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Health, Department of

Medicaid

Chapter 45: DD Waiver Provider Standards, 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 Wyoming Statute § 9-2-102 and the Wyoming Medical Assistance and Services Act at Wyoming Statutes §§ 42-4-101 through 121.

Section 2. Purpose and Applicability.

(a) This Chapter was adopted to govern certification of providers under the Wyoming Medicaid Supports Waiver and Comprehensive Waiver (hereinafter collectively referred to as the “DD Waivers”).

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

(c) The Behavioral Health Division, hereinafter referred to as the “Division,” may issue Provider Manuals and Provider Bulletins 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.

(i) Wyoming’s currently approved Centers for Medicare and Medicaid Services (CMS) Comprehensive and Supports Waiver Applications and the Comprehensive and Supports Waiver Service Index apply to this Chapter.

(d) The requirements of Title XIX of the Social Security Act, 42 C.F.R., Part 441, Subpart G and the Medicaid State Plan apply to this Chapter.

Section 3. General Provisions.

(a) Terminology. Except as otherwise specified in Chapter 1, or as defined in this Section, 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 individualized 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) “Licensed Medical Professional” means a medical professional licensed to practice in the State of Wyoming and authorized to prescribe medication.

(iv) “Relative” means a participant’s biological or adoptive parent(s) or stepparent(s).

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 shall not be modified or suspended except in accordance with state or federal law and this Chapter.

(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 rights. 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 disallows a limitation of a right in an individualized plan of care, this decision will apply to any provider offering services to the participant. Rights restrictions shall constitute a material change to the individualized plan of care. The following participant rights shall not be denied or limited, except for the purpose of an identified health or safety need, which shall 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, and choose with whom and where they live;

(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, and associate with people of their choosing;

- (x) The ability to communicate with people of their choosing;
- (xi) Freedom to keep and use their personal possessions and property;
- (xii) Control over how they spend their personal resources;
- (xiii) All settings shall be physically accessible to the individual;
- (xiv) The right to access the community;

(xv) The right to make and receive telephone calls. No person shall 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 shall not be denied or limited unless a court, the participant, or the participant's legally authorized representative authorizes the denial or limitation in writing.

(i) Such denial or limitation shall be included in the participant's individualized plan of care and shall 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 of this Chapter.

(ii) The authorizing document shall be made part of the participant's individualized 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 shall 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 is informed of the participant's rights and responsibilities;

(A) The information shall 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 shall 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 are supported in exercising their rights while receiving waiver services;

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

(vi) Retaliation against a participant's services and supports due to the participant, family members, or legally authorized representatives advocating on behalf of the participant or initiating a complaint with an outside agency, is prohibited.

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

(g) Providers shall 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 individualized plan of care shall include a rights restriction protocol that shall include the following:

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

(ii) For any rights restriction imposed, the following items shall be addressed and documented in the individualized 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 individualized plan of care;

(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, the individualized plan of care

shall address how the team will work to restore any right described in this Section that has been limited or denied.

Section 5. Provider Qualifications for Each Waiver Service.

(a) All individual waiver providers, subcontractors, and provider employees providing direct services to waiver participants shall complete and maintain the following requirements unless otherwise specified in this section:

- (i) Be eighteen (18) years or older;
- (ii) Be certified by the Division to provide the indicated service;
- (iii) 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;
- (iv) Have a valid email address, internet access, and the means to upload documentation into a Division designated portal; and
- (v) If assisting with medications, maintain a current certificate in medication assistance training offered through the Division.

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

(i) 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.

(ii) Case Management.

(A) All providers of case management services shall 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 subsection (I) above 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 subsection (I) above 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 shall obtain and maintain his or her own National Provider Identifier (NPI) number for case management services through the Medicaid enrollment process.

(C) 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.

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

(I) Identify a back-up case manager from the list of Division certified case managers for each participant, and have policies and procedures for backup case management for each person's caseload, which include a process for how and when the case manager will notify the plan of care team that the backup case manager should be the primary contact. Case managers shall meet with their designated backup to review all participant cases on a quarterly basis. The review shall be documented in case notes.

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

(III) Meet the following conflict of interest requirements:

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

(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 shall not be related within the third degree by blood or marriage to the owner, operator, or managing employee of any other waiver service provider on the participant's individualized plan of care;

a. A relationship within the third degree includes the spouse; biological, step, or adoptive parent; mother, father, brother, or sister-in-law; biological, step, or adoptive child; biological, step, or adoptive sibling; grand or great grand-parent or child; or aunt, uncle, niece, or nephew.

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

(5.) The case management agency shall not:

a. Employ case managers that are related to the participant, the participant's guardian, or a legally authorized representative, within the third degree, served by the agency. If the case management agency is a sole proprietor, the case manager shall not be related to the participant, the participant's guardian, or a legally authorized representative served by the agency;

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 individualized plan of care in which they provide case management services.

(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. 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.

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

(iii) 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.

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

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

(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.

(v) 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).

(vi) 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 shall report critical incidents as defined in Section 20.

(vii) 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 in the field of DD/ID or ABI.

(viii) 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.

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

(x) 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).

(xi) 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 NPI.

(xii) Prevocational. Within one (1) year of certification in prevocational services, a provider shall have one (1) staff person certified in a supported employment curriculum approved by the Division and be available to train direct care staff on exploring employment interests, working on job readiness skills, or other employment related activities with participants.

(xiii) 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 NPI.

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

(xv) 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.

(xvi) 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, and have a current NPI.

(xvii) 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 supported employment curriculum approved by the Division, and be able to train direct care staff on working with participants to explore employment interests, work on readiness skills, or participate in other employment related activities.

(xviii) 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 the provider;
and

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

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

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

(C) Are reviewed at least annually with employees; and

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

(b) 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 the provider 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 shall 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.

(c) 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.

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

(e) 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.

(f) 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 individualized plan of care.

(g) 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.

(h) Providers that subcontract for services shall be responsible for assuring that the subcontractors meet all applicable requirements, qualifications, and standards for the services being provided. Failure of a provider who subcontracts to assure that the subcontractor meets all applicable requirements and standards may result in revocation of the provider's certification pursuant to Section 30 of this Chapter.

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 shall 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 shall comply with the requirements for hospital records identified in Wyoming Statute § 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 shall 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 Wyoming Statute § 40-21-107, and shall have automated tracking of all attempts to alter or delete information that was previously entered.

(i) Electronic records shall not be altered or deleted prior to submission of payment unless incorrect, and the purpose of the correction shall 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 shall make a participant's electronic case file, specific to the case manager's caseload, available to a case manager in the electronic record 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 (EMWS), or its successor, once marked 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 shall include:

(i) Full legal name of participant;

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

(iii) Name, type, and billing code of service provided;

(iv) Legible signature of each person performing a service, if initials are being used for documentation purposes.

(f) For written documentation, the following information shall be included each time a service is documented:

(i) Location of services;

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

(iii) 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;

(iv) Initial or signature of person performing the service;

(v) A detailed description of services provided that:

(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 legally authorized representative has provided input;

(B) Support recommendations from assessments by therapists, licensed medical professionals, 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; and

(D) Includes specific objectives for habilitation services, support needs, and health and safety needs.

(g) Documentation for different services shall be on separate forms and shall 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.

(h) A provider shall 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.

(i) A provider staff member shall not bill for the provision of more than one direct service for different participants at the same time.

(j) A provider shall not round up total service time to the next unit, except as outlined in the Skilled Nursing section of the Comprehensive and Supports Waiver Service Index.

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

(l) Services shall meet the service definitions outlined in the Comprehensive and Supports Waiver Service Index, and be provided pursuant to a participant's individualized plan of care.

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

(n) The provider shall make service documentation 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. 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.

(o) The provider shall make unit billing information for services rendered available to the case manager by the tenth (10th) business day of the month after unit billing has been submitted for payment.

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 and legally authorized representative(s) at all times, and update any changes to the Division and other providers.
- (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, and 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 individualized 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 individualized 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, in EMWS, 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 individualized 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 individualized 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, as well as the participant's satisfaction with the supports and services. On a quarterly basis, the case manager shall include this information in a report prescribed 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 individualized 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 individualized 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. The case manager shall provide monitoring of, and review trends regarding, the usage of the participant's over-the-counter and prescription medications through a monthly review of medication assistance records and PRN medication usage records.

(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 shall be timely and occur at times and locations that are convenient for the participant.

(c) The Case Manager shall provide notice of the plan of care meeting to all team members at least thirty (30) calendar days prior to the meeting.

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

(e) The individualized plan of care shall 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 and 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 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 the 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) Relevant protocols that have been updated within the past year;
- (xviii) Informed consent of the participant or legally authorized representative in writing; and
- (xix) Signatures of all providers listed in the individualized plan of care after the draft plan, as written, is completed by the team including participant's signature for informed consent.

(f) The individualized 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.

(g) The individualized plan of care shall be written in plain language that is understandable to the participant, legally authorized representative(s), and persons serving the participant.

Section 11. Rate Reimbursement Requirements.

(a) Providers shall be reimbursed for services through the rate methodology established in the corresponding waiver agreement with CMS.

(b) Rates paid to providers for waiver services shall be less than or equal to the usual and customary rates for similar non-waiver services.

(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) If third party expertise is necessary, 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 CMS 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.

(d) Providers shall participate in reasonable audits of the data submitted in subsection (c).

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 shall meet all applicable federal, 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 home and community based services (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, 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) Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;

(ii) Any setting that is in a building on the grounds of, or immediately adjacent to, a public institution; or

(iii) Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

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

(e) Provider facilities certified prior to the effective date of this rule shall continue to provide services in settings that do not meet this requirement, but shall begin transition to HCBS compliance by June 2021. Providers that do not start the transition process in good faith by June 2021 may be decertified.

(f) 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 shall be completed by one or more of the following outside entities:

(A) A fire marshal or designee;

(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 shall 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 shall 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 written plan on how deficiencies will be remediated, including the anticipated date of completion, shall be completed within thirty (30) calendar days of the initial report and available to the Division upon request.

(A) The written 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 shall 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.

(g) 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.

(h) 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, wildfires;

(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.

(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, with staff and participants, at least once every twelve (12) months 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; and

(C) Evidence of one fire drill, including an evacuation of the premises.

(iv) If provider is not providing 24 hour services, the provider shall document

the review of all applicable emergency plans, with staff and participants, during normal working hours at least once every twelve (12) months, 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; and
- (C) Evidence of one fire drill, including an evacuation of the premises.

(i) Other service standards. All service settings owned or controlled by a provider shall 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 meal and snack options. Providers shall not require a regimented meal schedule except as outlined in subsection (o) of this Section.

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

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

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

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

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

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

(viii) All medications, chemicals, poisons, or household cleaners shall be secured in a manner that minimizes the risk of improper use or harm to individuals in the setting.

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

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

(xi) The overall condition of the home or facility shall 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) Providers shall not use video monitors in participant bedrooms or bathrooms. Other forms of remote monitoring or sensors may be used where appropriate, and shall be documented in the participant's individualized plan of care.

(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 shall be signed by the participant or legally authorized representative, and the provider. The lease or agreement shall 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. A participant shall not 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) The right to access the community;

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

(E) A private bedroom with no more than one (1) person to a bedroom unless a more preferred situation is identified in his or her individualized plan 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.

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

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

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

(I) A key or other type of access to a lock for 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

(J) 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 12, 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 shall 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.

(xv) Written policies to address health, safety, and rights when:

(I) Any occupants or visitors of the home smoke, a policy on smoking that assures protection of health of the participant.

(II) Any occupants or visitors have pets, a plan to protect participant, including verification that the pets are current with vaccinations.

(III) Any occupants or visitors have weapons in the home, a policy on weapons that shall include the requirements that weapons are stored in a locked cabinet or in an inaccessible location and that, for firearms, ammunition is stored in a separate location from the firearm.

(IV) Providers shall share policies with participants before the participant formally chooses the provider.

(j) 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.

(k) Unless otherwise directed by the participant's licensed medical professional, or is otherwise indicated in the individualized plan of care, residential providers shall ensure each participant receives a medical evaluation every twelve (12) months.

(l) 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.

(m) 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 and replenish first aid supplies in the vehicle; and

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

(n) 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.

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

(p) 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 individualized plan of care with the restriction being time-limited and following the requirements listed in Section 4 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 shall 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.

(c) Any person or entity that subsequently fails to pass a renewed background screening shall 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 shall 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 (Wyo. Stat. Ann. §§ 6-2-101 et seq.)

(II) Kidnapping (Wyo. Stat. Ann §§ 6-2-201 et seq.)

(III) Sexual assault (Wyo. Stat. Ann §§ 6-2-301 et seq.)

(IV) Robbery and blackmail (Wyo. Stat. Ann §§ 6-2-401 et seq.)

(V) Assault and battery (Wyo. Stat. Ann §§ 6-2-501 et seq.), and

(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 (Wyo. Stat. Ann §§ 6-4-401)

- (II) Incest (Wyo. Stat. Ann. §§ 6-4-402)
- (III) Abandoning or endangering children (Wyo. Stat. Ann §§ 6-4-403)
- (IV) Violation of order of protection (Wyo. Stat. Ann. §§ 6-4-404)
- (V) Endangering children; controlled substances (Wyo. Stat. Ann. §§ 6-4-405), and
- (VI) Similar laws of any other state or the United States relating to these crimes.

(g) No person ages eighteen (18) or older shall 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) shall not be left unsupervised in the vicinity of any participant, except as provided by subsection (h).

(j) Notwithstanding subsection (h), staff shall 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 Office of Inspector General check is not required.

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

(ii) Providers shall 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 shall not have any unsupervised access or provide billable services to participants until the 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) Background screenings shall not be transferred from one provider entity to another.

(o) The background screening notification shall not be altered in any manner, including the crossing out of names or use of whiteout. If altered, the release forms shall be determined null and void.

(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 a trained 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 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;

(A) Providers of only environmental modification services, specialized equipment, or homemaker services are exempt from this training requirement.

(iii) Confidentiality;

- (iv) Dignity and respect;
- (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, legally authorized representatives, provider employees, and community members; and
- (x) Implementing and documenting participant objectives and progress on objectives.

(e) To verify each provider and provider staff meets the qualification standards, evidence of a completed training summary or test of each training topic shall be retained in the employer's files.

(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) Each provider and provider staff shall receive participant specific training prior to the individualized plan of care start date. Impacted staff shall receive participant specific training prior to changes to the individualized plan of care.

(ii) All case managers shall train one employee from each provider on the individualized 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 individualized plan of care start date and before each employee provides services.

(iii) A provider of waiver services shall 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.

(i) Documentation of participant specific training and general training shall 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 shall be designed to maximize the potential of the participant. Services shall be provided in the setting that is the least restrictive for the participant.

(b) Participants shall have a positive behavior support plan in place if restraints are outlined in their individualized plan of care.

(c) A participant with a challenging behavior identified by the plan of care 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 challenging 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, shall 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 shall describe agreed upon supports to assist the participant using proven support techniques and non-restrictive interventions. At a minimum, a positive behavior support plan shall:

- (i) Include the components of the template provided on the Department's website.
- (ii) Maintain the dignity, respect, and values of the participant;
- (iii) Use a person-centered approach with the participant involved in the development of the plan on a level appropriate for that person;
- (iv) Aim to minimize the use of restraints;
 - (A) 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;
- (v) Be specific and easily understood, so direct care employees can implement it appropriately and consistently;
- (vi) 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 shall be given by the provider to the participant and any legally authorized representative(s);
 - (B) This education shall include information about positive behavior supports that may be used and the risks and benefits of any supplemental plan for the use of a restraint or prescribed psychoactive medication if the positive behavior support plan fails.
- (vii) Define the antecedents and the targeted behavior(s) that need to be replaced or reduced;
- (viii) List positive behavioral supports that assist the participant in replacing targeted or challenging behaviors with appropriate replacement behaviors;
- (ix) Provide protocols for providers and provider employees to recognize emerging targeted behaviors, and determine the appropriate interventions to implement positive behavioral supports;
- (x) Provide protocols, which focus on positive interventions that are deemed least restrictive and most effective, for employees to use when targeted behaviors take place;
- (xi) Reference the 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 shall comply with Section 19(b) of this Chapter;
- (xii) 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;

(xiii) 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; and

(xiv) Be included as a formal component of the individualized plan of care.

(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. Restraint Standards.

(a) Restraint includes physical, chemical, and mechanical restraints, as further defined in this Section.

(b) The entire plan of care team shall agree to the use of restraints, confirmed with a signature from the participant, legally authorized representative, and all providers involved, and be consistent with 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 restraint protocol to supplement the positive behavior support plan, subject to the provisions of this Section.

(d) Providers shall 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 restraints in their plans are required to have one (1) employee complete training on positive behavior supports through any program approved by the Division. An additional employee shall be certified for every ten (10) additional participants with restraints in their plan.

(f) The plan of care team shall review the participant's plan thoroughly to ensure the individualized plan of care is not so restrictive that it repeatedly provokes behaviors that lead to the use of restraints.

(g) When restraints are deemed necessary, the individualized plan of care shall include a restraint protocol that includes the following:

(i) If a person other than the participant authorizes the use of restraint, the legal document, court order, guardianship papers, or medical orders that demonstrate this authority shall be provided.

(ii) For any restraint imposed, the standards outlined in Section 4(h)(ii) shall be met.

(h) The case manager shall reconvene the participant's plan of care team if any

restraints are used in the previous calendar quarter. When convened under this section, the team shall review all restraints for the previous quarter and make plans for reducing the number of restraints performed. On a quarterly basis, the case manager shall report data received from the provider concerning the number of restraints performed on the participant.

(i) The provider shall notify the case manager within one (1) business day of any use of an emergency restraint that is not written in a participant's individualized plan of care. A case manager who receives notice of restraint under this provision shall call a team meeting within two (2) weeks to discuss the incident and decide if the individualized plan of care shall be modified to include a crisis intervention protocol and a revised positive behavior support plan.

(j) Restraints shall only be performed by an individual trained and certified in restraint usage.

(k) Providers employing restraints shall:

(i) Adopt policies and procedures that:

(A) Identify the provider's chosen certifying entity consistent with subsection (l) of this Section;

(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 (l) of this Section, unless the restraints are prohibited in subsection (d) of this Section.

(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) Restraints shall 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 shall only use restraints when the risk of injury without restraint is greater than the risk associated with the restraint. Restraints may include, but are not limited to, the following:

(i) A chemical restraint is any drug that is administered to manage a participant's behavior in a way that reduces the safety risk to the participant or others, has the temporary effect of restricting the participant's freedom of movement, and is not a standard treatment for the participant's medical or psychiatric condition.

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

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

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

(D) Chemical restraints shall not be used on persons under the age of 18.

(ii) A mechanical restraint is any device attached or adjacent to a participant's body that he or she cannot easily move or remove that restricts freedom of movement or normal access to the body.

(A) Mechanical restraints shall only be used under the direct supervision of a licensed medical professional for the purpose of medical treatment procedures when compliance is deemed necessary to protect the health of the participant.

(B) Mechanical restraints shall not be used on persons under the age of 18.

(iii) A physical restraint is the application of physical force without the use of any device, for the purposes of limiting the free movement of a participant's body. Physical restraint does not include briefly holding a participant, without undue force, in order to calm or comfort him or her, or holding a participant's hand to safely escort him or her from one area to another.

(n) Seclusion is the involuntary confinement of a participant alone in a room or an area from which the participant is physically prevented from leaving. Seclusion is prohibited, and may result in repayment of funds for waiver services and other sanctions.

(o) A provider using restraints shall:

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

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

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

(iv) Address and correct staff using restraints incorrectly;

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

(vi) Within five (5) 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 legally authorized representative within five (5) business days or notify the legally authorized representative 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; and

(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 of notification of the incident to ensure the participant is safe, uninjured, and to ensure the restraint 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 any incident of restraint performed by a provider or provider staff.

(p) Restraints shall 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.

(q) Any restraint shall be time-limited and removed immediately when the participant no longer presents a risk of immediate harm to self or others.

Section 19. THIS SECTION RESERVED FOR FUTURE RULEMAKING.

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 Wyo. Stat. Ann. § 35-20-102 or Wyo. Stat. Ann. § 14-3-202;

(ii) Suspected self-abuse;

(iii) Suspected neglect as defined in Wyo. Stat. Ann. § 35-20-102 or Wyo. Stat. Ann. § 14-3-202;

(iv) Suspected self-neglect as defined Wyo. Stat. Ann. § 35-20-102;

(v) Suspected abandonment as defined in Wyo. Stat. Ann. § 35-20-102;

(vi) Suspected exploitation as defined in Wyo. Stat. Ann. § 35-20-102;

(vii) Suspected intimidation as defined by Wyo. Stat. Ann. § 35-20-102;

(viii) Sexual abuse as defined in Wyo. Stat. Ann. § 35-20-102; and

(ix) Death.

(b) All providers shall report the following non-critical incidents to the Division, Protection & Advocacy System, Inc., the case manager, and any legally authorized representative(s) within one (1) 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 restraint;
- (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) of this Section, 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 shall 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) of this Section 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 any reported critical or non-critical incident.

Section 21. Complaint Process.

(a) 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 to report incidents or concerns.

(c) A provider shall have policies and procedures for complaints, including:

(i) How it will attempt to resolve the complaint;

(ii) How it will document actions, follow-up, and resolution of the complaint;

(iii) How and when information shall be shared with the complainant, legally authorized representative, and the case manager; and

(iv) How the complainant will be informed of the process to file a formal complaint with the Division.

(d) Complaints may be filed with the Division in writing or verbally. If a provider files a complaint, the complaint shall be submitted in writing unless the complaint involves a participant whose health or safety is in jeopardy. Upon receipt of a complaint from any person, the Division shall:

(i) Notify the complainant within fifteen (15) business days in writing that the complaint is received. The notification shall address:

(A) Anticipated timeframe for completing the follow-up and resolution of a complaint, and

(B) The authority for taking actions.

(ii) Notify the provider in writing within fifteen (15) business days 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 visit that indicates a complaint has been received, the nature of the complaint, and that complaint follow-up is being conducted.

(iii) Within fifteen (15) business days of complaint resolution, notify the complainant in writing that the complaint has been resolved.

(iv) Within fifteen (15) business days of the complaint resolution, submit a written report to the provider(s) involved in the complaint summarizing the results of the complaint findings. The report may include findings, recommendations, and timeframes to address the recommendations through a corrective action plan. If the complaint involves a specific participant, the report will also be sent to the participant and legally authorized representative.

(v) A provider's failure to complete a corrective action plan may result in sanctions per Section 30 of this Chapter.

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) calendar days prior to ending services, unless the Division approves a shorter transition period in advance. Failure to provide services during this thirty (30) calendar 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, 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's or legally authorized representative'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, requests a change of case manager, the case manager shall review choice and make provider lists available to the participant and legally authorized representative.

(B) If the participant or legally authorized representative 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.

(ii) Complete the transition checklist(s) as required by the Division;

(iii) Schedule individualized plan of care team meetings and notify all current and new providers, the participant, any legally authorized representative, 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

(iv) Modify the participant's individualized plan of care.

(A) If a revised individualized plan of care is required, the case manager shall complete the revised plan and submit it to the Division at least thirty (30) calendar days before the new provider 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 individualized 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 transitioning to supported living services.

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

(g) It is the responsibility of the case manager to ensure providers have received training on all participant information including health and safety, behavioral concerns, and the individualized plan of care.

Section 23. Notice of Costs to the Participant.

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

(b) Written notice shall be given to the participant before initiation of service and before any change. Providers shall allow participants and their legally authorized representative 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 shall 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 shall 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 shall 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 shall be communicated to the participant or legally authorized representative, including:

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

(ii) How the participant or legally authorized representative may access the records of the funds;

(iii) How funds are segregated for accounting and reporting purposes to the participant, legally authorized representative, 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 service 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 shall not use or allow participant funds or personal property to be used:

(i) As a reward or punishment, unless specified in the individualized 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 legally authorized 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, or any Supported Employment Service shall receive and maintain national accreditation in the accreditation areas specific to the service being provided if:

(i) The provider is on the individualized plan of care for three (3) or more participants; and

(ii) The provider's total income for all billed waiver services equals or exceeds \$125,000 collectively per calendar year.

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

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

(i) 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.

(ii) 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.

(e) 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.

(a) The Division shall review deaths of participants receiving waiver services.

(b) Providers shall provide information requested by the Division. 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, results of licensed medical professional's office visits, and hospital visits.

(c) The Division 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) The Division shall only certify one provider per physical location.

(c) The Division shall 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.

(iii) The person has not successfully passed a background screening as provided in Section 14 of this Chapter.

(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 shall not be certified.
- (f) The Division shall 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 or provider agency providing any service for one year. The provider must complete a provider certification renewal at the end of the first year to continue providing services
- (j) A person or entity may dispute an adverse action related to provider initial certification by a request for an administrative hearing, which will be administered pursuant to Chapter 4 of the Department of Health's Medicaid Rules.

Section 28. Provider Certification Renewal.

- (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 that the provider shall meet in order to renew their certification.
- (b) The Division shall renew a provider certification at least once every three years. Based on the services provided, an on-site visit may be required.
- (c) Provider certification renewal 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) The Division will notify the provider of the certification renewal and site 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 provider is not complying with state or federal rules and regulation, or at the Division's discretion.
- (f) 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 visit for a case manager, specialized equipment, or environmental modification certification renewal.

(h) Providers shall submit verification that they have met all applicable certification renewal 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 certification renewal requirements to the Division as described above, the Division shall notify the provider in writing of the expiration of the certification.

(A) If the provider does not meet the certification renewal requirements within fifteen (15) calendar days of the certification expiration, the Division shall begin the decertification process.

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

(i) During any certification renewal, 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 shall be addressed within thirty (30) calendar days in order to maintain certification.

(i) The Division may approve a certification period for up to three (3) years depending on deficiencies noted during the certification renewal 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.

(j) A provider may dispute an adverse action related to renewal of certification by a request for an administrative hearing, which will be administered pursuant to Chapter 4 of the Department of Health's Medicaid Rules.

Section 29. Corrective action plan requirements.

(a) The Division shall, 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 shall 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 in Section 30 of this Chapter.

(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 rejection of the plan.

(i) If a corrective action plan is rejected, the provider shall receive notification in writing of the reasons for the rejection, and will be required to submit a revised plan within ten (10) business days of receipt of the written rejection from the Division.

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

(iii) If the revised corrective action plan is rejected, the provider shall have ten (10) business days from the notification of rejection to submit an acceptable corrective action plan or the Division may proceed with the sanction process as outlined in Section 30 of this Chapter.

(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 the corrective action plan and that participants remain safe during the implementation.

Section 30. Sanctions.

(a) Sanctions shall be imposed in accordance with the provisions of Chapter 16 of the Department of Health's Medicaid Rules.

(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, 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.

(i) The transition plans shall not be implemented until approved by the Division.

(ii) 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.

(iii) Transition plans shall adhere to the requirements in Section 22 of this Chapter.

(d) A provider may dispute a sanction under this Section or any other adverse action, including those related to certification or renewal of certification, by a request for an administrative hearing, which will be administered pursuant to Chapter 4 of the Department of Health's Medicaid Rules.

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 shall 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 legally authorized 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 shall 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 and supported living services, the relative shall not live in same residence as the participant.

(ii) Personal care services reimbursed to a relative provider shall not exceed four (4) hours per day, and can only be reimbursed 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 shall 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 shall align with the needs and supports specified in the individualized plan of care which demonstrate the need for extraordinary care; and

(B) The participant's Adaptive Behavior Quotient shall 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 licensed medical professional and the Behavioral Health Division.

(g) If a parent, stepparent, or legally authorized representative is providing personal care to his or her ward, the individualized plan of care shall 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, appropriate team members, and the Division as needed to choose other providers as appropriate and modify the individualized 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 and how the conflict of interest is mitigated. The policy shall be shared with the participant and legally authorized representative(s).

Section 32. Interpretation of Chapter.

(a) 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.

(b) 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.

Section 35. Incorporation by Reference.

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

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

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

(iii) The incorporated code, standard, rule, or regulation is maintained at the Department and is available for public inspection and copying at cost at the same location.

(b) Each code, rule, or regulation incorporated by referenced in these rules is further identified as follows:

(i) Referenced in Section 2 of this Chapter is Title XIX of the Social Security Act, 42 C.F.R. Part 441, Subpart G, incorporated as of the effective date of this Chapter and can be found at <http://www.ecfr.gov>.

(ii) Referenced in Section 2 of this Chapter is Wyoming Medicaid's State Plan, incorporated as of the effective date of this Chapter and can be found at <http://www.health.wyo.gov/healthcarefin/medicaid/spa>.

(iii) Referenced in Section 2 and 8 of this Chapter is Wyoming's Comprehensive and Supports Waiver Applications, incorporated as of the effective date of this Chapter and can be found at <https://health.wyo.gov/behavioralhealth/dd/waivers/>.

(iv) Referenced in Section 2 of this Chapter is Wyoming's Comprehensive and Supports Waiver Service Index, incorporated as of the effective date of this Chapter and can be found at <https://www.health.wyo.gov/behavioralhealth/dd/comprehensive-support-waivers/>.

(v) Referenced in Section 7 of this Chapter is Wyoming Statute § 35-2-607, incorporated as of the effective date of this Chapter and can be found at <https://legisweb.state.wy.us/>.

(vi) Referenced in Section 8 of this Chapter is Wyoming Statute § 40-21-107, incorporated as of the effective date of this Chapter and can be found at <https://legisweb.state.wy.us/>.

(vii) Referenced in Section 14 of this Chapter is Title 6 of the Wyoming Statutes Annotated, incorporated as of the effective date of this Chapter and can be found at <https://legisweb.state.wy.us/>.

(viii) Referenced in Section 20 of this Chapter is Wyoming Statute § 35-20-102, incorporated as of the effective date of this Chapter and can be found at <https://legisweb.state.wy.us/>.

(ix) Referenced in Section 20 of this Chapter is Wyoming Statute § 14-3-202, incorporated as of the effective date of this Chapter and can be found at <https://legisweb.state.wy.us/>.