the participant, such as friends, family, professionals, specific staff or providers;

(xvi) Learning objectives for habilitation services that address the training activities, training methods, and the measurement used to gauge learning;

(xvii) Schedules to document each direct care service provided. The purpose of the schedule shall be to provide information about the services and supports needed throughout a participant's day. Schedules shall be personalized and shall:

(A) Reflect the purpose of the services;

(B) Reflect support recommendations from assessments by therapists, physicians, psychologists, and other professionals in a manner that prevents the provision of unnecessary or inappropriate services and supports;

(C) Reflect the participant's desires and goals;

(D) Include all information required by this chapter in Section 8, Documentation standards;

(xviii) Informed consent of the participant in writing; and

(xix) Signatures of all providers listed in the plan of care after the draft plan, as written, is completed by the team including participant's signature for informed consent.

(e) The plan of care shall be reviewed at least semi-annually, when the participant's circumstances or needs change significantly, or at the request of any team member. The plan shall be revised upon reassessment of functional need, as needs arise, and every twelve (12) months for a new plan year.

(f) The individual plan of care must be written in plain language that is understandable to the participant, legal representative(s), and persons serving the participant.

Section 11. Rate Reimbursement Requirements.

(a) Providers shall be reimbursed for services through the Department's cost-based reimbursement system.

(b) Rates paid to providers for waiver services must be less than or equal to the usual and customary rates for similar services in the community.

(i) The Department shall consult with waiver service providers, developmental disability waiver program participants and their families to gather information about reimbursement rates prior to calculating the new reimbursement rates.

(ii) The Department shall follow a competitive bidding process to procure the services of an expert in the development of cost-based waiver program payments to assist with the development of new reimbursement rates for waiver providers.

(iii) The Department shall receive approval from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services prior to the implementation of a new or modified reimbursement rate setting methodology.

(c) Upon request, providers shall submit the following information to the Division:

(i) Cost data;

(ii) Claims data; and

(iii) Participant needs assessment data.

(iv) Providers shall also participate in reasonable audits of the data submitted.

Section 12. THIS SECTION RESERVED FOR FUTURE RULEMAKING

Section 13. Home and Community Based Services Standards for Waiver Services.

(a) All certified waiver providers that provide direct care services to participants in a facility they own or lease must meet all applicable federal and state, city, county, and tribal health and safety code requirements. A facility includes the provider's home, if services are provided in that setting.

(b) All certified waiver providers shall provide services that are home and community-based in nature, which means the service setting:

(i) Assists the participant to achieve success in the setting environment and supports full access to the greater community to the same degree as individuals not receiving Medicaid HCBS;

(ii) Is selected by the individual from options including non-disability specific settings;

(iii) Assists the participant to self-advocate and participate in life-long learning opportunities;

(iv) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;

(v) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices including daily activities, recreational activities, physical environment, and with whom to interact;

(vi) Facilitates individual choice regarding services and supports, and who provides them; and

(vii) Encourages individuals to have visitors of their choosing at any time.

(c) Settings that are not considered home and community-based include, but are not limited to:

(i) A non-residential facility located in an area that does not have established sidewalks, walking paths, or access to the broader community and other businesses where the participants may visit within a safe and reasonable walking distance from the facility;

(ii) Any other facility with characteristics that appear to be institutional in nature, adjacent to an institution, or have the effect of isolating the participants from the community; or

(iii) A non-integrated setting designed to provide multiple services on-site to the same participants, including housing, day services, medical, behavioral, therapeutic services, or social and recreational activities.

(iv) New provider owned or operated residential settings serving five (5) or more participants will not be certified.

(v) Provider facilities certified prior to the effective date of this rule may continue to provide services in settings that do not meet this requirement, but must begin transition to home and community-based setting compliance by June 2018. Providers that don't start the transition process in good faith by June, 2018 may be decertified.

(d) Provider facility inspections.

(i) For each location where services are provided to a participant, except the participant's own home, the provider shall receive a facility inspection by an outside entity at least once every thirty six (36) months. The Division may require more frequent inspections if the Division suspects that the provider or employee's facility would not pass the inspection.

(ii) The facility inspection must be completed by one or more of the following outside entities:

(A) A fire marshal or designee, or

(B) A certified or licensed home or building inspector, or

(C) Other appropriate contractor inspecting a part of the facility within the scope of the contractor's license.

(iii) Facility inspections required by this section must include verification that:

(A) All areas are free of fire and safety hazards, including, but not limited to, all living and service areas, as well as the garage, attic, and basement areas; and

(B) The facility is free of any other significant health or safety concerns, including structural concerns, wiring problems, plumbing problems, and any major system concerns.

(iv) Facility inspections must include a written report that describes the items checked and recommendations to address areas of deficiencies.

(v) If the facility inspection identifies deficiencies, the provider shall remediate deficiencies within thirty (30) calendar days. If deficiencies cannot be corrected within thirty (30) calendar days, a corrective action plan on how deficiencies will be remediated will be submitted to the Division within thirty (30) calendar days of the initial report.

(A) The corrective action plan should address all identified deficiencies and the intended completion dates.

(B) The Division may request additional corrective actions or proof of corrected problems based on the inspector's report.

(C) No services shall be provided in a facility that does not pass the initial inspection until all deficiencies have been corrected.

(vi) External inspections shall be required on all new locations before services are provided in the new location.

(A) The provider shall notify the Division of the new location at least thirty (30) calendar days before the location is to be used to provide services.

(B) The provider shall not provide services in the new location until the Division has reviewed the external inspection report and has verified that all recommendations have been addressed. The Division shall complete an on-site visit within six (6) months.

(vii) Providers that are not required to have a home or facility inspection shall sign a form designated by the Division to verify they are not providing services in any provider-owned or leased facility.

(viii) Providers may not provide services in a facility that is owned or leased by the provider or an employee, which has not had a current inspection completed. The Division may sanction or decertify any provider or self-directed employee when they are subsequently found to be providing services in a facility owned, or leased, by the provider or employee, which has not previously passed inspection.

(e) Self-Inspections. A provider providing services in a facility they own or lease shall complete an annual self-inspection of the facility to verify that the provider is in compliance with this section.

(f) Emergency plans.

(i) Providers shall have written emergency plans and procedures for:

(A) Fires.

(B) Bomb threats.

(C) Natural disasters, including but not limited to earthquakes, blizzards, floods, tornadoes, fires.

(D) Power failures.

(E) Medical/behavioral emergencies/missing person.

(F) Safety during violent or other threatening situations.

(G) Vehicle emergency; and

(H) How the provider is able to care for or provide supervision to both participants and any children under the age of 12 or other individuals requiring support and

supervision.

(I) Providers shall notify the Division in writing within seven (7) calendar days if additional individuals move into the home or have the intent of staying in the home for a period longer than one month pursuant to (H) in this section.

(ii) The emergency plans shall include a contingency plan that assures that there is a continuation of essential services when emergencies occur.

(iii) If the provider is providing 24 hour services, the provider shall document the review of all applicable emergency plans at least once a year on each shift. The documentation shall include:

(A) Written identification of concerns noted during the review of plans.

(B) Written documentation of follow-up to concerns noted during the review of plans.

(C) Review shall not necessarily require actual evacuation, but one actual evacuation shall be required once a year for applicable emergency plans.

(iv) If provider is not providing 24 hour services, the provider shall document the review of all applicable emergency plans during normal working hours at least once a year on each shift. The documentation shall include:

(A) Written identification of concerns noted during the review of plans.

(B) Written documentation of follow-up to concerns noted during the review of plans.

(C) Review does not necessarily require actual evacuation, but one actual evacuation shall be required at least once a year for applicable emergency plans.

(g) Other service standards. All service settings owned or controlled by a provider must meet the following requirements.

(i) In residential service and day service facilities, the provider shall ensure participants have access to food at all times, and provide nutritious meals and snacks options. Providers may not require a regimented meal schedule except as outlined in subsection (m) of this Section.

(ii) Food, whether raw or prepared, if removed from the container or package in which it was originally packaged, must be stored in clean, covered, dated, and labeled containers. Fruit and vegetable produce may remain unmarked unless partially prepared or used.

(iii) All food must be served in a clean and sanitary manner.

(iv) Floors and floor coverings must be maintained in good repair, with the exception of incidental stains natural to the life of the carpet, and may not be visibly soiled, malodorous, or damaged.

(v) The walls, wall coverings, and ceilings must be maintained in good repair and may not be visibly soiled or damaged.

(vi) All doors, windows, and other exits to the outside must be reasonably protected against the entrance of insects and rodents and shall be maintained in good repair.

(vii) All windows must be free of cracks or breaks.

(viii) All chemicals, poisons, or household cleaners must be secured in a manner that prevents the risk of improper use or harm to individuals as outlined in the plan of care.

(ix) All restrooms must contain trash receptacles, towels, hand cleansers, and toilet tissue at all times.

(x) Toilet facilities must be kept clean and sanitary, and maintained in good repair.

(xi) The overall condition of the home or facility must be maintained in a clean, uncluttered, sanitary, and healthful manner that does not impede mobility or jeopardize a participant's health or safety, and allows physical access.

(xii) The use of video monitors by providers in participant bedrooms or bathrooms is prohibited. Other forms of remote monitoring or sensors may be used, where appropriate.

(xiii) A provider facility with a private water supply shall have a bacterial test conducted every three (3) years, and the written results shall be submitted to the Division within thirty (30) days of receiving test results.

(xiv) Providers shall ensure that all participants residing in a provider owned or leased facility have:

(A) A lease or residency agreement for the location in which they are agreeing to reside. The lease or agreement must be signed by the participant or legally authorized representative (if applicable), and the provider. The lease or agreement must allow the same responsibilities and protections from eviction as all tenants under landlord tenant law of the state, county, and city where the facility is located. At no time may a participant be asked to leave their residence on a regular basis to accommodate the provider;

(B) Freedom and support to control their schedules and activities;

(C) Freedom to furnish and decorate their sleeping and living units within the lease or other agreement;

(D) A private bedroom with no more than one (1) person to a bedroom unless a more preferred situation is identified in their plans of care and one of the following criteria is met:

(I) The participant is under two (2) years of age;

(II) The services provided are episodic;

(III) The arrangement is determined medically necessary; or

(IV) The participants request to share a bedroom.

(E) An individual bed, unless the participants are legally related or joint sleeping accommodations are specifically requested by the participant, and specified in the approved plan of care;

(F) Access to appropriate egress and a lockable entrance, which can be unlocked by the participant. No devices may be used that prohibit a participant's entry or exit from the bedroom;

(G) A secure place for personal belongings, which the participant may freely access;

(H) A key or other type of access to a lock for both the housing unit, the participant's bedroom, and any form of locked storage where the participant's personal belongings are kept, with only appropriate staff having keys to doors; and

(I) Other appropriate sleeping quarters as necessary to meet health and safety needs for an emergency placement, as long as the sleeping area allows for personal privacy and immediate egress.

(I) Emergency placement, due to situations defined in Chapter 46, Section 13, shall be limited to one week. A participant may request additional emergency placement on a week-by-week basis if the emergency continues and affirmative steps to secure alternative permanent placement are not successful.

(II) Following emergency placement, the participant must be permitted to transfer to permanent housing. If the provider is no longer able to serve the participant in permanent housing, the case manager will present the participant with options to transition to other certified providers.

(h) The provider may be required to provide written verification of their organization's ability to provide support and supervision to children under the age of twelve (12) or other participants requiring support and supervision who are in the care and responsibility of the provider. This may include, but is not limited to, licensure by the Department of Family Services or other appropriate state agency.

(i) Unless otherwise directed by the participant's physician, nurse practitioner, or

physician assistant, or is otherwise indicated in the individual plan of care, residential providers shall ensure each participant receives a medical evaluation every twelve (12) months.

(j) Each provider shall identify, in writing, the potential conflicts of interest among employees, other service providers on the participant's plan, relatives to participants, or any legally authorized representative(s), and address how a conflict of interest shall be mitigated. The provider shall share this information with any potential participants, and legally authorized representative(s), before the provider is chosen to provide services.

(k) Any provider that is transporting participants shall comply with all applicable federal, state, county, and city laws and requirements, including but not limited to, vehicle and driver licensing and insurance, and shall:

(i) Maintain vehicles in good repair;

(ii) Keep current emergency information on each participant in the vehicle or demonstrate how emergency information is quickly accessible each time a participant is transported. If emergency information is kept in the vehicle, the provider shall develop and implement policies to protect the confidentiality and security of participant's health information;

(iii) Keep and replenish first aid supplies in the vehicle; and

(iv) Conduct quarterly self-inspections or have the vehicle inspected by a mechanic to ensure that the vehicle is operational, safe, and in good repair.

(l) Each provider certified to provide employment services, including supported employment and group supported employment services, shall ensure that:

(i) The participant is involved in making informed employment related decisions;

(ii) The participant is linked to services and community resources that enable them to achieve their employment objectives;

(iii) The participant is given information on local job opportunities; and

(iv) The participant's satisfaction with employment services is assessed on a regular basis.

(m) Settings that include any modification to a participant's right to food or a non-regimented meal schedule imposed by a provider must be ordered by the participant's attending medical professional with evidence in the plan of care that details the assessed need for the order and the protocols that must be followed.

(n) Settings that include any restriction to a participant's right to visitors, communication, privacy or other standard in this Section may only be restricted as documented in an approved plan of care with the restriction being time-limited and following the requirements listed in Sections 4 and 18 of this Chapter.

Section 14. Background Check Requirements.

(a) All persons providing waiver services including: managers, supervisors, direct care staff, participant employees hired through self-direction, and any other person who may have unsupervised access to participants shall complete and pass a background screening as referenced in this section. Persons who do not successfully pass a background screening may not supervise, provide, or bill for waiver services, or otherwise have unsupervised access to participants on behalf of a provider.

(b) Certified providers, their employees, and all legal entities supervising, providing, or billing for waiver services shall also pass and maintain documentation of successful Department of Family Services Central Registry screening and an Office of Inspector General Exclusion Database screening. Entities that do not successfully pass these screenings shall be denied certification or terminated. Screenings must be maintained in the corporate name of the organization or entity, and any trade name(s) used in this State.

(c) Any person or entity that subsequently fails to pass a renewed background screening may not supervise, provide, or bill for waiver services following a failed background screening.

(d) Any provider or participant who employs an individual or entity to supervise, provide, or bill for waiver services who has not completed all required background checks may be subject to sanctions under these rules.

(e) Providers and self-direction employees must show evidence of current background screenings for all required persons as part of the provider or employee's recertification.

(f) A successful background screening shall include:

(i) A Wyoming Department of Family Services Central Registry Screening, which shows that the individual is not listed on the Central Registry.

(ii) A United States Department of Health and Human Services, Office of Inspector General's Exclusions Database search result, which shows that the individual or entity is not currently excluded.

(iii) A state and national fingerprinted criminal history record check which shows that the individual has not been convicted, plead guilty, no contest to, or does not have a pending deferred prosecution for:

(A) An Offense Against the Person, including:

(I) Homicide (W.S. § 6-2-101 et seq.)

(II) Kidnapping (W.S. § 6-2-201 et seq.)

(III) Sexual assault (W.S. § 6-2-301 et seq.)

(IV) Robbery and blackmail (W.S. § 6-2-401 et seq.), and

(V) Assault and battery (W.S. § 6-2-501 et seq.), or

(VI) Similar laws of any other state or the United States relating to these crimes.

(B) An Offense Against Morals, Decency and Family including:

(I) Bigamy (W.S. § 6-4-401)

(II) Incest (W.S. § 6-4-402)

(III) Abandoning or endangering children (W.S. § 6-4-403)

(IV) Violation of order of protection (W.S. § 6-4-404), and

(V) Endangering children; controlled substances (W.S. § 6-4-405), or

(VI) Similar laws of any other state or the United States relating to these crimes.

(g) No person ages eighteen (18) or older may provide waiver services, or have unsupervised access to a waiver participant, unless the Department of Family Services and Office of Inspector General screenings come back with no findings and the state and national criminal history screenings are in process.

(h) An individual provider staff may provide services to a participant ages 18 or older following a successful Department of Family Services and Office of Inspector General screening while the state and national criminal history screenings are pending.

(i) Persons who do not successfully pass the criminal history screenings listed in subsection (f) may not be left unsupervised in the vicinity of any participant, except as provided by subsection (h).

(j) Notwithstanding subsection (h), staff may not provide any services to participants ages seventeen (17) or younger until all successful background screenings listed in subsection (f) have come back with no findings.

(k) Each individual eighteen (18) years of age or older who is living in a provider's home where services are provided, or staying in the home for a period longer than one (1) month, shall pass a background check as listed in subsection (f). An OIG check is not required.

(i) Waiver participants receiving services in this location are not required to complete a background screening.

(ii) Providers may not employ or permit individuals registered as a sexual offender to stay in the home. This requirement does not apply to waiver participants.

(l) If a criminal history screening does not include a disposition of a charge or if an individual is charged with an offense listed in subsection (f)(iii), the individual may not have any unsupervised access or provide billable services to participants until provider is able to provide proof of a successful background check.

(m) Volunteers and individuals under the age of eighteen (18) shall be under the direct supervision of an adult who has passed a background check. Individuals convicted of a sexual offense are not permitted as volunteers.

(n) Any individual that has had a successful background screening may transfer their background check confirmation form from one provider entity to another as long as they have submitted a signed and notarized release to the receiving provider entity and the background check confirmation form is no more than sixty (60) months old. The background check confirmation form belongs to the individual that was screened and can only be used for the purposes listed in the original request. Each time an individual terminates employment and goes to work for another provider where a gap in employment exists of more than thirty (30) calendar days, a full background check must be completed for the new employer.

(o) Only one (1) provider or employee may be listed on the DFS central release forms and criminal history records requests. The background screening notification may not be altered in any manner, including the crossing out of names or use of whiteout. If altered, the release forms shall be determined as null and voided.

(p) The Division may request a background screening at the Division's expense as part of an investigation.

Section 15. Provider Training Standards.

(a)In addition to the other training standards in this Chapter and the Wyoming Medicaid rules, providers shall ensure that employees, including management staff responsible for providing supports and services to participants, are qualified to provide waiver services by receiving training in the areas specified in this Section prior to working unsupervised with participants in services.

(b) Staff responsible for providing direct services shall receive training under the guidance of an already trained and proficient staff member prior to working alone with participants.

(c)The provider shall maintain documentation that staff are qualified to provide waiver services through evidence of completed trainings, including when it was completed, who provided the training, and how the employee demonstrated understanding. The provider shall ensure that training is performed by persons with expertise in the topic area, who are qualified by education, training, and experience, and maintain complete verification of such.

(d) All persons qualified to provide waiver services through traditional services or self-directed services shall complete training in the following areas within one month of an employee's hire or provider certification date. Providers may choose to develop their own training modules for employees or use Division modules, as long as the provider covers the key elements of each topic specified in the Division module with Division approval. General training topics include:

(i) Participant choice;

(ii) The rights of participants in accordance with state and federal laws, and any rights restrictions for each participant with whom a person works. Providers of only environmental modification services, specialized equipment, or homemaker services are exempt from this training requirement;

(iii) Confidentiality;

(iv) Dignity and respectful interactions with participants;

(v) Preventing, recognizing and reporting abuse, neglect, intimidation, exploitation, and all other categories listed on the Division's Notification of Incident form;

(vi) Responding to injury, illness, and emergencies;

(vii) Billing and documentation of services;

(viii) Releases of information;

(ix) Grievance and complaint procedures for participants, guardians, provider employees, and community members; and

(x) Implementing and documenting participant objectives and progress on objectives.

(e)To verify each provider, provider staff, and self-directed employee meets the qualification standards, evidence of a completed training summary or test of each training topic must be retained in the employer's files, or the Employer of Record's files for self-direction.

(f) One representative from the provider agency shall receive training on the provider recertification process.

(g) Any person who provides a service for which a license, certification, registration, or other credential is required shall hold the current license, certification, registration, or credential in accordance with applicable state laws. The provider shall maintain documentation of the staff credentials.

(h) Participant specific training.

(i) A provider of waiver services must be trained on any specific assistive technology devices, disabilities, diagnoses, or medical or risk conditions as necessary for the

participants served by the provider. This training shall be unique to, and meet the needs of, the participant.

(ii) Each provider, provider staff, and self-directed employee shall receive participant specific training prior to the plan of care start date. Impacted staff shall receive participant specific training prior to changes to the individualized plan of care.

(iii) All case managers shall train one employee from each provider on the plan of care. The provider shall ensure that all other employees of the provider receive plan of care training. The case manager and the participant or any legally authorized representative(s) may request verification of the provider's participant specific training. Training shall occur before the plan of care start date and before each employee provides services.

(i) Documentation of participant specific training and general training must include:

(i) The date of the training;

(ii) The name, signature, and title of the trainer;

(iii) The name and signature of the person receiving the training; and

(iv) A detailed agenda of the training topic(s), including the method of training.

Section 16. THIS SECTION RESERVED FOR FUTURE RULEMAKING

Section 17. Positive Behavior Supports.

(a) Treatment and habilitation services must be designed to maximize the potential of the participant. Services shall be provided in the setting that is the least restrictive of the participant's personal liberty.

(b) Providers must implement positive behavior supports as behavioral intervention prior to the use of any restrictive intervention.

(c) A participant with a challenging behavior identified by the team shall have a current functional behavioral analysis conducted within the last year to learn what the person is trying to communicate through the behavior(s), the function or possible purpose for the behavior(s), to explore antecedents and contributing factors to behaviors, and to review and describe potentially positive behavioral supports and interventions in order to develop a positive behavior support plan.

(i) Challenging behaviors may include actions by the participant that constitute a threat to the person's immediate health and safety, the health and safety of others in the environment, a persistent pattern of behaviors that inhibit the participant's functioning in public places and integration within the community, or uncontrolled symptoms of a physical or mental condition.

(ii) The functional behavioral analysis shall include data compiled regarding all behaviors exhibited and be utilized to develop the positive behavior support plan used by the provider during the provision of waiver services.

(iii) A provider or provider staff knowledgeable of the participant shall complete the functional behavior analysis, which shall include input from the team, participant, and any legally authorized representative(s).

(d) A positive behavior support plan, based upon a current functional behavioral analysis, must be developed for a participant in order for employees working with the person to understand and recognize the communication and behaviors exhibited by the person. The positive behavior support plan must describe agreed upon supports to assist the participant using proven support techniques and non-restrictive interventions. A positive behavior support plan must include the components included on the template provided on the Department's website. At a minimum, a positive behavior support plan must:

(i) Maintain the dignity, respect, and values of the participant;

(ii) Use a person-centered approach with the participant involved in the development of the plan on a level appropriate for that person;

(iii) Minimize the use of restrictive interventions. If restraints are used then the positive behavior support plan has failed, and must be reviewed to possibly add or modify the service environment or behavioral interventions;

(iv) Be specific and easily understood, so direct care employees can implement it appropriately and consistently;

(v) Be approved by verification of a signature by the participant or any legally authorized representative(s) through informed consent;

(A) As part of the informed consent process, education must be given by the provider to the participant and any legally authorized representative(s);

(B) This education must include information about positive behavior supports that may be used and the risks and benefits of any supplemental plan for the use of a restrictive intervention or prescribed psychoactive medication if the positive behavior support plan fails.

(vi) Define the antecedents and the targeted behavior(s) that need to be replaced or reduced;

(vii) List positive behavioral supports that assist the participant in replacing targeted or challenging behaviors with appropriate replacement behaviors;

(viii) Provide protocols for providers and provider employees to recognize emerging targeted behaviors, and determine the appropriate interventions to implement positive behavioral supports;

(ix) Provide protocols, which focus on positive interventions that are deemed least restrictive and most effective, for employees to use when targeted behaviors take place;

(x) Include the protocols, or reference the separate protocol in the plan, for the use of any PRN medication that may be a part of the positive behavior support plan as recommended by the treating medical professional and can be requested by the participant to help manage stress, anxiety, or behaviors. The use of a PRN for this purpose must comply with Section 19(b) of this Chapter;

(xi) Be reviewed every six (6) months by the provider(s) and the case manager to assess the effectiveness of the plan, or more frequently if needed; and

(xii) Include specific guidelines for tracking and analyzing the antecedents related to the occurrence of a targeted behavior, the actual behavior(s) displayed, and the results of positive behavioral interventions.

(e)A provider employee implementing a positive behavior support plan shall receive participant specific training on the positive behavior support plan, and on specific positive de-escalation techniques and interventions before they begin working with the participant.

Section 18. Restrictive Intervention Standards.

(a)Restrictive intervention includes physical, chemical and mechanical restraints, cooling down periods, and community access restrictions as further defined in this section.

(b) Use of restrictive interventions must be chosen and deemed appropriate and effective by the entire plan of care team, confirmed with a signature from the participant, legally authorized representative and all providers involved, and be consistent with subsection (g) of this section.

(c)When the use of positive behavior supports is not effective in modifying or changing a participant's challenging behavior, the participant's plan of care team may implement a restrictive intervention protocol to supplement the positive behavior support plan, subject to the provisions of this section. Participants who need support from providers to accomplish activities of daily living that may have perceived restrictions on privacy or communication do not need a restrictive intervention protocol since other parts of the plan of care will describe the supports needed.

(d) Providers may not use aversive techniques to modify a person's behavior. Aversive techniques include any intervention that causes pain, harm, discomfort, or social humiliation for the purpose of modifying or reducing a behavior.

(e)A provider serving more than five (5) participants with restrictive interventions in their plans are required to have one employee complete training on positive behavior supports through any program approved by the Division. An additional supervisor shall be certified for every ten (10) additional participants with restrictive interventions in their plan.

(f) The plan of care team shall review the participant's plan thoroughly to ensure the plan

of care is not so restrictive that it repeatedly provokes behaviors that lead to the use of restrictive interventions, such as the use of restraints.

(g) When restrictive interventions are deemed necessary, the individual plan of care shall include a restrictive intervention protocol that must include the following:

(i) If a person other than the participant authorizes a restriction to be imposed, the reason for the restriction(s) shall be provided, including the legal document, court order, guardianship papers, or medical orders.

(ii) For any restrictive intervention imposed, the following items must be addressed and documented in the individual plan of care as follows:

(A) Identify the specific and individualized assessed need;

(B) Document the positive interventions and supports used prior to any modifications to the person-centered service plan;

(C) Document less intrusive methods of meeting the need that have been tried but did not work;

(D) Include a clear description of the condition that is directly proportionate to the specific assessed need;

(E) Include regular collection and review of data to measure the ongoing effectiveness of the modification;

(F) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;

(G) Include the informed consent of the individual; and

(H) Include an assurance that interventions and supports will cause no harm to the individual.

(iii) In addition to the items mentioned above, a restriction must have a restoration plan that addresses the following:

(A) Minimize the effect of the restriction;

(B) Assist the participant with exercising their rights more fully;

(C) Ensure that a participant’s rights are not completely removed;

(D) Identify what part of the right is restricted;

(E) Set goals for restoration of rights (participant training); and

(F) Establish time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(h) The case manager shall reconvene the participant's plan of care team if any restrictive interventions are used in the previous calendar quarter. When convened under this section, the team shall review all restrictive interventions for the previous quarter and make plans for reducing the number of restrictions imposed. On a quarterly basis, the case manager shall report data received from the provider concerning the number of restrictions imposed on the participant.

(i) The provider shall notify the case manager within three (3) business days of any use of an emergency restrictive intervention that is not written in a participant's plan of care. A case manager who receives notice of restrictive intervention under this provision shall call a team meeting within two (2) weeks to discuss the incident and decide if the plan of care must be modified to include a crisis intervention protocol and a revised positive behavior support plan.

(j) Restraints employed as a form of restrictive intervention may only be imposed by an individual trained and certified to impose the restriction.

(k) Providers employing restraints as a form of restrictive intervention must:

(i) Adopt policies and procedures that:

(A) Identify the provider's chosen certifying entity consistent with subsection (m);

(B) Specify the types of restraints that may be used by provider staff; and

(C) Establish provider-specific training requirements for staff.

(ii) Adhere to all state and federal statutes, rules, and regulations, regarding the use of restraints.

(iii) Only utilize restraints approved by the provider's chosen certifying entity recognized in subsection (m) unless the restraints are prohibited in subsection (d).

(l) The provider and provider staff shall maintain certification, and provider shall require ongoing training for employees in de-escalation techniques, crisis prevention and intervention, and proper restraint usage from entities certified to conduct the training such as Crisis Prevention Intervention (CPI), MANDT, or other entity approved by the Division.

(m) All provider staff trained to use restrictive interventions shall also receive training in:

(i) The needs and behaviors of the population served;

(ii) Relationship building;

(iii) Alternatives to restrictive interventions;

(iv) The difference between natural consequences and punitive consequences;

(v) Avoiding power struggles;

(vi) Thresholds for restraint;

(vii) Monitoring signs of distress and obtaining medical assistance;

(viii) Legal issues related to restrictive interventions;

(ix) Position related asphyxia;

(x) Escape and evasion techniques;

(xi) Time limits;

(xii) The process for obtaining approval for continued restraints;

(xiii) Procedures to address problematic restrictive interventions;

(xiv) Documentation;

(xv) Any participant specific medical concerns and processes;

(xvi) Follow-up with staff and the participant; and

(xvii) Investigation of injuries and complaints.

(n) Restrictive interventions may only be used in emergency circumstances to ensure the immediate physical safety of the participant, a provider staff member, or other persons, and when less restrictive positive behavior supports have been determined to be ineffective. Providers may only use restrictive interventions when the risk of injury without intervention is greater than the risk associated with the restrictive intervention. Restrictive interventions may include but are not limited to the following:

(i) A "Cooling down Period" which is a time limited behavior management technique in which the provider encourages the participant to go to a separate area, away from his or her peers, in a non-locked setting, for the purpose of calming. Any isolation of the participant that does not meet this definition shall be deemed seclusion, which is prohibited and shall result in recovery of funds and additional sanctions against the provider.

(ii) A chemical restraint, which is the use of a psychotropic medication given against a person's will in an attempt to exert control over a person's behavior.

(A) A chemical restraint may not be used unless ordered by a treating physician, chosen by the participant or any legally authorized representative(s), and administered by person licensed to administer the medication.

(B) Standing orders for chemical restraints are prohibited, except where deemed necessary to prevent extreme reoccurring behavior by a participant's plan of care team and limited to one (1) month. A standing order must include clarification on the circumstances of its usage by the treating physician.

(C) If a provider uses three (3) or more instances of a chemical restraint on a participant in six (6) consecutive months, the participant's team must arrange for the participant to see his or her treating medical professional for a formal medical review in case the treatment plan needs to change. The participant's plan of care team must meet to determine if the positive behavior support plan or crisis intervention protocol needs to change. The formal medical review must be documented in the participant's file with the restraining provider, and the case manager. If it is determined that the treatment plan or plan of care will not be changed, then the case manager shall document the reasons it is not being changed in the electronic plan of care.

(D) The use of chemical restraints on persons under the age of 18 is prohibited.

(iii) A mechanical restraint, which includes any device attached or adjacent to a participant's body that he or she cannot easily move or remove, restricts freedom of movement or normal access to the body. Mechanical restraints may only be used under the direct supervision of a physician for the purpose of medical treatment procedures when compliance is deemed necessary to protect the health of the participant. The use of mechanical restraints on person under the age of 18 is prohibited.

(iv) A physical restraint.

(A) Physical restraint includes:

(I) The application of physical force or physical presence without the use of any device for the purposes of manually holding all or part of a person's body in a way that restricts the person's free movement;

(II) The use of any approved physical maneuvers, such as a physical escort, team positions, or other holds to move a participant to another place or position; or

(III) Any other physical or manual technique intended to interrupt or stop a behavior from occurring, except holding a participant's hand to safely escort him or her from one area to another due to a potentially dangerous environmental concern that is not a result

of the participant's behavior.

(B) Before physical restraints may be used, the participant's crisis intervention plan must include a letter from a physician or other licensed medical professional who prescribes medication specifying that the use of a physical restraint will likely do no harm to the participant if used in accordance with the crisis intervention plan.

(v) A community access restriction: Community access may not be restricted as a consequence due to non-compliance with attending a service or not completing a goal or training activity. If the community access restriction is imposed, the protocol must also include:

(A) Specific target behaviors that must be present in order for a restriction to the community to be imposed, a description of the risk to the community, the specific measureable and observable criteria for restoring access to the community, and not exceed 36 hours unless the plan includes information from a psychologist on the health, safety or therapeutic reasons for a longer restriction.

(B) Community access restrictions may not be imposed by a person who is also designated to reassess the participant throughout the day to ensure health and safety needs are being met. The reassessment must include measureable progress made on restoring access to the community.

(C) Opportunities for the participant to reduce the length of time of restriction.

(D) The provider may not restrict community access for any other participant for which the restriction is not directly imposed.

(E) The provider may not charge a participant for services missed as a result of a community access restriction.

(o) Seclusion is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, or physically restrain a person back to such a room once he or she leaves during the provision of the waiver services. Seclusion is prohibited, and may result in repayment of funds for waiver services, and other sanctions.

(p) A provider using restraints as a restrictive intervention shall:

(i) Maintain internal documentation to track and analyze: each use of a restrictive intervention, its antecedents, reason(s) for the restrictive intervention, the participant's reaction to the restrictive intervention, and actions that may make future restrictive interventions unnecessary;

(ii) Implement additional supports with the participant in an effort to minimize restrictive interventions;

(iii) Use appropriate de-escalation techniques to redirect or mitigate a behavior before restrictive interventions occur;

(iv) Address and correct staff using any incorrect or inconsistent support or intervention;

(v) Hold a debriefing meeting with the participant, guardian, and case manager as soon as practicable after an incident to discuss the use of the restriction. Guardians may be part of the participant's debrief discussion either by phone or in person;

(vi) Within three (3) business days of the event, provide case managers with a copy of the provider's completed internal tracking form, or notify the case manager that the electronic form is available for viewing;

(vii) Send a copy of the completed internal tracking form to the guardian within five (5) business days or notify the guardian that the electronic form is available for viewing;

(viii) Submit a critical incident report to the Division for each instance when a restraint is used as a restrictive intervention;

(ix) Regularly collect and review all available data regarding the use of restraints and work to reduce their duration and frequency, and eliminate their occurrence.

(x) The case manager shall follow up on each incident within two (2) business days to ensure the participant is safe, uninjured, and to ensure the restrictive intervention protocol, and participant's positive behavior support plan was implemented appropriately and documentation demonstrates that less restrictive intervention techniques were used prior to the use of restraint. The case manager shall also review whether the items in this section were completed and report any suspected non-compliance to the Division**.**

(xi) The Division may request an interdisciplinary team meeting with the provider, case manager, and legally authorized representative to review a participant's restrictive interventions.

(q) Restrictive interventions may not be used for the following purposes. Violation of this provision may result in immediate sanctions of the provider:

(i) For the convenience of the provider;

(ii) To coerce, discipline, force compliance, or retaliate against a participant;

(iii) As a substitute for a habilitation program or in quantities that interfere with services, treatment, or habilitation;

(iv) Restraint that is contraindicated by the person's medical or psychological

condition;

(v) Restraint procedures or devices that obstruct a person's airway or constrict the person's ability to breathe;

(vi) The use of any supine or prone restraint including, but not limited to, restraining a person on the floor, in a bed, in any form of reclined chair, or using any other horizontal flat surface; and

(vii) Any use of physical, mechanical, or chemical restraint not provided for in this section.

(r) Any restrictive intervention used, including a restraint, must be time-limited and removed immediately when the participant no longer presents a risk of immediate harm to self or others.

Section 19. Psychoactive Medication Usage Standards.

(a) If a participant is prescribed psychoactive medication as standard treatment, then the plan of care must include information from the attending medical provider with prescription authority to ensure the following:

(i) The participant is diagnosed with a medical condition by a licensed psychiatrist, physician, or other licensed medical professional who prescribes medication, and may benefit from the use of psychoactive medications; and

(ii) The medical section of the participant's approved individualized plan of care must:

(A) Describe the medical conditions or behaviors for which the medication is prescribed;

(B) Justify use of the medication(s), including the benefits and potential side effects;

(C) State the length of time considered sufficient to determine if the medication is effective (i.e., treatment trial);

(D) Identify the behavioral criteria to determine whether the medication is effective, such as the changes in behavior, mood, thought, or functioning that may be considered evidence the medication is effective;

(E) Describe the plan to monitor medication side effects; and

(F) Describe the plan to simplify the number and types of medications and to reduce dosages and discontinue medications, unless otherwise contraindicated.

(b) If the attending medical physician prescribes a psychoactive medication PRN that may be used during the provision of waiver services, a PRN protocol for use of the medication must be developed to supplement the positive behavior support plan pursuant to the Sections 17 of this Chapter. In addition:

(i) The prescription or other medical orders must be specific to the participant's condition and be considered the standard of treatment for the participant's condition;

(ii) The participant must receive assistance with a prescribed psychoactive medication in order to manage the participant's behavior with the approval of the participant or the participant's legally authorized representative(s);

(iii) Any psychoactive medication given against the participant's will is considered a chemical restraint;

(iv) Upon notice of a medication change, the participant's individualized plan of care must be updated;

(v) The use of such drugs and medications must be in the best interest of the participant to improve his or her quality of life;

(vi) The use or threat of physical force for the administration of psychoactive medications is prohibited; and

(vii) Providers must document the non-pharmacological interventions which will be used prior to the use of a psychoactive medication PRN.

(c) Psychoactive medication monitoring requires the provider to monitor the participant's response to one or more prescribed medications, to observe the participant for side effects, correct dosage and intervals, and follow other medically approved best practice monitoring methods, in conjunction with orders from the treating physician.

(d) Providers shall review each participant's PRN usage monthly. If there is an upward trend in PRN psychoactive medications usage, then the provider shall notify the prescribing medical professional and report all psychoactive medication usage by a participant, including any instances of PRN administration and chemical restraints. A change to the participant's treatment plan, medication regimen, or plan of care must be considered if possible to reduce the use of any PRN or restrictive intervention.

(e) Any participant's medication regimen that includes psychoactive medications, contraindicated medications, or other classifications of medications that are intended to have a psychotropic effect may be subject to a polypharmacy referral to Medicaid.

(f) If a scheduled psychoactive medication dosage is missed, it must be reported as a medication error.

Section 20. Notification of Incident Process.

(a) A provider shall report the following categories of critical incidents involving waiver participants to the Division, the Department of Family Services, Protection & Advocacy System, Inc., the case manager, any legally authorized representative(s), and to law enforcement immediately after assuring the health and safety of the participant and other individuals:

(i) Suspected abuse as defined by W.S. § 35-20-102 or W.S. § 14-3-202;

(ii) Suspected self-abuse;

(iii) Suspected neglect as defined in W.S. § 35-20-102 or W.S. § 14-3-202;

(iv) Suspected self-neglect as defined W.S. § 35-20-102;

(v) Suspected abandonment as defined in W.S. § 35-20-102;

(vi) Suspected exploitation as defined in W.S. § 35-20-102;

(vii) Suspected intimidation as defined by W.S. § 35-20-102;

(viii) Sexual abuse as defined in W.S. § 35-20-102; and

(ix) Death.

(b) All providers shall report the following non-critical incidents to the Division, Protection & Advocacy Systems, Inc., the case manager, and any legally authorized representative(s) within one business day:

(i) Police involvement, such as arrests of participants or the participant's direct care provider, while they are providing services, or questioning of participants by law enforcement;

(ii) Any use of restrictive interventions;

(iii) Any use of seclusion;

(iv) Injuries caused by restraints;

(v) Serious injury to the participant;

(vi) Elopement,

(vii) Medication errors, including:

(A) Wrong medication;

(B) Wrong dosage;

(C) Missed medication;

(D) Wrong participant;

(E) Wrong route; and

(F) Wrong Time, which is any deviation from accepted standard time frame for the medication assistance; and

(viii) Medical or behavioral admission and Emergency Room visits that are not scheduled medical visits.

(c) In addition to provisions of subsection (a) and (b), if, at any time, a significant risk to a waiver participant's health and safety is found, the provider shall report the incident to the Division.

(d) Medication error reports, that do not result in emergency medical attention, must be filed no later than three (3) business days after the event is discovered, in order to give the provider time to complete all follow-up listed in subsection (e) prior to reporting.

(e) Providers shall have incident reporting policies and procedures that include the requirements of this section and maintain internal incident reports for all critical and non-critical incidents identified in this section.

(i) Providers shall review internal incident data including the people involved in the incident, the preceding events, follow up conducted, causes of reoccurring critical incidents, other trends, actions taken to prevent similar incidents from reoccurring, evaluation of actions taken, education and training of personnel, and internal and external reporting requirements.

(ii) Providers shall provide access of internal incident data to case managers within five (5) business days.

(f) A provider shall comply with Division, or other agency requests, for additional information relating to the incidents upon request.

Section 21. Complaint Process.

(a) Accredited Providers. All accredited providers shall adhere to the current accreditation requirements for complaints or grievances.

(b) A provider who believes a participant's health or safety is in jeopardy, shall immediately contact the Division, Protection & Advocacy, and other governmental agencies, such as law enforcement or DFS.

(c) Upon receipt of a complaint from any person, the Division shall:

(i) Notify the complainant within ten (10) calendar days in writing that the complaint is received. The notification must address:

(A) Anticipated timeframe for completing complaint investigation, and

(B) The authority for taking actions.

(ii) Notify the provider in writing when a complaint is received involving that provider, unless the complaint involves significant health, safety, or rights concerns, which require an unannounced on-site visit. In these cases, the Division shall provide written documentation to the provider at the time of the on-site investigation that a complaint has been received, the nature of the complaint, and that the complaint is being investigated.

(iii) Notify the complainant when the complaint has been investigated and closed.

(iv) Submit a written report to the provider(s) involved in the complaint summarizing the results of the complaint investigation. The report may include findings, recommendations, and timeframes to address the recommendations through a corrective action plan.

(v) A provider's failure to complete a corrective action plan may result in sanctions.

Section 22. Transition Process.

(a) The participant may choose to change any provider at any time and for any reason.

(b) A provider who is terminating services with a participant shall notify that participant in writing at least thirty (30) days prior to ending services, unless the Division approves a shorter transition period in advance. Failure to provide services during this thirty (30) day period shall be considered abandonment of services and may result in decertification of the provider.

(c) When a participant, or any legally authorized representative(s), chooses to change providers, they shall inform the participant's case manager of the decision. All case managers shall notify the provider of a participant or guardian's decision to discontinue services within three (3) business days.

(d) When a transition occurs, the case manager shall:

(i) Notify the Division of the request for change within five (5) business days of request;

(A) If the participant, or any legally authorized representative(s), requests a change of case manager, the Division shall review choice and provider lists with the participant and guardian.

(B) If the participant or legally authorized representative(s) requests a change of a provider other than the case manager, the case manager shall review choice and provider lists with the participant or legally authorized representative(s).

(ii) Complete the Transition Checklist as required by the Division;

(iii) Gather and share appropriate information as outlined in the Transition Checklist;

(iv) Schedule individualized plan of care team meetings and notify all current and new providers, the participant, any legally authorized representative(s), and the Division at least two (2) weeks prior to the meeting. Team meetings may be scheduled sooner than two (2) weeks due to an emergency situation. Case managers shall notify the Division of any emergency requiring a faster transition schedule; and

(v) Modify the participant's plan of care.

(A) If a revised individual plan of care is required, the case manager shall complete the revised plan and submit it to the Division at least thirty (30) days before the new provider(s) is scheduled to begin providing services.

(B) If the individualized plan of care only requires minor modification, the case manager shall complete and submit plan of care modifications to the Division at least seven (7) days prior to the scheduled start date of the new services.

(e) All providers on the plan of care shall share pertinent information with the case manager and the individualized plan of care team in a timely manner.

(f) If a provider providing residential services to a participant requires a participant to move to another residential location, the participant shall be given the opportunity to choose from all available options without limitation to that provider's settings.

(i) The participant may choose from other setting options that are appropriate for the participant, which may include a new provider or supported living.

(ii) The provider shall notify the participant, family, case manager, and any legally authorized representative(s) of the move at least thirty (30) days in advance so the participant can exercise the choice to find a new residence or provider.

Section 23. Notice of Costs to the Participant.

(a) The provider shall develop and implement a system to notify participants and legal representatives of any associated cost to the participant for a service or item and the terms of payment, which are the responsibility of the participant or the legally authorized representative(s).

(b) Written notice must be given to the participant before initiation of service and before any change. Providers shall allow participants and their legal representative(s) adequate time to review the notice before the participant chooses services from the provider or before the changes are implemented.

(c) A provider's cost notice must specify that participants will not be charged for services or items that are covered through other funding sources. This includes, but is not limited to, items necessary to provide habilitation and transportation related to habilitation. The cost notice must also identify:

(i) Who is responsible for replacement or compensation when the participants' personal items are damaged or missing; and

(ii) How participants will be compensated when staff, guests, or other participants in service, who do not reside in the location (i.e., respite), utilize the environment and eat food paid for by participants.

(d) Providers may not charge participants for changes to the provider's staffing, facilities, or services, if the change is required by state or federal law.

Section 24. Participant Funds and Personal Property.

(a)Standards in this Section apply to any provider who takes responsibility for the funds or personal property of a participant. This includes:

(i) Serving as representative payee;

(ii) Involvement in managing the funds of the participant;

(iii) Receiving benefits or funds on behalf of the participant; or

(iv) Temporarily safeguarding funds or personal property for the participant.

(b) The provider shall develop and implement written policies and procedures to identify and detail the system used to protect participant's funds and property. These policies and procedures must be communicated to the participant or legally authorized representative(s), including:

(i) How the participant or any legally authorized representative(s) will give informed consent for the expenditure of funds;

(ii) How the participant or legal representative(s) may access the records of the funds;

(iii) How funds are segregated for accounting and reporting purposes to the participant, guardian, and regulatory agencies, such as Social Security Administration or the Division of Healthcare Financing;

(iv) Safeguards used to ensure that funds are used for the designated and appropriate purposes;

(v) If interest is accrued, how interest is credited to the accounts of the participant;

(vi) How services fees are charged for managing funds; and

(vii) How the person's funds or personal property will be replaced or recouped in the event of theft or an unexplainable disappearance at the provider facility or during the provider's provision of services.

(c) Providers may not use or allow participant funds or personal property to be used:

(i) As a reward or punishment, unless specified in the plan of care as a restriction of rights that complies with the requirements in this Chapter and is approved by the participant and legally authorized representative;

(ii) As payment for damages unless otherwise specified in the lease or other written agreement with evidence provided showing the charge is appropriate for the participant to make restitution, the rationale is documented, and the participant or legal representative gives written informed consent to make restitution for damages;

(iii) As payment for damages when the damage is the result of lack of appropriate supervision;

(iv) To purchase inventory or services for the provider; or

(v) On loan to the provider or the provider's employees.

(d) Participant funds shall not be comingled with provider business accounts or monies.

Section 25. Additional Standards for Providers that Require National Accreditation.

(a) Providers who are certified in Residential Services, Supported Living, Community Integration, Adult Day Services, Prevocational, any Supported Employment Service, and are on plans of care for three (3) or more participants shall receive national accreditation in the accreditation areas specific to the service being provided, and if the provider's waiver income equals or exceeds $125,000 collectively per calendar year. Providers shall obtain accreditation in the area applicable to each service within eighteen (18) months of qualifying under this provision.

(b) Provider accreditation options include Commission on Quality and Leadership (CQL) or Commission on Accreditation of Rehabilitation Facilities (CARF). Regardless of the accreditation attained, all references to accredited providers in this rule apply to the provider.

(c) A provider shall maintain accreditation as long as they provide qualifying services to three (3) or more participants for one of these services.

(i) The Division shall decertify a provider who fails to obtain or maintain accreditation.

(ii) If a provider fails to obtain or maintain accreditation, a transition plan must be implemented for each participant who is leaving the provider's services.

(A) Each waiver participant shall be relocated to a different provider within ninety (90) days of the date the Division receives confirmation that the provider did not receive accreditation. If a provider fails to obtain or maintain accreditation, the Division shall complete an immediate site survey and onsite assessment.

(B) The provider's decertification date shall begin ninety (90) days from the date of written notice from the accrediting entity that the provider did not receive accreditation.

(d) An accredited provider shall submit all national accreditation report documents to the Division within thirty (30) days of receiving the report documents from the accrediting entity.

Section 26. Mortality Review Committee.

(a) The Division shall maintain a Mortality Review Committee to review deaths of participants receiving waiver services.

(b) Providers shall provide information requested by the Mortality Review Committee. This may include, but is not limited to:

(i) Copies of documentation of services;

(ii) Copies of incident reports; and

(iii) Copies of any health related records, including assessments, and results of physicians' office visits and hospital visit.

(c) The Committee may make provider specific recommendations or systemic recommendations.

Section 27. Initial Provider Certification.

(a) An individual or entity may apply to become a provider by completing the Division's initial provider certification packet and all required trainings. The applicant shall supply evidence that the applicant meets the qualifications for each service in which the applicant is seeking waiver certification.

(b) After the effective date of this rule, the Division will only certify one provider per physical location.

(c) The Division may not certify any person or entity as a waiver provider if:

(i) The person or entity has an open or pending corrective action plan with the Division, or

(ii) The person or entity has any open cases with the Medicaid Fraud Control Unit.

(d) The Division may refuse to certify an entity that has an officer, administrator, or board member, who was previously sanctioned by the Division. This refusal shall apply for a period of two (2) years from the date the person was sanctioned. The Division may also refuse to certify such person related to his or her involvement in any open or pending corrective action plan, or Medicaid Fraud Control Unit case until after the two (2) year period.

(e) Any person who has been convicted of Medicaid fraud may not be certified.

(f) The Division may refuse to certify or subsequently decertify a provider applicant who fails to disclose any convictions in a court of law on the Division's provider application or organization's application.

(g) Any falsifications of statements, documents, or any concealment of material fact may result in a denial or certification, decertification, or referral for criminal prosecution.

(h) If the Division receives information that the provider no longer meets the qualifications for each service for which the provider is certified, the Division will send notice to the provider within one business day regarding this missing qualification and the applicable sanction. If the missing qualification is not obtained within the timeframe given by the Division, the provider will be disqualified from providing such waiver service(s).

(i) The Division shall initially certify a new provider agency providing any service for one year. The agency must complete an on-site recertification at the end of the first year to continue providing services

Section 28. Recertification of Providers.

(a) The Division shall notify all providers that their waiver certification is expiring at least ninety (90) calendar days prior to the certification expiration date. The letter shall detail requirements the provider shall meet to be recertified.

(b) After the initial year certification, the Division shall recertify an agency annually. This certification will include an on-site visit at least once every three (3) years.

(c) Recertification for providers includes a Division review of the provider's evidence of compliance with state and federal regulations for home and community based services and a review of the provider's self-assessment of compliance. For providers who provide services in a facility they control, own or lease, the Division shall also review the provider's self-inspection of facilities and a current inspection report from an outside entity.

(d) For a scheduled on-site recertification, the Division will notify the provider of the visit sixty (60) days prior to the evaluation.

(e) At any time, the Division shall conduct an on-site visit when a concern is identified during a complaint, incident report, or internal referral, if there is an indication the agency is not complying with state or federal rules and regulation, or at the Division's discretion.

(f) Non-accredited providers may sign a form verifying that they do not provide services in their home or a provider-owned, leased, or controlled facility. The Division will not conduct on-site evaluations for providers signing these forms, but may verify the accuracy of these statements. Falsification of these forms may result in sanctions.

(g) The Division does not require an on-site recertification for a case manager or providers of specialized equipment or environmental modifications.

(h) Providers shall submit verification that they have met all applicable recertification requirements to the Division at least forty-five (45) calendar days prior to their certification expiration date.

(i) If a provider fails to submit the applicable recertification requirements to the Division as described above, the Division shall notify the provider in writing of the expiration of the certification and may grant the provider fifteen (15) calendar days to meet the recertification requirements.

(ii) If the provider does not meet the recertification requirements within fifteen (15) business days after the date of the Division's letter, the Division shall decertify the provider.

(A) The provider may not apply to become a certified provider for a period of two (2) years from the date the provider was decertified.

(B) The provider shall be notified in writing through certified mail that their certification has expired.

(i) During any on-site recertification, the Division shall review provider certification requirements and compliance with all home and community based regulations, then complete a written report, including a statement of the recommendations that must be addressed within thirty (30) calendar days in order to maintain certification.

(i) The Division may approve a certification period for up to one year depending on deficiencies noted during the recertification process.

(ii) The Division may approve the certification for a period of less than one (1) year, if deficiencies are identified that seriously affect the health, safety, welfare, rights, or habilitation of a participant, or if the provider has otherwise substantially failed to comply with the rules and standards applicable to the services they are providing.

(iii) The Division may deny the certification.

Section 29. Corrective action plan requirements.

(a) The Division will, to the extent practicable and consistent with the provisions of applicable law, seek the cooperation of providers in obtaining compliance with these standards. The Division may provide technical assistance to providers to help them voluntarily comply with any applicable provision of these rules.

(b) The Division may also attempt to resolve any suspected noncompliance with this chapter through a corrective action plan.

(c) Corrective action plans must address each area of suspected non-compliance to the Division's satisfaction. This includes identifying the suspected noncompliance area, action steps needed to address the area of noncompliance, the responsible people in the organization for each action item, due dates, and dates of completion for each recommendation.

(d) Corrective action plans may also include a recommendation for specialized training for the provider organization or individual employees. Specialized training may include, but is not limited to, training on positioning, feeding protocols, positive behavior supports, person-centered planning, or trauma-informed care.

(e) Suspected non-compliance that relates to the immediate health, safety, welfare, or rights of participants, shall be addressed immediately after the situation is discovered. Providers addressing suspected non-compliance under this section shall be given fifteen (15) business days from the date of the report issued by the Division to submit a corrective action plan.

(f) If a corrective action plan is not implemented to address all areas of suspected non-compliance, the Division may impose sanctions as warranted.

(g) The Division shall notify the provider in writing within thirty (30) business days after receipt of the provider's corrective action plan regarding the approval or disapproval of the plan.

(h) The provider shall complete appropriate follow-up monitoring to assure that the actions identified in their corrective action plan have been completed within the specified time frame(s) and submit a monthly status report to the Division in the form and manner required by the Division until all action items have been satisfactorily completed. If the Division does not receive the monthly status report from the provider, the Division may proceed with the sanctioning process.

(i) The Division may complete follow-up investigations or review additional items during the provider's recertification process to assure the provider has fully implemented and evaluated and that participants remain safe during the corrective action plan implementation.

Section 30. Sanctions.

(a) Sanctions may be imposed in accordance with the provisions of Chapter 16, Medicaid Program Integrity.

(b) Notwithstanding the provisions of Section 29 of this Chapter, the Division may impose sanctions for any violation of these rules.

(c) If the Division revokes a provider's certification or suspends a national provider identification number,

(i) The provider shall submit transition plans to the Division detailing the transition of each participant to other settings within thirty (30) calendar days of the date that the sanction is deemed final.

(ii) The transition plans may not be implemented until approval by the Division.

(iii) The transition plans shall be implemented and participants shall move to different certified providers or receive non-waiver supports and services from persons approved by the participants or any legally authorized representative(s) within ninety (90) calendar days of the date the Division informed the provider of the revocation of certification.

(iv) Transition plans must adhere to the requirements in Section 22 of this Chapter.

Section 31. Relative Providers.

(a) The Division shall allow a participant's relative to become a certified waiver provider and receive reimbursement for services provided to the related participant.

(b) A participant's legally authorized representative may not directly or indirectly receive reimbursement for providing waiver services for their ward except as indicated in this Section. Direct or indirect reimbursement shall include, but is not limited to, providing direct services at or serving as the owner or officer of a provider organization serving the ward, residing in a provider owned facility serving the ward, or being married to a person providing waiver services to the ward.

(c) A participant's spouse may receive direct or indirect reimbursement only if they present the Division with a certified copy of a court order establishing another party as the legal representative of the participant.

(d) To provide waiver services to a related participant, the relative shall:

(i) Form a Limited Liability Company (LLC) or other corporation, and

(ii) Maintain provider certification in accordance with this chapter.

(e) No parent, step-parent, or legally authorized representative may be hired to provide services through self-direction.

(f) Services that a relative provider may provide include residential habilitation and supported living for participants over the age of 18, personal care, specialized equipment, any supported employment service, prevocational services, and environmental modifications with the following limitations:

(i) For residential habilitation, the parent or stepparent cannot live in same residence as the participant.

(ii) Personal care and supported living services reimbursed to a relative provider cannot exceed four (4) hours per day if the provider lives in the same residence as the participant.

(iii) A provider who is the parent, stepparent, or legally authorized representative of a participant age zero through seventeen may only be reimbursed for providing personal care services up to four (4) hours per day and for extraordinary care purposes only. No other waiver services are reimbursable.

(A) Extraordinary care personal care services must align with the needs and supports specified in the plan of care which demonstrate the need for extraordinary care; and

(B) The participant's Adaptive Behavior Quotient must be 0.35 or lower on the Inventory for Client and Agency Planning (ICAP) assessment; and meet one of the following criteria:

(I) The participant needs assistance with Activities of Daily living (ADLs) or Instrumental Activities of Daily Living (IADLs) exceeding the range of expected activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; or

(II) The participant requires care from a person with specialized medical skills relating to the participant's diagnosis or medical condition as determined appropriate by the participant's physician and the Behavioral Health Division.

(g) If a parent, stepparent, or legally authorized representative is providing personal care to his or her ward, the plan of care must be developed and monitored by a case manager without a conflict of interest.

(h) If the relative provider is not providing services in the best interest of the participant, the case manager shall work with the participant and appropriate team members, and the Division as needed, to choose other providers as appropriate and modify the plan of care to better suit the needs of the participant.

(i) Payment to any relative specified in subsections (f) and (g) shall only be made when the service provided is not a function that the relative would normally provide for the individual without charge as a matter of course in the usual relationship among family members; and the service would otherwise need to be provided by a qualified provider.

(j) Any relative who provides services either as an owner, employee, officer of a provider or who intends to provide services to a related waiver participant shall disclose the relationship in the participant's team meeting and acknowledge and address the safeguards set forth in documentation required by the Division.

(k) If a provider permits the hiring of a legally authorized representative of a participant receiving services from the provider, or if a provider permits the hiring of relatives of provider employees working for the organization, the provider shall have a written policy on how it

addresses potential conflicts that arise from these relationships, how the conflict of interest is mitigated, and the policy is shared with the participant and legally authorized representative(s).

Section 32. Interpretation of Chapter. The order in which the provisions of this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision. The text of this Chapter shall control the titles of its various provisions.

Section 33. Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Division, including Provider Manuals and Provider Bulletins, which are inconsistent with this Chapter.

Section 34, Severability. If any portion of this Chapter is found invalid or unenforceable, the remainder shall continue in full force and effect.