Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
The Adult Developmental Disabilities (DD) waiver is intended to support individuals with developmental disabilities and their families so the individuals can remain in their home communities and learn skills that will assist them in becoming more independent.

The Wyoming Department of Health, Developmental Disabilities Division within the Single State Medicaid Agency worked to address gaps and clarify services in the application for the renewal of the Adult Developmental Disabilities (DD) waiver.

Additional safeguards will be implemented by December 31, 2009 to ensure that case managers are assuring choice, developing plans in the best interest of the participant, and monitoring the implementation of the plan of care.

The Prevocational Service is being removed so that services can more accurately reflect the supports participants are receiving either through day habilitation or supported employment.

The Supported Employment Service is enhanced to include Individual Community Employment Services and Group Supported Employment.

The In-Home Support Service is being removed so that services can more accurately reflect services received either through supported living or personal care.

Respiratory Therapy is being removed as a service due to no utilization, but it is still available on the Medicaid State plan for restorative therapy.

The definition of Personal Care services has been expanded to include instrumental activities of daily living.

The Respite Service are better defined to reflect the CMS guidance that respite services should not be used so the caregiver can go to work but is intended on a short term basis when the caregiver is absent or needs relief.

There is an addition of restrictions on the total units available for Respite and Personal Care.

The application also identifies a gap in medication assistance. A plan has been developed to implement policy and procedures on medication assistance and to train direct service professionals.

Performance measures have been identified for the six assurances and the Quality Improvement Strategy has been explained.

The State is electing to limit services at any one point in time for each year of the renewal. Specifying a point in time maximum will assist the State in managing waiver expenditures.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Wyoming** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

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

C. Type of Request: renewal

☐ **Migration Waiver** - this is an existing approved waiver

☑ **Renewal of Waiver:**

Provide the information about the original waiver being renewed

Base Waiver Number: 0226

Amendment Number (if applicable):

Effective Date: *(mm/dd/yy)* 07/01/91

Waiver Number: WY.0226.R04.00
Draft ID: WY.09.04.00

Renewal Number: 04

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

E. Proposed Effective Date: *(mm/dd/yy)*
07/01/09

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

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

☑ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

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

1. Request Information (3 of 3)

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

Select one:

- ◉ **Not applicable**
- ○ **Applicable**

Check the applicable authority or authorities:

- ☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- ☐ **Waiver(s) authorized under §1915(b) of the Act.**

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

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

  - ☐ **§1915(b)(1) (mandated enrollment to managed care)**
  - ☐ **§1915(b)(2) (central broker)**
  - ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
  - ☐ **§1915(b)(4) (selective contracting/limit number of providers)**
- ☐ **A program operated under §1932(a) of the Act.**

  Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
- ☐ **A program authorized under §1915(i) of the Act.**
- ☐ **A program authorized under §1915(j) of the Act.**
- ☐ **A program authorized under §1115 of the Act.**

  Specify the program:

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Adult DD Waiver is administered through the Wyoming Department of Health, Developmental Disabilities (DD) Division within the Single State Medicaid Agency (referred to as the DD Division in this application). The Adult DD Waiver's mission is to assist participants and their families in obtaining the training, services and supports needed to keep participants in their home communities. This program is available across the entire state and individuals ages 21 and older can access services. Clinical eligibility for the waiver is determined by the Division's review of the psychological evaluation, Inventory of Client and Agency Planning (ICAP) assessment, and the Level of Care determination.

Once clinical eligibility is determined and there is a funding opportunity, the DD Division generates the individualized budgeted amount (IBA) and notifies the participant and/or guardian of the funding opportunity and of their budgeted amount. Financial eligibility is then verified through the Department of Family Services. Using a person-centered approach, the participant and the team work together to develop a plan of care that will allocate that Individually Budgeted Amount for

needed waiver services. The plan of care also identifies non-waiver services needed by the participant. Once the participant and the team complete the plan of care, the participant's case manager submits the plan to the DD Division for review and approval.

Plans are approved for no longer than one year. However, a guardian, participant, case manager or any other team member can request a revision to the plan of care at any time during the plan year. When this occurs, the participant works with the case manager and the team to determine what modifications are needed. The modification is prepared by the case manager, signed by the participant and/or guardian, and sent to the DD Division for review and approval.

The DD Division reviews and approves all plans of care and modifications to plans of care. The DD Division's plan of care and plan modification approval process focuses on assuring the plan addresses the participant's personal goals and assessed needs, including health and safety risk factors, and to assure there is no duplication of payment for waiver services listed in the plan, or services that may be covered under the Medicaid state plan or by other sources. The DD Division signs and dates the preapproval page of the plan of care and returns the signed preapproval page back to the case manager verifying approval of the plan. Services can begin the day the plan or modification to the plan is approved by the DD Division. The case manager distributes the signed pre-approval form to the participant or guardian and all providers on the plan, thereby notifying them that services can begin.

The DD Division sends the information on approved services electronically to the Medicaid Management Information System (MMIS) that generates a prior authorization number. The provider receives written notification of the prior authorization number from the MMIS.

All providers certified to provide Adult DD Waiver services are required to have a current provider agreement in place with the State Medicaid Agency. Participants and guardians can choose a case manager employed by a provider agency or a self-employed case manager. Participants and guardians also have choice of over 700 Adult DD service providers in Wyoming.

CMS is requiring the state to utilize the National Quality Enterprise (NQE) for technical assistance regarding the Quality Improvement Strategy (QIS) for global performance measures and related implementation activities that affect the Adult Developmental Disabilities Waiver (WY 0226.R04.00). The state along with assistance from the NQE will develop goals for the quality improvement strategy and a related work plan with associated steps that address design, development, and implementation of specific performance measures and related remediation and improvement strategies. The work plan is subject to CMS approval. In order to realize the work plan for revamping the QIS, the appropriate utilization of performance measures and implementation of remediation the State will hold monthly meetings, starting August 1, 2009 in which it will update CMS and Thomson Reuters on its accomplishments relative to work plan (these monthly monitoring meetings should also be accompanies by written documentation, a format where the State can update the plan with notes on its accomplishments). Once the work plan is achieved, these meetings can stop after formal CMS acknowledgement. The State recognizes that further development of performance measures is needed and intends to utilize the 372 reporting process to incorporate other performance measures and updates to the QIS during this process.

3. Components of the Waiver Request

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

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

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

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

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

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to

participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

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

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

4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

C. **Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

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

H. **Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the

Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
The Developmental Disabilities (DD) Division has an Advisory Council with representation from Protection & Advocacy Systems Inc., the Governor's Council for Developmental Disabilities, Wyoming Department of Education, Wyoming Institute for Disabilities, waiver service providers, and recipients of waiver services. Presentations were made to this group to seek their input about the waiver renewal. The DD Division also convened five stakeholder sessions that included family members, providers, and participants to gain input on the design and content of this waiver. All waiver participants and guardians were notified by letter about the dates, times, and subjects of the stakeholder meetings, where to find information on a waiver revisions website and how input can be provided on the changes. A presentation was made to participants and guardians at an event sponsored by the Governor's Council for Developmental Disabilities. In addition, a working group of case managers convened with DD Division staff three times to discuss specifically the safeguards to be put in place for case management. Input was also solicited over the web. That input was summarized and placed on a website specific to waiver changes and used in the preparation of this application. The DD Division has had ongoing extensive discussions with providers and advocacy groups to gain further input and provide further clarification of issues and concerns. The DD Division has also been in ongoing dialogue with the State Medicaid Agent.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Staunton
First Name:	Jamie
Title:	Adult Developmental Disabilities Waiver Manager
Agency:	Wyoming Department of Health/Developmental Disabilities Division
Address:	6101 Yellowstone Rd, Suite 186 E
Address 2:	
City:	Cheyenne
State:	**Wyoming**
Zip:	82002
Phone:	(307) 777-5660 **Ext:** ☐ **TTY**
Fax:	(307) 777-6047
E-mail:	jamie.staunton@health.wyo.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	
First Name:	

Title:	
Agency:	
Address:	
Address 2:	
City:	
State:	**Wyoming**
Zip:	
Phone:	**Ext:** ☐ **TTY**
Fax:	
E-mail:	

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	Teri Green
	State Medicaid Director or Designee
Submission Date:	Jun 18, 2009

Last Name:	Green
First Name:	Teri
Title:	State Medicaid Agent
Agency:	Wyoming Department of Health, Office of Healthcare Financing
Address:	6101 Yellowstone Road, Suite 210
Address 2:	
City:	Cheyenne
State:	**Wyoming**
Zip:	82002
Phone:	(307) 777-7908
Fax:	(307) 777-6964
E-mail:	teri.green@health.wyo.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

The renewal of the Adult DD Waiver includes the changes described below. The DD Division obtained input on the changes as described in the main section of this application, under 6-I.

Participants and guardians, as well as case managers impacted by these changes, were notified by letter by June 1, 2009. The letter explained the process to change to another service, which includes working with the case manager and the participant's plan of care team to discuss other service options that are available within the individual budgeted amount. After the participant and guardian determine the appropriate changes in services, the case manager must submit a modification to the plan to the DD Division for review and approval. These changes will not result in a participant losing waiver eligibility and the participant's plan of care team will be able to modify the existing plan of care to add the appropriate service(s) so that one's health and safety are not affected. The letter included the process to request a Fair Hearing.

Changes:
1. Prevocational Service is being eliminated so that services can more accurately reflect the supports individuals are receiving, either through Day Habilitation or Supported Employment.

Transition Plan for Adult DD Waiver Participants Currently Receiving Prevocational Services:
199 Adult DD Waiver participants will need to change from Prevocational Services to either Day Habilitation or Supported Employment. This change will not be required until October 1, 2009 to give the participant and team time to review the services options and revise the plan of care. The deadline for submitting modifications to the plan of care is September 1, 2009 so the DD Division has sufficient time to review and approve each modification in services.

2. In-Home Support Service is being removed so that services can more accurately reflect services received either through Supported Living or Personal Care.

Transition plan for Adult DD Waiver Participants Currently Receiving In-Home Support Services:
191 Adult DD Waiver participants will need to change from In Home Support Services and choose either Supported Living Services or Personal Care Services, depending on the service that best meets their needs. This change will not be required until October 1, 2009 to give the participant and team time to review the services options and revise the plan of care. The deadline for submitting modifications to the plan of care is September 1, 2009 so the DD Division has sufficient time to review and approve each modification in services.

3. Supported Living Service is being added to more accurately reflect the supports participants are receiving who currently live in their own home, family home, or rental unit and who do not require ongoing 24-hour supervision but do require a range of community-based support to maintain their independence.

Transition plan for Adult DD Waiver Participants Moving to Supported Living Services from intermittent Residential Habilitation Services:
Up to 200 Adult DD Waiver participants currently receiving residential habilitation service will need to meet with their teams to evaluate their living arrangements and provide documentation for the most appropriate service; either Residential Habilitation with 24 hour ongoing staff supervision or Supported Living with staff available. When necessary, a modification to the plan of care will be submitted to the DD Division. This documentation will be submitted to the DD Division no later than November 30, 2009 to give the participant and team time to evaluate the living arrangements and to submit the required documentation.

4. The definition for Personal Care has been expanded to include instrumental activities of daily living (IADLs) and will have a restriction on the number of units allowed on a plan. (Based upon need and limited to 7,280). The broadening of the service definition to include IADL's makes this service available to more Adult DD Waiver participants who are living semi-independently but need assistance in those areas. The cap has been added to assure participants are receiving this service appropriately. Participants requiring more than 7,280 units of Personal Care may require a higher level of service such as Supported Living or Residential Habilitation. If a participant needs units above the cap limit and the use of other waiver services are not sufficient or appropriate to meet a person's needs, the request shall go through the DD Division's Extraordinary Care Committee for approval.

Transition Plan for Adult DD Waiver Participants Currently Receiving Personal Care Services over Newly Implemented Cap:

Those Adult DD Waiver participants who currently are exceeding the maximum limit for Personal Care units under the newly implemented cap will be required to make the required plan adjustments no later than their plan renewal date. The plans may be modified earlier than that date.

5. Respite Service has been better defined to reflect the Centers for Medicare and Medicaid Services (CMS) guidance that

respite services are intended on a short-term basis when the caregiver is absent or needs relief and are episodic in nature. Respite will have a restriction on the number of units allowed on a plan. (Based upon need and limited to 7280).

Transition Plan for Adult DD Waiver Participants Currently Receiving Respite Services Over the Newly Implemented Cap:
Those Adult DD Waiver participants who currently are exceeding the maximum limit for respite units under the newly implemented cap will be required to make the required plan adjustments no later than their plan renewal date. The plans may be modified earlier than that date. If a participant needs units above the cap limit and the use of other waiver services are not sufficient or appropriate to meet a person's needs, the request shall go through the DD Division's Extraordinary Care Committee for approval.

6. Day Habilitation for the daily unit will require a minimum of 4 hours in service. A 15-minute unit will be added for those Adult DD Waiver participants who routinely have less than 4 hours of service a day.

Transition Plan for Participants Currently Receiving less than 4 hours of Day Habilitation Services:
Those Adult DD Waiver participants who are not currently receiving at least 4 hours of Day Habilitation daily must meet with their teams and modify the plan of care to accurately reflect the services being delivered. This change will not be required until October 1, 2009 to give the participant and team time to review the services options and revise the plan of care. The deadline for submitting modifications to the plan of care will be September 1, 2009 so the DD Division has sufficient time to review and approve each modification in services.

7. Residential Habilitation will have targeting criteria for new people who come on to the waiver and for Adult DD Waiver participants not currently receiving Residential Habilitation Services. Waiver participants, who are not receiving 24-hour residential services but are at significant risk due to extraordinary needs that cannot be met in current living arrangement, may request Residential Habilitation Services if the participant meets targeting criteria detailed under the Residential Habilitation Service definition in Appendix C.

Transition Plan for Targeting Criteria for Residential Habilitation Services:
No Adult DD Waiver participants currently receiving Residential Habilitation Services will need to change services so no transition plan is required. However, effective July 1, 2009, any proposed move to a residential placement must meet the criteria listed in Appendix C.

8. Case Management changes: In order to address safeguards that must be in place when the state allows case managers to provide other services on a plan of care, the following changes will be put in place by December 31, 2009. More information on these changes is found in Appendix C-1-B and D-1-B of this application.
• Case managers currently employed by organizations that are certified to provide case management services will be required to be certified as a case manager under their own provider number
• Effective July 1, 2009 the plan of care includes a conflict of interest statement that summarizes how conflict will be addressed, how the best interest of the participant is assured, how monitoring will be enhanced, and what actions the participant/guardian should take if he or she has concerns with any aspects of the case manager’s roles and responsibilities.
• Case managers will be required to have policies and procedures in place addressing conflicts of interest when a case manager is providing other services on the plan of care
• The Division will develop a web-based complaint system so participants, guardians, and others can easily file a complaint with the Division, including complaints regarding the conflict of interest if a case manager is not working in the best interest of the participant.

Transition Plan for Case Management Safeguard Changes:
The Division will work with each case manager employed by an organization to assist them in obtaining their own provider number and in developing appropriate policies and procedures that are compliant with state standards. As needed plans of care will be revised to reflect the actual case manager for the participant, not the organization's name. These changes will be in place by December 31, 2009. Adult DD Waiver Participants and guardians will continue to be able to choose their case manager, but will have expanded options since they will be able to choose a specific case manager within an organization or a self employed case manager.

9. A new state policy for Medication Assistance goes into effect July 1, 2009 that includes new requirements for an Approved Medication Assistant, which will be a qualified person trained to assist with medications according to the new Division's standards. More information on these changes is found in Appendix G-3.

Transition Plan for Medication Assistance Requirements:
The state policy includes new requirements for an Approved Medication Assistant, which is the qualified person trained to assist with medications according to the new DD Division's standards. The DD Division will have the core training curriculum for Medication Assistance developed by July 1, 2009. Provider training for the curriculum will begin in July with a statewide training for all providers who can attend, using a train-the-trainer approach. The providers will then be able to

return to their agencies and begin training the staff they choose on the curriculum and establishing core staff to be Approved Medication Assistants. The training will be held once a month by the DD Division after July for three months, then quarterly thereafter. The state's training can certify people to be an Approved Medication Assistant, or with additional training, certify a person to be an Approved Medication Assistant trainer. Providers who assist participants with medications, will have until December 31, 2009 to certify enough staff necessary to comply with the state's policy, so each participant has an Approved Medication Assistant or other qualified person assisting with medications according to their medication regimens.

Changes have been made to the plan of care effective July 1, 2009 to include more required information from the team on conflict of interest, risk management, back up plans and employment planning.

The DD Division will track the implementation of these changes weekly to assure timelines are being met. If barriers arise that may result in delay in implementation of a change, the DD Division will work with the State Medicaid Agent and other appropriate entities to address the barrier quickly so the delay does not result in missing the implementation deadline.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   - (●) **The waiver is operated by the State Medicaid agency.**

     Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

     - ( ) **The Medical Assistance Unit.**

       Specify the unit name:

       (Do not complete item A-2)

     - (●) **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

       Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
       Developmental Disabilities Division
       (Complete item A-2-a).

   - ( ) **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

     Specify the division/unit name:

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

2. Oversight of Performance.

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

The Developmental Disabilities Division performs the following functions:
(1) Develop and implement standards for the operation of the waiver;
(2) Develop administrative rules, written policies and procedures for the waiver;
(3) Verify qualifications for waiver providers;
(4) Track and manage utilization, expenditures, participant counts, costs, and waiting list information;
(5) Track waiver performance measure data and trends related to the data;
(6) Set and implement provider rates;
(7) Participate in activities designed to identify and prevent fraud and abuse of Medicaid resources;
(8) Develop and implement written standards for quality assurance measures, especially those related to level of care, service plans, provider qualifications, and health and welfare of participants;
(9) Monitor providers to ensure compliance with policies, procedures, quality assurance standards, service definitions, billing procedures, federal rules, regulations and guidelines;
(10)Provide Program Integrity Manager reports of monitoring activities of providers;
(11)Provide Program Integrity Manager information sufficient to monitor waiver expenditures, service appropriateness, and accuracy of billing by providers;
(12)Meet with State Medicaid Agent or Programs Coordinator at least monthly to review issues related to the operation of the waiver;
(13)Monitor and report to the Medicaid Agent or Programs Coordinator information related to expenditures and capacity for the waiver.

(b) The document utilized to outline the roles and responsibilities related to waiver operation

The Department of Health will have a Letter of Agreement between the Office of Healthcare Financing and the Developmental Disabilities Division in place by July 1, 2009 which outlines the roles and responsibilities related to waiver administration and operation and documents the administrative authority of the State Medicaid Agent for the operation of the Adult Developmental Disabilities Home and Community Based Services Waiver.

(c) Methods that are employed by the State Medicaid Director in the oversight of these activities
The Wyoming Department of Health is the Medicaid Agency and the Adult DD Waiver is operated by the Developmental Disabilities Division within the Department of Health, under the direction of the State Medicaid Agent. The State Medicaid Agent reports to the Director of the State Medicaid Agency through the Deputy Director of Administration.

The Administrator of the Developmental Disabilities Division reports to the Director of the State Medicaid Agency through the Deputy Director of Administration. Effective July 1, 2009, there will be a Letter of Agreement between the Office of Healthcare Financing and the Developmental Disabilities Division outlining the responsibilities of each.

Effective July 1, 2009, all program integrity work for the Adult DD waiver will be centralized under the Medicaid Program Integrity Manager who reports directly to the State Medicaid Agent.

The Medicaid Program Integrity Unit is responsible for the following activities: 1) reviewing claims quarterly, which includes random samples, queries (for aberrant behavior, for example), and filters 2) preliminary investigations 3) recovery 4) reviewing criteria for payment by MMIS 5)reviewing provider certification process used by waiver program 6) reviewing waiver program report of provider suspensions and terminations 7) tracking of cases referred to Medicaid Fraud Control Unit for investigation of fraud and abuse by a

provider 8) tracking of cases referred to PRICE for investigation of suspected fraud and abuse by a participant 9) provider specific education related to a billing problem.

The Waiver Program is responsible for the following activities: 1) creating criteria for payment by MMIS 2) creating provider certification process 3) performing provider certification activities 4) provider terminations and suspensions 5)making referrals to the Program Integrity Unit when program quality assurance activities produce discoveries which warrant preliminary investigation and possible recovery 5) provider specific education related to a documentation problem.

A new Programs Coordinator position was created within the Medicaid Office to maximize oversight of and involvement in the day to day operations of the HCBS waivers. This position was filled on September 1, 2008 and reports directly to the State Medicaid Agent. Under the direction of the State Medicaid Agent, the Programs Coordinator has oversight over the administrative and operational functions of the waiver performed by the Developmental Disabilities Division. The Programs Coordinator works closely with the Program Integrity Manager within Medicaid to identify areas that need increased involvement and oversight by the State Medicaid Agent. The State Medicaid Agent, Programs Coordinator, Program Integrity Manager, Senior Eligibility Manager, and Operations Manager, who combined provide oversight over all areas of the Medicaid waivers, report directly to the State Medicaid Agent within the Medicaid Office.

The Program Integrity Manager, the Programs Coordinator and/or the State Medicaid Agent review all rules, policies and procedures, and contracts developed by the Developmental Disabilities Division related to the operation of the Adult DD waiver.

The Programs Coordinator has weekly (if not daily) contact with the Waiver Program Manager. A monthly meeting is held with all Program Managers of Home and Community Based Services waivers in attendance. The goal of these meetings is to keep the Programs Coordinator abreast of the day to day management activities of the waivers, to create as much consistency across the waivers as possible, and to provide adequate oversight of the waiver programs to ensure compliance with federal and state regulations and requirements. The direct supervisors of the Waiver Managers often attend these meetings and are kept current on requirements and concerns through additional status meetings and e-mails. After reviewing quarterly performance measure reports for the waiver, these Waiver Manager meetings will be the vehicle for providing feedback to the Waiver Program Manager from the State Medicaid Agent or her designee.

The Programs Coordinator meets at least monthly with Medicaid staff in the Developmental Disabilities Division. These meetings often include additional Medicaid staff, the Program Integrity Manager, and/or the State Medicaid Agent as appropriate. Agenda items are documented, discussed, and tracked until resolution.

Medicaid Waiver staff from the Developmental Disabilities Division attends monthly Medicaid staff meetings, monthly CURT (Core Utilization Review Team) meetings, and monthly MMIS status meetings. Senior Managers from the Division attend monthly meetings with the State Medicaid Agent and Programs Coordinator.

The Programs Coordinator, Program Integrity Manager and other Medicaid staff attend quarterly Mortality Review Committee meetings and Extraordinary Care Committee meetings at the Developmental Disabilities Division to participate in reviews related to the Adult DD waiver.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative

functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- (●) **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
  Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
  Medicaid has a contract for the operation and management of the MMIS system to review and pay all claims submitted by providers for the Adult DD waiver. This Contractor assists the State with Prior authorization, provider enrollment, and the execution of provider agreements. For prior authorization, the Contractor generates the prior authorization number after the Division loads the approved service plan into the client database which interfaces with the MMIS system. For provider enrollment, the Contractor processes the Medicaid provider enrollment application after the Division certifies the provider. For provider agreements, the Contractor executes and stores the provider agreements according to contractor requirements.

  Medicaid has a Utilization Review contract which includes case review for the Developmental Disabilities Division's Mortality Review Committee. Cases reviewed by the committee include Adult DD waiver participants.

  The Developmental Disabilities Division has a contractor to conduct participant satisfaction surveys.
- ( ) **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- (●) **Not applicable**
- ( ) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
  - [ ] **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

    Specify the nature of these agencies and complete items A-5 and A-6:

  - [ ] **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

    Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
Medicaid, within the State Medicaid Agency (Department of Health), has a MMIS Contract Manager who assesses the on-going performance of the MMIS Contractor. Additionally, the Program Integrity Manager and the Waiver Manager review information provided under this contract related to prior authorization, provider enrollment, and provider agreements.

The Utilization Contract Manager for Medicaid assesses the performance of the Utilization Review Contractor related to mortality reviews for the Adult DD waiver. The Contract Manager works closely with the Survey Certification Manager in the developmental Disabilities Division, who is Chair of the Mortality Review Committee.

The Department of Health, Developmental Disabilities Division has a contractor to conduct participant satisfaction surveys. The Developmental Disabilities Division oversees the performance of duties related to the contract.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The Contract Manager for the MMIS contract assesses the performance and compliance of the contractor on an on-going basis based on requirements in the RFP and contract, and the Business Rules provided to the contractor by Medicaid. Monthly contract management meetings are held by the Contract Manager with the contractor to review the status of projects and to address any identified problems. Monthly status meetings are held by the contractor to update the Contract Manager, the Program Integrity Manager, and the Waiver Manager, to review project lists and monitor timeline for completion. Minutes of each meeting are kept and distributed to each person who attends the meeting. The MMIS Contract Manager communicates identified contract issue to the Waiver Managers, Program Integrity Manager, and Programs Coordinator as necessary. In addition, the Contractor and the Waiver Manager attend monthly CURT (Case Utilization Review Team) meetings held by the Medicaid Program Integrity Unit.

The Contract Manager for the Utilization Review contract assesses the performance and compliance of the contractor on an on-going basis based on requirements in the RFP and contract. The Contract Manager attends the quarterly Mortality Review Committee meetings held by the Developmental Disabilities Division and monitors the case review information provided by the Contractor. Monitoring criteria includes making sure the Contractor requested and obtained records based on six month claim period, did an objective and thorough case review, and submitted a timely written report of the findings to the Survey/Certification Manager at the Developmental Disabilities Division.

The Developmental Disabilities Division monitors and evaluates the Contractor doing the participant satisfaction survey annually for compliance by comparing the annual satisfaction report provided by the Contractor (based on questions from CORE indicators) with the requirements set forth in the contract. The contractor will also generate other reports as requested.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☑	☐

Waiver enrollment managed against approved limits	☑	☐
Waiver expenditures managed against approved levels	☑	☐
Level of care evaluation	☑	☐
Review of Participant service plans	☑	☐
Prior authorization of waiver services	☑	☑
Utilization management	☑	☐
Qualified provider enrollment	☑	☑
Execution of Medicaid provider agreements	☑	☑
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐
Quality assurance and quality improvement activities	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Proportion of Inventory for Client and Agency Planning (ICAP) assessments for Adult DD waiver participants completed within 30 calendar days from the date the ICAP was requested (the total number of ICAP assessments completed within 30 calendar days of request divided by the total number of ICAPs requested)

Data Source (Select one):
Other
If 'Other' is selected, specify:
ICAP spreadsheet report with dates of requests and completions

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: ICAP database maintained by contractor completing ICAPS	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of waiver prior authorization error reports which are reviewed by Medicaid. Percentage=number of waiver prior authorizations reports reviewed by Medicaid/number of waiver prior authorization error reports created.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of rules, contracts, policies and procedures related to Adult DD waiver submitted by the DD Division that have been approved by the State Medicaid Agent or

her designee prior to implementation. Percentage=number of rules, contracts, policies and procedures approved by SMA prior to implementation/total number of rules, contracts, policies and procedures implemented by the DD Division.

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

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

Data Aggregation and Analysis:

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

	Specify:

Performance Measure:
Percentage of Performance Measure reports provided by the DD Division that are reviewed by the State Medicaid Agent or her designee. Percentage=number of Performance Measure reports reviewed by the State Medicaid Agent or her designee/number of Performance Measure reports submitted by the DD Division for review.

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

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

Data Aggregation and Analysis:

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

Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of Contractor reports provided to the Mortality Review Committee that were complete. Percentage=number of Mortality Review Committee reports that were complete/number of Mortality Review Committee reports that were done.

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

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

Data Aggregation and Analysis:

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

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of quarterly Reports (utilization, expenditures, participant counts, projected costs, and waiting list information) provided by the DD Division that are reviewed by the State Medicaid Agent or her designee. Percentage=number of quarterly reports reviewed by the State Medicaid Agent or her designee/number of quarterly reports submitted by the DD Division for review.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of rates and rate changes approved by the State Medicaid Agent or her designee before implementation by the DD Division. Percentage=number of rates and rate changes approved by the State Medicaid Agent or her designee prior to implementation/total number of rates and rate changes implemented.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of National Core Indicator Adult DD participant satisfaction interviews conducted by the contractor (the number of interviews conducted by the contractor divided by the number of interviews required by contract)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contractor's National Core Indicator database

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

Specify: Contractor for National Core Indicators		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Developmental Disabilities Division prepares monthly reports that include: unduplicated recipients, actual costs, number of individuals on the waiting list. These actual numbers are compared with projections. This is reviewed by Developmental Disabilities Division Management staff and made available to Medicaid for review by the State Medicaid Agent, Program Integrity Manager, and Programs Coordinator.

During quarterly Mortality Review meetings, cases are analyzed to reveal possible concerns.

During weekly Extraordinary Care Committee meetings, the Medicaid representative presents information on Medicaid utilization regarding specific cases to assist with decision making. They are a voting member of the Committee.

The Medicaid Programs Coordinator meets on a regular basis with and reports directly to the State Medicaid Agent. Communication concerning waiver updates or strategies which are discussed at the waiver Program Managers meeting are relayed to the State Medicaid Agent through the Programs Coordinator. This conduit to the State Medicaid Agent facilitates the communication and coordination of all state HCBS waiver programs. This regular communication can be especially proactive in planning and aligning strategies which are appropriate across all Medicaid waivers. The Programs Coordinator and the State Medicaid Agent have monthly meetings with the Developmental Disabilities Division.

The Medicaid Programs Coordinator is routinely involved with all policy changes. This includes input on all reports and waiver renewals submitted to CMS, legislative queries or changes, and policies that affect other Divisions or governmental agencies. The Medicaid Programs Coordinator also works with Contract Managers in Medicaid to resolve any concerns or issues related to waivers.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Developmental Disabilities Division reviews the monthly report of utilization. The ability to fund any portion of the waiting list is based on this monthly review. The DD Division Management team will make policy decisions with Medicaid oversight. If necessary the waiver is amended if unduplicated recipients and over all costs exceed approved amounts.

During Mortality Review, provider specific or systemic recommendations may be generated.

During Extraordinary Care Committee meetings, input is solicited from the case manager on alternative strategies that have been implemented. The Committee can make recommendations on service options that would not require additional funding. Decisions are made to approve or disapprove additional funding.

Methods for remediation with contractors include: verbal and/or written notification to the contractor about any concerns the State has with performance as soon as they are identified, education and guidance provided to the Contractor stating the State's expectations for performance under the contract, and modifying the language in the contract to more clearly articulate the expectations of the State.

Methods for remediation with the Division include feedback given by the State Medicaid Agent to the Administrator of the Developmental Disabilities Division about expectations related to the operation of the waiver at monthly Senior Management Medicaid meetings. If that communication is not successful in resolving the concern, concerns can be discussed at monthly Department of Health Senior Management meetings, directed by the head of the State Medicaid Agency.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
The Medicaid Agency acknowledges that although we have already been doing some important work related to Quality Improvement, we still have additional work to do. Included in our Medicaid quality improvement goals are:

Phase 1 (July 1, 2009)
(1)Expand and centralize the Medicaid Program Integrity Unit to better address program integrity needs related specifically to the waivers;
(2)Assess activities related to the review of performance of contracted activities that are specifically related to the waivers;
(3)Solidify the process for documenting the review by the State Medicaid Agent or her designee of rules, contracts, policies and procedures, etc. created by the Division.

Phase 2 (December 31, 2009)
(1) Routinely compile and review data specific to the waivers that measures quality improvement activities;
(2) Create and document strategies to improve quality;
(3) Routinely and systematically measure the effectiveness of the improvement strategies utilized.

By December 31, 2009, an additional performance measure will be added related to the contractual oversight of provider enrollment. Wyoming currently does not collect data by waiver program related to provider enrollment. The percentage of Medicaid provider enrollment applications submitted by potential waiver providers which are finalized timely by the Contractor after Medicaid approval. Percentage=number of Medicaid provider enrollment applications submitted by potential waiver providers which are finalized timely by Contractor after Medicaid approval/number of Medicaid provider enrollment applications submitted by potential waiver providers which are approved by Medicaid.

The MMIS Contract Manager is developing a Contract Compliance Journal (comprehensive monitoring plan) to monitor the MMIS contract, which will include provider enrollment activities, provider agreement activities, and prior authorization activities related to the HCBS Medicaid Waivers. The Monitoring Plan will be finalized by December 31, 2009 and will be reviewed for additional oversight specific to the waivers, as appropriate.

By December 31, 2009, the Utilization Contract Manager will research additional ways in which the current Utilization Review contract for Medicaid can be used to focus on quality improvement efforts related to the waivers.

The State will report on our progress toward these goals in the next Annual 372 Report on December 31, 2009.

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged			
		Disabled (Physical)			
		Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			

	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
◉ **Mental Retardation or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☑	**Developmental Disability**	21		☑
	☑	**Mental Retardation**	21		☑
○ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

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

Individuals who are U.S. citizens, a resident of Wyoming, 21 or older, and meets the following clinical eligibility:

- A psychological examination administered by a licensed psychologist, which confirms that the individual meets the criteria for diagnosis of mental retardation, or
- A diagnosis of a developmental disability due to a related condition as determined by a physician and significant functional limitations verified by a psychologist, and
- An Inventory for Client and Agency Planning (ICAP) service score of 70 or less or when the ICAP score is more than 70, the individual has an ICAP deficit in three (3) or more of the domain areas: self care, language, learning/cognition, Mobility, Self-direction, Independent Living. ICAP administered by a contracted agency)

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

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

◉ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

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

  Specify the percentage: _____

- **Other**

  Specify:

- **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

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

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

  - **The following dollar amount:**

    Specify dollar amount: _____

    The dollar amount *(select one)*

    - **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

    - **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
  - **The following percentage that is less than 100% of the institutional average:**

    Specify percent: _____

  - **Other:**

    Specify:

Appendix B: Participant Access and Eligibility

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

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

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	1353
Year 2	1369
Year 3	1385
Year 4 (renewal only)	1401
Year 5 (renewal only)	1417

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number

of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- ○ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ◉ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	1320
Year 2	1336
Year 3	1352
Year 4 (renewal only)	1368
Year 5 (renewal only)	1384

Appendix B: Participant Access and Eligibility

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

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

- ◉ **Not applicable. The state does not reserve capacity.**
- ○ **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

When there is sufficient funding, individuals are admitted to the waiver upon completion of the clinical and financial eligibility process.

Per Wyoming Medicaid rules, Chapter 41, Section 13, when there is insufficient funding to add additional participants, the DD Division maintains one waiting list for the Adult DD Waiver as specified below.

The DD Division assigns two rankings to each person on the waiting list based on the following two factors:
1) The severity of the person's condition based on Inventory for Client and Agency Planning(ICAP) service score, and
2) the person's placement date on the waiting list.

When covered services become available, the DD Division shall alternate between the two factors beginning with the waiting list based on severity, in selecting the next person to whom covered services shall be provided.

In cases when the severity levels are the same or when the placement date on the waiting list is the same, the DD Division shall use the date that the Case Management Selection form was received by the DD Division to determine which name goes first on the waiting list.

The DD Division shall determine the availability of funding for the approved individualized budget amounts for applicants on the waiting lists waiting for funding opportunities.

The DD Division can also fund a person from the Adult DD Waiver waiting list if it is determined he or she is in an emergency situation, such as homelessness or loss of primary caregiver. The DD Division, through the Extraordinary Care Committee (ECC) has established criteria to determine if a situation is an emergency, and reviews pertinent information to determine if the situation meets the emergency criteria.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ( ) **No**
   - (●) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42

CFR §435.217)

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ( ) **100% of the Federal poverty level (FPL)**
- ( ) **% of FPL, which is lower than 100% of FPL.**

Specify percentage: _____

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

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

- ( ) **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- (•) **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

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

Check each that applies:

- [x] **A special income level equal to:**

Select one:

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

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

  Specify dollar amount: _____
- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- [ ] **Aged and disabled individuals who have income at:**

  Select one:

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

    Specify percentage amount: _____
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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

- (●) **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

  In the case of a participant with a community spouse, the State elects to (*select one*):

  - ( ) **Use spousal post-eligibility rules under §1924 of the Act.**
    (Complete Item B-5-b (SSI State) and Item B-5-d)
  - (●) **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
    (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

○ **The following standard included under the State plan**

Select one:

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage: _____

○ **A dollar amount which is less than 300%.**

Specify dollar amount: _____

○ **A percentage of the Federal poverty level**

Specify percentage: _____

○ **Other standard included under the State Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: _____ If this amount changes, this item will be revised.

◉ **The following formula is used to determine the needs allowance:**

Specify:

The maintenance needs allowance is equal to the individual's total income as determined under the post-eligibility process which includes income that is placed in a Miller trust.

- ( ) **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

- (•) **Not Applicable (see instructions)**
- ( ) **SSI standard**
- ( ) **Optional State supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

Specify dollar amount: _____ If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

- (•) **Not Applicable (see instructions)**
- ( ) **AFDC need standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

Specify dollar amount: _____ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

Specify:

- ( ) **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- (●) **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The State does not establish reasonable limits.**
- ( ) **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the

reasonable indication of the need for services:

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. **Frequency of services.** The State requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- (●) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

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

The DD Division performs the initial level of care evaluation for waiver applicants. Division staff performing the initial level of care evaluation are required to have any combination of training and experience equivalent to a bachelor's degree in business or public administration, social services, psychology, counseling or education, PLUS two years of professional work experience in training, counseling, planning or administering services for persons in a developmental disability program or a visually impaired program.

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

The DD Division uses the LT-MR 104 or its successor for determination and redetermination of ICF/MR level of care. The LT-MR 104 includes verification the person has a developmental disability as well as verification the person meets the ICF/MR level of care criteria based on the following criteria: 1) Medical Criteria due to requiring daily monitoring due to his/her medical condition where overall care planning is necessary and/or supervision is needed due to medication effects, or the individual meets 2) Psychological criteria due to requiring supervision due to impaired judgment, limited capabilities, behavior, abusiveness, assaultiveness, and/or psychotropic drug effects. The individual must also have functional limitations requiring assistance with activities of daily living, self-help skills, ambulation, mobility, routine incontinence care, catheter care, ostomy, and/or a structured and safe environment that provides 24-hour supervision.

The individual is determined to meet the ICF/MR level of care if the assessed needs in the Medical, Psychological, and Functional Limitation areas require the provision of waiver services monthly to develop skills necessary for maximum independence and/or the prevention of regression or loss of current skills/abilities.

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

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

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

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

Evaluation process effective July 1, 2009:
The DD Division first requires verification of the level of care. The DD Division uses the LT-MR 104 level of care screening tool (or its successor) to verify the person meets the ICF/MR level of care. If the applicant meets the ICF/MR level of care, a psychological evaluation and a Inventory for Client and Agency Planning (ICAP) are completed to verify the applicant meets the targeting criteria in Section B-1-b, to provide information to calculate the individualized budget and, when applicable, to determine the supervision level and corresponding rate for Residential Habilitation and Day Habilitation services. The ICAP also serves as verification that the LT-MR 104 screening on ICF/MR level of care is accurate and the person meets that level of care.

Reevaluation process:
The DD Division uses the LT-MR 104 level of care screening tool to verify the person continues to meet the ICF/MR level of care. On an annual basis before the plan of care is submitted to the Division for approval, the case manager uses the level of care form to gather information that indicates the individual meets either 1) Medical Criteria due to requiring daily monitoring due to his/her medical condition where overall care planning is necessary and/or supervision is needed due to medication effects, or the individual meets 2) Psychological criteria due to requiring supervision due to impaired judgment, limited capabilities, behavior, abusiveness, assaultiveness, and/or psychotropic drug effects. The individual must also have functional limitations requiring assistance with activities of daily living, self-help skills, ambulation, mobility, routine incontinence care, catheter care, ostomy, and/or a structured and safe environment that provides 24-hour supervision.

Based upon the assessed needs in the Medical, Psychological, and Functional Limitation areas, a waiver specialist within the Medicaid State agency evaluates and determines that the individual continues to meet the ICF/MR level of care if the provision of waiver services are needed at least monthly to develop skills necessary for maximum independence and/or the prevention of regression or loss of current skills/abilities.

The psychological evaluation and the ICAP assessment are completed every 5 years to provide continued verification the person meets the targeting criteria in Section B-1-b, to update information for the individualized budget and to serve as verification that the LT-MR 104 screening on ICF/MR level of care is accurate and the person continues to meet the ICF/MR level of care.

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

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

Specify the other schedule:

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

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  Specify the qualifications:

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

In Chapter 41 Section 9 of the Wyoming Medicaid rules, the DD Division requires annual submission of level of care assessment and the plan of care from the individual's case manager. These items are required to be submitted 30 days prior to the plan start date, so the DD Division within the state Medicaid agency can determine level of care based upon recommendations by the case manager before services are authorized.

The DD Division reviews a level of care assessment to assure it meets the eligibility requirements as detailed in B.6.f. and has been completed within the required time frames. Level of care assessments must be completed annually, which is no more than 365 days from the last level of care evaluation date. The case managers' submission of the annual level of care assessment to the DD Division is tracked through the Adult DD Waiver Access database. A report is generated for the level of care determinations that are due within the next 30 days, which have not been submitted to the DD Division by the case manager. The case manager is notified by the DD Division in writing of the requirement to submit the level of care form within seven (7) business days. Once the level of care form is received, DD Division staff complete the level of care determination and enter the date that the redetermination was completed and the results of the redetermination. In instances, where assessments are not reevaluated within the required time frames, the DD Division tracks the concern and notifies the case manager that an evaluation is needed for continued eligibility. If expired assessments are identified as a concern with a provider, then the DD Division will require a quality improvement plan from the provider to ensure timeliness of continued eligibility assessments.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Maintenance of these records is required by the providers of case management. The case manager and the DD Division will maintain all documentation relevant to evaluations and reevaluations for a minimum of 6 years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

a. *Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes

are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of individuals who present for an Adult DD Level of Care assessment for whom a Level of Care assessment was completed (the number of LOC assessments completed divided by the number of individuals who present for an LOC)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult DD application referral database

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

Data Aggregation and Analysis:

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

Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of individuals who had a Level of Care assessment who were determined to be eligible for Adult DD waiver services (the number of individuals who met LOC divided by the number of individuals who had an LOC assessment completed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult DD application referral database

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

Data Aggregation and Analysis:

Responsible Party for data	**Frequency of data aggregation and**

aggregation and analysis *(check each that applies):*	**analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Proportion of Adult DD Level of Care reassessments conducted within a year of the previous Level of Care assessment (the number of LOC reassessments completed within one year divided by the total number of waiver participants)

Data Source (Select one):
Other
If 'Other' is selected, specify:
waiver access database

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

		Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Proportion of Level of Care determinations that were based on required assessments in the approved waiver (number of LOC determinations that were based on the required assessments specified in the approved Adult DD waiver divided by the total number of LOC determinations completed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult DD Plan of Care excel spreadsheet

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

Data Aggregation and Analysis:

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

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of Level of Care forms that require case management correction before Division approval (the number of LOCs requiring case management correction after review by DD Waiver Specialist divided by the total number of LOC determinations)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult DD Plan of Care excel spreadsheet

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

Data Aggregation and Analysis:

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

that applies):	
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Sub-Assurance #1: An evaluation for Level of Care (LOC) is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

The submission of the level of care assessment by the targeted case manager is tracked by the DD Division through the Adult DD Waiver Application referral database. If a case manager fails to submit the level of care assessment within 30 days of becoming the applicant's targeted case manager, DD Division staff notifies the case manager of the requirement to submit the LOC information within seven (7) business days. An application is considered complete once the applicant has completed the application form for the waiver, submitted guardianship papers (if applicable) and has a completed case management selection form signed by the case manager chosen. If the case manager submits a level of care form that is incomplete or not accurate, DD Division requires the correction of the form within seven (7) business days and tracks this information in the Adult DD Waiver Application referral database. The DD Division completes the level of care determination and tracks the determination in the Adult DD Waiver Application referral database, so the number of level of care determinations and results of the determinations can be quantified. Once an LOC determination is made, the case manager and participant/guardian are notified that either 1) the psychological and ICAP may be scheduled, or 2) the participant is not eligible for the waiver based upon the level of care determination and he/she is given the right to a fair hearing.

Sub-Assurance #2: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

The case managers' submission of the annual level of care assessment to the DD Division is tracked through the Adult DD Waiver Access database. A report is generated for the level of care determinations due within the next 30 days, which have not been submitted to the DD Division by the case manager. The case manager is notified by the DD Division in writing of the requirement to submit the level of care form within seven (7) business days. Once the level of care form is received, DD Division staff complete the level of care determination and enter the date that the redetermination was completed and the results of the redetermination. When case managers submit level of care assessments that are incomplete or inaccurate, they are required to correct it and resubmit it to the DD Division within three (3) business days. This information is

also tracked in the Adult Waiver Access database, so reports and notifications can be generated.

Sub-Assurance #3: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

The level of care assessment submitted to the DD Division by the case manager is accompanied with required assessments listed in the waiver, which are the psychological evaluation and the ICAP summary. A participant's continued eligibility for the waiver, according to the targeting criteria in B.1.b., is reviewed by the DD Division in addition to a new annual level of care assessment submitted each year or as otherwise required for a participant. Due to various dates of assessments, although required every five years, the psychological evaluation and ICAP are not often renewed at the same time. Therefore, the annual level of care determination ensures that required assessments are not outdated and reviews the diagnosis and functional limitations in the current assessments to ensure the participant still meets the targeting criteria as specified in the approved waiver. The completed level of care assessment tool is compared to the diagnosis and functional limitations specified in the other assessment tools to determine if the information in the LOC assessment is accurate and meets the requirements of an ICF/MR level of care. If the information in the LOC assessment is not reflective of the functional limitations listed in the other assessments, then the DD Division will request that one or both of the other assessments are completed again due to the possibility of a significant change in the person's condition. Or through further information gathering on the participant, the DD Division may determine the participant is no longer eligible for the waiver. If a participant becomes ineligible because of one or more of the assessment tools, then an adverse action letter will be sent to the participant and case manager to notify them of the denial of eligibility of the waiver and the participant's right to a fair hearing. If a person exits the waiver due to being determined ineligible, then a transition meeting is held for the participant to ensure that all other services and supports available to the person are accessible or arranged.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

○ **No**

◉ **Yes**

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

To help improve the DD Division's follow-up to determine whether a person has progressed in the eligibility process, The DD Division will develop a tickler system in the electronic plan of care being developed. The system will track key milestones in the application process, including selection of case manager, completion of Level of Care Assessments, etc. When milestones are not completed within the anticipated time frame, a reminder for follow-up would be sent to DD Division staff to complete follow-up with the applicant and case

manager as appropriate. The electronic application system will be web-based and implemented at the same time the electronic plan of care, which the proposed time line for implementation is December 2010.

In the interim, beginning July 1, 2009, a quarterly list of individuals that have an incomplete application packet will be generated from the Adult DD Waiver application referral database and DD Division staff will notify the applicants and their case managers in writing of all the pertinent information that has not been submitted to the DD Division. The letters will include DD Division contact information so the Division can assist the case manager and applicant through the process if needed. A copy of this list will be provided to the Adult DD Waiver Manager.

Choice of Institution or Adult DD Waiver Services:
Currently the applicant handbook distributed by the DD Division does not include written information stating the applicant has a choice of waiver or institutional services, although this information is reviewed verbally with applicants. The DD Division is adding this information directly to the application for services effective July 1, 2009 and applicants will sign the application stating they understand they have a choice of institutional or community based services.

The state accepts CMS' recommendation to complete the LOC earlier in the eligibility process. The process outlined in Appendix B-6-f will begin July 1, 2009. For individuals on the wait list, an LOC will be completed by September 30, 2009. For new applicants in the eligibility process, an LOC will be completed before they are placed on the wait list. The order of eligibility assessments will be completed as follows:
1) LOC
2) Psychological evaluation
3) ICAP

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

DD Division staff contact each Adult DD Waiver applicant in person or by telephone to explain the application process and to provide information on both Adult DD Waiver and institutional services available so the applicant can make an informed choice of institution or community based services. If Division staff are able to meet with the applicant in person the applicant is also given the DD Division's application handbook. If DD Division staff are unable to meet with the applicant in person, this information is provided over the phone and the handbook is mailed to the applicant, along with DD Division contact information. Currently the handbook does not include written information stating the applicant has a choice of waiver or institutional services. The DD Division is adding this information directly to the application for services effective July 1, 2009 and applicants will sign the application stating they understand they have a choice of institutional or community based services.

After completing the application the applicant chooses a targeted case manager who coordinates completion of the assessments needed to determine the person meets the targeting criteria and ICF/MR level of care.

Once the applicant is determined to meet the targeting criteria and ICF/MR level of care, he or she can choose to receive services in the institution or on the Adult DD Waiver. If the applicant chooses the institution, the targeted case manager assists the applicant in completing the process for applying at the institution.

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

This is a component part of case management. The case manager and the DD Division will maintain all freedom of choice forms for a minimum of 6 years.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The DD Division utilizes a Medicaid approved interpreter service. Case Managers will complete a form to request interpreter services. This interpreter service is capable of providing interpretation over 50 different languages.

Individual Plans of Care can be translated into another language upon request. If there is a significant number of beneficiaries requesting written materials in a language different than English, the DD Division will contract to have printed materials in different languages.

Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	Case Management
Statutory Service	Day Habilitation
Statutory Service	Personal Care
Statutory Service	Prevocational Services - phased out Year 1
Statutory Service	Residential Habilitation
Statutory Service	Respite
Statutory Service	Supported Employment
Statutory Service	Supported Living
Extended State Plan Service	Occupational Therapy
Extended State Plan Service	Physical Therapy
Extended State Plan Service	Speech Therapy
Other Service	Dietician Services
Other Service	Environmental Modifications
Other Service	In Home Support - Phased out Year 1
Other Service	Skilled Nursing
Other Service	Specialized Equipment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Case Management

Alternate Service Title (if any):

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

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

Service Definition *(Scope):*
Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.
Case managers are responsible for the following functions:
• Assessment and/or reassessment of the need for waiver services for final determination by DD Division;
• Development and/or review of the service plan;
• Coordination of multiple services and/or among multiple providers;
• Linking waiver participants to other Federal, state and local programs;
• Monitoring the implementation of the service plan and participant health and welfare,
• Addressing problems in service provision; and
• Responding to participant crises.

Subsequent assessments are provided under case management but will include the necessary collaboration of professionals to assess the needs, characteristics, preferences, and desires of the waiver participant. Case managers initiate and oversee the subsequent assessments. These include the psychological assessment that is required for continued eligibility, level of care re-evaluation and any other assessments that are necessary to meet the participant's needs.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is reimbursed on a monthly basis. The case manager is required to complete the following monthly:
• A home visit with the participant present to monitor the participant’s health and welfare, as well as to discuss satisfaction with services and needed changes to the plan of care with the participant.
• A minimum of 60 minutes of direct contact each month with participant and/or guardian, which must include the home visit but may also include observation of services to assess implementation of the plan of care, telephone contact with participant or guardian and/or meeting with the participant and/or guardian to complete follow up on concerns identified through incident reports, complaints or identified through other means. These contacts must be documented with time in and time out.
• Follow-up on all concerns or questions raised by the participant, guardian or plan of care team or identified through incident reports, complaints or through observation of services.
• Review service utilization and provider documentation of service, identify significant health changes, trends through incident reports, evaluate the use restraints and restrictive interventions, interview participant and/or guardian on satisfaction with services, and completing follow-up on concerns identified in any of these processes.

The case manager has the responsibility of carrying out the scope of the service definition regardless of hours needed to complete those duties.

A parent, legally responsible person, or guardian may provide case management services to their ward if they meet all the provider requirements and complete the process to become a certified Adult DD Medicaid Waiver case manager, including signing a Medicaid provider agreement. Wyoming state law does not permit parents or legally responsible persons to be reimbursed for services provided to their ward but the parent or legally responsible person may provide the service in accordance with the case manager requirements with no pay. However, they can be reimbursed for case management services they provide to other Adult DD Waiver participants who have chosen them to provide these services.

Case management services on the waiver can only be billed and reimbursed after the plan of care is approved by the DD Division. Prior to entrance to the waiver, targeted case management services are reimbursed through the Medicaid State Plan.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF-accredited agency certified to provide case management services
Agency	Agency certified to provide case management
Individual	Individual certified to provide case management services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency

Provider Type:
CARF-accredited agency certified to provide case management services

Provider Qualifications

License *(specify):*

Certificate *(specify):*
The DD Division requires agencies certified to provide case management services who are also serving three or more participants in Residential Habilitation Services or Day Habilitation Services to maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 23 of the Wyoming Medicaid rules.

Other Standard *(specify):*
Case managers must have a minimum of one year experience in the field of Mental Retardation and a Bachelors degree, master's degree or doctoral degree; OR two years (48 credit hours) of college credit and two years of experience in the field of mental retardation. Case managers must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Case managers are required to complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Case managers are required to facilitate team meetings, complete and submit the individual plan of care to the DD Division for approval, and monitor the implementation of the individual plan of care, including health and safety, progress on objectives, satisfaction with services, and appropriateness and quality of services being provided, per Developmental Disabilities Division rules, Chapter 1.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards, including standards

on case management services. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accreditation report and corresponding quality improvement plans.

In addition to the CARF accreditation, the DD Division initially certifies a new agency certified to provide case management for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a two year recertification.

The DD Division has the authority to monitor agencies certified to provide case management services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the case manager is not complying with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
Agency certified to provide case management
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Agencies certified to provide case management services must verify case management staff have a minimum of one year experience in the field of Mental Retardation and a Bachelors degree, master's degree or doctoral degree; OR two years (48 credit hours) of college credit and two years of experience in the field of mental retardation. Case Managers must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Case managers are required to complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Case managers are required to facilitate team meetings, complete and submit the individual plan of care to the Division for approval, and monitor the implementation of the individual plan of care, including health and safety, progress on objectives, satisfaction with services, and appropriateness and quality of services being provided, per Developmental Disabilities Division rules, Chapter 1.
Verification of Provider Qualifications
Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The DD Division initially certifies a new agency providing case management for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency certified for up to two years. Agencies certified

to provide case management who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the case manager is not complying with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Individual
Provider Type:
Individual certified to provide case management services
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Individuals certified to provide case management services must have a minimum of a Bachelors degree and ½ year of experience working with individuals with acquired brain injury (ABI) or an Associate's degree and two years of experience working with individuals with ABI or equivalent training and experience in ABI. Individuals certified to provide case management services must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Individuals certified to provide case management services are required to complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Individuals certified to provide case management services are required to facilitate team meetings, complete and submit the individual plan of care to the Division for approval, and monitor the implementation of the individual plan of care, including health and safety, progress on objectives, satisfaction with services, and appropriateness and quality of services being provided, per Developmental Disabilities Division rules, Chapter 1.
Verification of Provider Qualifications
Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
Individuals certified to provide case management services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide case management services can be recertified for up to two years. Individuals certified to provide case management services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide case management services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The DD Division has the authority to monitor individuals certified to provide case management services throughout their recertification period through the DD Division's complaint process, incident reporting process,

or the DD Division's internal referral process. The DD Division has the authority to monitor case managers throughout their recertification period through the DD Division's complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

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

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

Service Definition *(Scope):*

Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished four (4) or more hours per day on a regularly scheduled basis for one (1) or more days per week or as specified in the participant's service plan. Day habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in other settings.

Individuals in Day Habilitation may be paid for work activities if the focus of the activity is not independent employment but a means to encourage acquisition, retention, or improvement of skills. If an organization is paying less than minimum wage, all wage and hour labor laws will be met.

All transportation including trips to and from the residence, therapy, volunteer sites, and any community activities will be included in the rate.

Day Habilitation Intervention can be added to a plan for situations where a participant's supervision level may not provide sufficient staffing for specific activities, but the extensive supervision is not needed at all times. Intervention provides an extra staff person to supervise a participant during times of behavioral episodes, extensive personal care, positioning, health, medical, or safety needs. Intervention for behavioral purposes is not intended for watching the person should the behavior occur, but for the purpose of teaching appropriate behaviors and keeping the participant safe.

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

The plan of care must identify either the daily unit or the 15 minute unit based on the participant's need. The daily unit requires a minimum of four (4) hours a day of service and assumes five (5) units per week. Units will be based on individual need with the maximum of 15-minute units being 3750 units in a plan year.

Day habilitation services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF Accredited agency certified to provide day habilitation services
Agency	Agency certified to provide day habilitation services
Individual	Individual certified to provide day habilitation services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Agency
Provider Type:
CARF Accredited agency certified to provide day habilitation services
Provider Qualifications
License *(specify):*

Certificate *(specify):*
The DD Division requires providers certified to provide day habilitation services who are serving three or more participants in Residential Habilitation Services or Day Habilitation Services to maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 23 of the Wyoming Medicaid rules.
Other Standard *(specify):*
Agencies must meet all applicable CARF Standards and maintain CARF accreditation. These standards cover leadership, strategic planning, health and safety, human resources, rights of participants, quality improvement within the agency, employment services, community services, and individualized services and supports. In addition, all staff providing day habilitation services to participants must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Provider staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition to the policies and procedures required by the CARF standards, providers must also have policies and procedures for incident reporting, restraint usage, and conflicts of interest.
Verification of Provider Qualifications
Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards, including standards

on day habilitation services. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accreditation report and corresponding quality improvement plans.

In addition to the CARF accreditation, the DD Division initially certifies agencies providing day habilitation services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Agency
Provider Type:
Agency certified to provide day habilitation services
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Agencies providing day habilitation services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 24, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing day habilitation services upon hire, maintaining current CPR and First Aid Certification for all direct care staff, and assuring staff transporting participants have a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must post emergency plans, complete emergency drills, complete internal and external inspections, adhere to documentation standards, and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest.
Verification of Provider Qualifications
Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The DD Division initially certifies a new agency providing day habilitation services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through

the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Individual

Provider Type:
Individual certified to provide day habilitation services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Individuals certified to provide day habilitation services must be 18 years of age or older, complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Individuals certified to provide day habilitation services must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition, individuals certified to provide day habilitation services serving people in a facility they own or lease must have policies and procedures in place addressing emergency situations and drills, external and internal inspections, weapons, smoking , pets, incident reporting, restraint usage, and conflicts of interest. They must complete Central Abuse Registry screenings and Criminal History Background checks on all people 18 years of age or older living in the home. Individuals certified to provide day habilitation services who are not serving people in a home or facility they own or lease must have policies and procedures in place addressing, as applicable, emergency situations and drills, weapons, smoking, pets, incident reporting, restraint usage, and conflicts of interest. They must also complete Central Abuse Registry screenings and Criminal History Background checks on all people 18 years of age or older participating in the delivery of services. If a person living in the home does not meet the background check requirements the individual certified to provide day habilitation services is not approved to provide services in that home. The individual certified to provide day habilitation services is also required to sign a "Not In My Home" form stating that under no circumstances will services be provided in their home or they may be decertified as a waiver provider.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
Individuals certified to provide day habilitation services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide day habilitation services can be recertified for up to two years. Individuals certified to provide day habilitation services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide day habilitation services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The DD Division has the authority to monitor individuals certified to provide day habilitation services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

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

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

Service Definition *(Scope):*

A range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by State law.

Such assistance may include assistance in performing activities of daily living (ADLs-bathing dressing, toileting, transferring, maintaining continence) and instrumental activities of daily living (IADLs -more complex life activities, e.g. personal hygiene, light housework, laundry, meal preparation, exclusive of the cost of the meal, transportation, grocery shopping, using the telephone, medication and money management). Personal care services cannot be used in conjunction with residential or day habilitation services.

This is a 1:1 service based on individual needs. The participant must be physically present. Personal care may be provided in the participant's home or in the community. Transportation costs must be included as part of this service.

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

Units will be based on individual need with a maximum of 7280 units of personal care in a plan year unless more are approved by the DD Division due to extraordinary circumstances.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title

Agency	**Agency certified to provide personal care services**
Agency	**Home Health Agency certified to provide personal care**
Agency	**CARF Accredited agency certified to provide personal care services**
Individual	**Individual certified to provide personal care services**

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Agency
Provider Type:
Agency certified to provide personal care services
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Agencies providing personal care services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 24, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing personal care services upon hire, maintaining current CPR and First Aid Certification for all direct care staff, and assuring staff transporting participants have a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must post emergency plans, complete emergency drills, complete internal and external inspections, adhere to documentation standards, and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest
Verification of Provider Qualifications
Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The DD Division initially certifies a new agency providing personal care services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Home Health Agency certified to provide personal care

Provider Qualifications

License *(specify):*

Medicare certified or state licensed Home Health Agency fully licensed in Wyoming.

Certificate *(specify):*

Other Standard *(specify):*

Home Health Agencies providing personal care services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 24, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing personal care services upon hire, maintaining current CPR and First Aid Certification for all direct care staff, and assuring staff transporting participants have a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must post emergency plans, complete emergency drills, complete internal and external inspections, adhere to documentation standards, and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new home health agency providing personal care services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify a home health agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor home health agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

CARF Accredited agency certified to provide personal care services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The DD Division requires agencies certified to provide personal care services who are also serving three or more participants in Residential Habilitation Services or Day Habilitation Services to

maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 23 of the Wyoming Medicaid rules.

Other Standard *(specify):*

Providers must meet all applicable CARF Standards and maintain CARF accreditation. These standards cover leadership, strategic planning, health and safety, human resources, rights of participants, quality improvement within the agency, employment services, community services, and individualized services and supports. In addition, all staff providing personal care services to participants must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Provider staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition to the policies and procedures required by the CARF standards, providers must also have policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards, including standards on case management services. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accreditation report and corresponding quality improvement plans.

In addition to the CARF accreditation, the DD Division initially certifies a new agency providing personal care services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Individual

Provider Type:

Individual certified to provide personal care services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals certified to provide personal care services must be 18 years of age or older, complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Individuals certified to provide personal care services must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition, individuals certified to provide personal care services serving people in a home or facility they own or lease must have policies and procedures in place addressing emergency situations and drills, external and internal inspections, weapons, smoking, pets, incident reporting, restraint usage, and conflicts of interest. They must also complete Central Abuse Registry screenings and Criminal History Background checks on all people 18 years of age or older living in the home. Individuals certified to provide personal care services who are not serving people in a home or facility they own or lease must have policies and procedures in place, as applicable, addressing emergency situations and drills, weapons, smoking, pets, incident reporting, restraint usage, and conflicts of interest. They must also complete Central Abuse Registry screenings and Criminal History Background checks on all people 18 years of age or older participating in the delivery of services. If a person living in the home does not meet the background check requirements the individual certified to provide personal care services is not be approved to provide services in that home. The individual certified to provide personal care services is also required to sign a "Not In My Home" form stating that under no circumstances will services be provided in their home or they may be decertified as a waiver provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

Individuals certified to provide personal care services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide personal care services can be recertified for up to two years. Individuals certified to provide personal care services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide personal care services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The DD Division has the authority to monitor individuals certified to provide personal care services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

Prevocational Services - phased out Year 1

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

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

Service Definition *(Scope):*
Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). When compensated, individuals are paid at less than 50 percent of the minimum wage.
Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.
Documentation will be maintained in the file of each individual receiving this service that:
Prevocational services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)).
The Wyoming Division of Vocational Rehabilitation do not provide funding for pre-vocational services, therefore funding opportunities are not otherwise available.

This service will be phased out in Year 1 of the waiver renewal.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual certified to provide prevocational services
Agency	Agency certified to provide prevocational services
Agency	CARF Accredited agency certified to provide prevocational services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services - phased out Year 1

Provider Category:
Individual
Provider Type:
Individual certified to provide prevocational services
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals certified to provide prevocational services must be 18 years of age or older, complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Individuals certified to provide prevocational services must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Individuals certified to provide prevocational services must have policies and procedures in place addressing, as applicable, emergency situations and drills, weapons, smoking , pets, incident reporting, restraint usage, and conflicts of interest. Individuals certified to provide prevocational services must also meet the applicable Medicaid rules and regulations, including assuring participants are involved in making informed employment related decisions, participants are linked to services and community resources that enable them to achieve their employment objectives, and are given information on local job opportunities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

Individuals certified to provide prevocational services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide prevocational services can be recertified for up to two years. Individuals certified to provide prevocational services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide prevocational services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The DD Division has the authority to monitor individuals certified to provide prevocational services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services - phased out Year 1

Provider Category:

Agency

Provider Type:

Agency certified to provide prevocational services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies providing prevocational services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 24, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing prevocational services upon hire, maintaining current CPR and First Aid Certification for all direct care staff, and assuring staff transporting participants have a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must post emergency plans,

complete emergency drills, complete internal and external inspections, adhere to documentation standards, and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new agency providing prevocational services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency certified for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services - phased out Year 1

Provider Category:

Agency

Provider Type:

CARF Accredited agency certified to provide prevocational services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The DD Division requires providers certified to provide prevocational services who are serving three or more participants in Residential Habilitation Services or Day Habilitation Services to maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 23 of the Wyoming Medicaid rules.

Other Standard *(specify):*

Agencies must meet all applicable CARF Standards and maintain CARF accreditation. These standards cover leadership, strategic planning, health and safety, human resources, rights of participants, quality improvement within the agency, employment services, community services, and individualized services and supports. In addition, all staff providing prevocational services to participants must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Agency staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition to the policies and procedures required by the CARF standards, providers must also have policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Agencies must also meet the applicable Medicaid rules and regulations, including assuring participants are involved in making informed employment related decisions, participants are linked to services and community resources that enable them to achieve their employment objectives, participants are given information on local job opportunities.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards, including standards on case management services. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accreditation report and corresponding quality improvement plans.

In addition to the CARF accreditation, the DD Division initially certifies a new agency for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Residential Habilitation
Alternate Service Title (if any):

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

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

Service Definition *(Scope):*
Individually-tailored supports for a waiver participant that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care, protective oversight and supervision.
Residential habilitation may be furnished in a home owned or leased by a provider or in the participant's home, where staff provides on-going 24 hour supervision. Provider owned or leased facilities where residential habilitation services are furnished must be compliant with the Americans with Disabilities Act.
Transportation between the participant's place of residence, other service sites, or places in the community is included in the rate.
Payment is not made, directly or indirectly, to members of the participant's immediate family, except as provided in Appendix C-2. Payment is not be made for the cost of room and board, including the cost of building

maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for residential habilitation is specified in Appendix I-5.

Residential Habilitation Intervention can be added to a plan for situations where a participant's supervision level may not provide sufficient staffing for specific activities, but the extensive supervision is not needed at all times. Intervention provides an extra staff person to supervise a participant during times of behavioral episodes, extensive personal care, positioning, health, medical, or safety needs. Intervention for behavioral purposes is not intended for watching the person should the behavior occur, but for the purpose of teaching appropriate behaviors and keeping the participant safe.

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

The provision of residential habilitation services includes personal care needs, so plans of care are not approved that include both residential services and personal care services. The participant must be in service a minimum of 8 hours in a 24 hour period (from 12:00am-11:59pm) for the provider to be reimbursed. Family visits and trips are encouraged. The provider will be allowed to be reimbursed on the day the participant returns home from a trip.

Waiver participants who are not receiving 24-hour residential services but are at significant risk due to extraordinary needs that cannot be met in their current living arrangement may request 24-hour Residential Habilitation services if the participant meets one of the following targeting criteria:

• A substantial threat to a person's life or health caused by homelessness or abuse/neglect that is either substantiated by Department of Family Services or corroborated by the Developmental Disabilities Division or Protection & Advocacy Systems, Inc.
• Situations where the person's condition poses a substantial threat to a person's life or health, and is documented in writing by a physician.
• Situations where a person has caused serious physical harm to him or herself or someone else in the home, or the person's condition presents a substantial risk of physical threat to him or herself or others in the home.
• Situations where there are significant and frequently occurring behavior challenges resulting in danger to the person's health and safety, or the health and safety of others in the home.
• Situations where the person's critical medical condition requires ongoing 24-hour support and supervision to maintain the person's health and safety.
• Loss of primary caregiver due to caregiver's death, incapacitation, critical medical condition, or inability to provide continuous care.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF Accredited agency certified to provide residential habilitation services
Individual	Individual certified to provide residential habilitation services
Agency	Agency certified to provide residential habilitation services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:
CARF Accredited agency certified to provide residential habilitation services
Provider Qualifications
License *(specify):*

Certificate *(specify):*
The DD Division requires providers certified to provide Residential Habilitation Services who are serving three or more participants in Residential Habilitation Services or Day Habilitation Services to maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 23 of the Wyoming Medicaid rules.
Other Standard *(specify):*
Agencies must meet all applicable CARF Standards and maintain CARF accreditation. These standards cover leadership, strategic planning, health and safety, human resources, rights of participants, quality improvement within the agency, employment services, community services, and individualized services and supports. In addition, all staff providing residential habilitation services to participants must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Provider staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition to the policies and procedures required by the CARF standards, providers must also have policies and procedures for incident reporting, restraint usage, and conflicts of interest.
Verification of Provider Qualifications
Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards, including standards on case management services. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accreditation report and corresponding quality improvement plans.

In addition to the CARF accreditation, the DD Division initially certifies a new agency certified to provide residential habilitation services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Individual
Provider Type:

Individual certified to provide residential habilitation services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals certified to provide residential habilitation services must be 18 years of age or older, complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Individuals certified to provide residential habilitation services must complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition, individuals certified to provide residential habilitation services serving people in a facility or home they own or lease must have policies and procedures in place addressing emergency situations and drills, external and internal inspections, weapons, smoking, pets, incident reporting, restraint usage, and conflicts of interest. They must also complete Central Abuse Registry screenings and Criminal History Background checks on all people 18 years of age or older living in the home. Individuals certified to provide residential habilitation services who are not serving people in a home or facility they own or lease must have policies and procedures in place addressing, as applicable, emergency situations and drills, weapons, smoking, pets, incident reporting, restraint usage, and conflicts of interest. They must also complete Central Abuse Registry screenings and Criminal History Background checks on all people 18 years of age or older participating in the delivery of services. If a person living in the home does not meet the background check requirements the individual certified to provide residential habilitation services is not be approved to provide services in that home. The individual certified to provide residential habilitation services is also required to sign a "Not In My Home" form stating that under no circumstances will services be provided in their home or they may be decertified as a waiver provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

Individuals certified to provide residential habilitation services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide residential habilitation services can be recertified for up to two years. Individuals certified to provide residential habilitation services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide residential habilitation services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The DD Division has the authority to monitor individuals certified to provide residential habilitation services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Agency certified to provide residential habilitation services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies providing residential habilitation services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 24, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing residential habilitation services upon hire, maintaining current CPR and First Aid Certification for all direct care staff, and assuring staff transporting participants have a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must post emergency plans, complete emergency drills, complete internal and external inspections, adhere to documentation standards, and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new agency providing residential habilitation services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

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

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

- [x] **Service is included in approved waiver. The service specifications have been modified.**
- [ ] **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Respite care consists of those services given to participants unable to care for themselves. Respite is intended to be on a short-term basis because of the absence or need for relief of the natural care giver. Respite services shall be based upon need. Respite cannot be used as a substitute for care while the primary caregiver is at work. Respite must be episodic, for special events when the caregiver needs relief. It cannot be used for daily scheduled supervision.

Respite care may be provided in the participant's home, the private residence of a respite care provider, in a group home as long as the staff person in the group home does not have supervision duties to others living in the group home. Respite providers may take participants to various community settings, such as parks, recreation centers and other outings.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Respite services shall not exceed 7280 units per year unless more are approved by the DD Division, due to extraordinary circumstances.
Respite services shall not be allowable for CARF certified providers of Residential Habilitation. Providers who serve 2 or less individuals in Residential Habilitation who are not CARF certified may receive a maximum of 1,344 units to cover vacations, sick days, or other emergencies.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency certified to provide respite services
Individual	Individual certified to provide respite services
Agency	CARF Accredited agency certified to provide respite services
Agency	Agency certified to provide respite services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Home Health Agency certified to provide respite services
Provider Qualifications
License *(specify):*
Medicare certified or state licensed Home Health Agency fully licensed in Wyoming.
Certificate *(specify):*

Other Standard *(specify):*

Home Health Agencies providing respite services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 24, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing respite services upon hire, maintaining current CPR and First Aid Certification for all direct care staff, and assuring staff transporting participants have a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must post emergency plans, complete emergency drills, complete internal and external inspections, adhere to documentation standards, and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new home health agency providing respite services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify a home health agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor home health agencies providing respite services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Individual certified to provide respite services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals certified to provide respite services must be 18 years of age or older, complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Individuals certified to provide respite services must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition, individuals certified to provide respite services serving people in a facility they own or lease must also have policies and procedures in place addressing emergency situations and drills, external and internal inspections, weapons, smoking, pets, incident reporting, restraint usage, and conflicts of

interest. They must also complete Central Abuse Registry screenings and Criminal History Background checks on all people 18 years of age or older living in the home. Individuals certified to provide respite services who are not serving people in a home or facility they own or lease must have policies and procedures in place addressing, as applicable, emergency situations and drills, weapons, smoking, pets, incident reporting, restraint usage, and conflicts of interest. They must also complete Central Abuse Registry screenings and Criminal History Background checks on all people 18 years of age or older participating in the delivery of services.

If a person living in the home does not meet the background check requirements the individual certified to provide respite services is not be approved to provide services in that home. The individual certified to provide respite services is also required to sign a "Not In My Home" form stating that under no circumstances will services be provided in their home or they may be decertified as a waiver provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

Individuals certified to provide respite services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide respite services can be recertified for up to two years. Individuals certified to provide respite services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide respite services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The DD Division has the authority to monitor individuals certified to provide respite services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

CARF Accredited agency certified to provide respite services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The DD Division requires providers certified to provide respite services who are serving three or more participants in Residential Habilitation Services or Day Habilitation Services to maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 23 of the Wyoming Medicaid rules.

Other Standard *(specify):*

Agencies must meet all applicable CARF Standards and maintain CARF accreditation. These standards cover leadership, strategic planning, health and safety, human resources, rights of participants, quality improvement within the agency, employment services, community services, and individualized services and supports. In addition, all staff providing respite services to participants must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Provider staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards,

provider recertification requirements, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition to the policies and procedures required by the CARF standards, providers must also have policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards, including standards on case management services. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accreditation report and corresponding quality improvement plans.

In addition to the CARF accreditation, the DD Division initially certifies a new agency certified to provide respite services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Agency certified to provide respite services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies providing respite services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 24, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing respite services upon hire, maintaining current CPR and First Aid Certification for all direct care staff, and assuring staff transporting participants have a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must post emergency plans, complete emergency drills, complete internal and external inspections, adhere to documentation standards, and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The DD Division initially certifies a new agency providing respite services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Supported Employment
Alternate Service Title (if any):

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

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

Service Definition *(Scope):*
Supported Employment Services may be provided as a 1:1 service under Individual Community Integrated Employment services or under a group rate under Group Supported Employment Services.

Supported Employment Services, provided as Individual Community Integrated Employment services or Group Supported Employment Services consist of intensive, ongoing support that enable a participant, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of his/her disability, need supports to perform in a regular work setting. Services may include assisting the participant to locate a job or develop a job on behalf of the participant. Services are conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Services include activities needed to sustain paid work by a participant, including supervision and training. When Supported Employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.
Objectives must be identified in the participant's plan that support the need for continued job coaching. The job coach must be in the immediate vicinity and available for immediate intervention and support. Transportation is included in the reimbursement rate.

Group Supported employment can include employment in community businesses or businesses that are part of a

provider organization. Individual Community Integrated Employment Services must be provided in a community employment setting.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to an participant's supported employment program.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified to provide supported employment services
Individual	individual certified to provide supported employment services
Agency	CARF Accredited agency certified to provide supported employment services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
Agency certified to provide supported employment services
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Agencies providing supported employment services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 24, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing support employment services upon hire, maintaining current CPR and First Aid Certification for all direct care staff, and assuring staff transporting participants have a current driver's license and automobile insurance. Agency direct care

staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must post emergency plans, complete emergency drills, complete internal and external inspections, adhere to documentation standards, and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest. Agencies must also meet the applicable Medicaid rules and regulations, including assuring participants are involved in making informed employment related decisions, participants are linked to services and community resources that enable them to achieve their employment objectives, participants are given information on local job opportunities, and participants' satisfaction with employment services is assessed on a regular basis.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new agency providing supported employment services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Individual

Provider Type:

individual certified to provide supported employment services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals certified to provide supported employment services must be 18 years of age or older, complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Individuals certified to provide supported employment services must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Individuals certified to provide supported employment services must have policies and procedures in place addressing, as applicable, emergency situations and drills, weapons, smoking , pets, incident reporting, restraint usage, and conflicts of interest. Individuals certified to provide supported employment services must also meet the applicable Medicaid rules and regulations, including assuring participants are involved in making informed employment related decisions, participants are

linked to services and community resources that enable them to achieve their employment objectives, participants are given information on local job opportunities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

Individuals certified to provide supported employment services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, Individuals certified to provide supported employment services can be recertified for up to two years. Individuals certified to provide supported employment services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide supported employment services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The DD Division has the authority to monitor individuals certified to provide supported employment services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

CARF Accredited agency certified to provide supported employment services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The DD Division requires providers certified to provide supported employment services who are serving three or more participants in Residential Habilitation Services or Day Habilitation Services to maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 23 of the Wyoming Medicaid rules.

Other Standard *(specify):*

Agencies must meet all applicable CARF Standards and maintain CARF accreditation. These standards cover leadership, strategic planning, health and safety, human resources, rights of participants, quality improvement within the agency, employment services, community services, and individualized services and supports. In addition, all staff providing supported employment services to participants must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Provider staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition to the policies and procedures required by the CARF standards, providers must also have policies and procedures for incident reporting, restraint usage, and conflicts of interest. Agencies must also meet the applicable Medicaid rules and regulations, including assuring participants are involved in making informed employment related decisions, participants are linked to services and community resources that enable them to achieve their employment objectives, participants are given information on local job opportunities, and participants' satisfaction with employment services is assessed on a regular basis.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division
Frequency of Verification:
The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards, including standards on employment services. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accreditation report and corresponding quality improvement plans.

In addition to the CARF accreditation, the DD Division initially certifies a new agency providing supported employment services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a two year recertification.

The DD Division has the authority to monitor agencies services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Habilitation
Alternate Service Title (if any):
Supported Living

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

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

Service Definition *(Scope):*
Supported Living Services assist persons with disabilities to live in their own home, family home, or rental unit. These individuals do not require ongoing 24-hour supervision but do require a range of community-based support to maintain their independence. They require individually-tailored supports to assist with the acquisition, retention, or improvement in skills related to living successfully in the community.

Supported living services shall be based upon need. These services can include: assisting with common daily living activities; performing routine household activities to maintain a clean and safe home; assistance with health issues, medications, and medical services; teaching the use of the community's transportation system; teaching the use of police, fire and emergency assistance; managing personal financial affairs; building and maintaining interpersonal relationships; participating in community life; and 24-hour emergency assistance. This service includes personal care, therefore personal care services cannot be added as a separate service on the plan of care.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The plan of care must identify either the daily unit or the 15 minute unit based on the participant's need. The

daily unit requires a minimum of 4 hours a day of services and can be reimbursed to up to three participants. The maximum of 15 minute units will be 5400 units in a plan year for the group rate and 3900 units for the individual rate.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual certified to provide Supported Living Services
Agency	Agency certified to provide supported living services
Agency	CARF Accredited agency certified to provide Supported Living Services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Living

Provider Category:
Individual

Provider Type:
Individual certified to provide Supported Living Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Individuals certified to provide Supported Living Services must be 18 years of age or older, complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Individuals certified to provide Supported Living Services must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Individuals certified to provide Supported Living Services must have policies and procedures in place addressing, as applicable, emergency situations and drills, weapons, smoking , pets, incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
Individuals certified to provide Supported Living Services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide Supported Living Services can be recertified for up to two

years. Individuals certified to provide Supported Living Services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide Supported Living Services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The DD Division has the authority to monitor individuals certified to provide Supported Living Services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Living

Provider Category:
Agency

Provider Type:
Agency certified to provide supported living services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Agencies providing supported living services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 24, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing supported living services upon hire, maintaining current CPR and First Aid Certification for all direct care staff, and assuring staff transporting participants have a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must post emergency plans, complete emergency drills, complete internal and external inspections, adhere to documentation standards, and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
The DD Division initially certifies a new agency providing supported living services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Living

Provider Category:
Agency
Provider Type:
CARF Accredited agency certified to provide Supported Living Services
Provider Qualifications
License *(specify):*

Certificate *(specify):*
The DD Division requires providers certified to provide supported living services who are serving three or more participants in Residential Habilitation Services or Day Habilitation Services to maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 23 of the Wyoming Medicaid rules.
Other Standard *(specify):*
Agencies must meet all applicable CARF Standards and maintain CARF accreditation. These standards cover leadership, strategic planning, health and safety, human resources, rights of participants, quality improvement within the agency, employment services, community services, and individualized services and supports. In addition, all staff providing supported living services to participants must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Provider staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition to the policies and procedures required by the CARF standards, providers must also have policies and procedures for incident reporting, restraint usage, and conflicts of interest.
Verification of Provider Qualifications
Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards, including standards on employment services. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accreditation report and corresponding quality improvement plans.

In addition to the CARF accreditation, the DD Division initially certifies a new agency providing supported living services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a two year recertification.

The DD Division has the authority to monitor agencies services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

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

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

Service Definition *(Scope):*

Occupational Therapy services consist of the full range of activities provided by a licensed occupational therapist. Services include assessing needs, development a treatment plan, determining therapeutic intervention, training and assisting with adaptive aids. Occupational Services through the waiver can be used for maintenance and the prevention of regression of skills. The units must be prior authorized and must be prescribed by a physician. State Plan Occupational Services are limited to restorative therapy.

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

Services are provided under the state plan when they are restorative. Maintenance therapy may be provided under the waiver. These services are uniquely coded. Edits to MMIS prohibit both restorative and maintenance therapy from being billed on the same day.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified to provide occupational therapy services
Individual	Individual certified to provide occupational therapy services
Agency	Home Health Agency certified to provide occupational therapy services

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Agency certified to provide occupational therapy services

Provider Qualifications

License *(specify):*

Agencies providing occupational therapy services must assure individuals providing the service have a current license to practice occupational therapy by the Wyoming Board of Occupational Therapy

per Wyoming Medicaid Rules, Chapter 45, Section 13.

Certificate *(specify):*

Other Standard *(specify):*

Agencies providing occupational therapy services must assure occupational therapists complete Central Abuse Registry Screenings and Criminal History Background checks, maintain current CPR and First Aid Certification, and have a current driver's license and automobile insurance if transporting participants. Occupational therapists must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new agency providing occupational therapy services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Individual certified to provide occupational therapy services

Provider Qualifications

License *(specify):*

Individuals certified to provide occupational therapy services must have a current license to practice occupational therapy by the Wyoming Board of Occupational Therapy per Wyoming Medicaid Rules, Chapter 45, Section 13.

Certificate *(specify):*

Other Standard *(specify):*

In addition to having a current license to practice occupational therapy, occupational therapists are required to complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Occupational therapists must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

Individuals certified to provide occupational therapy services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide occupational therapy services can be recertified for up to

two years. Individuals certified to provide occupational therapy services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide occupational therapy services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The DD Division has the authority to monitor individuals certified to provide occupational therapy services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency certified to provide occupational therapy services

Provider Qualifications

License *(specify):*

Medicare certified or state licensed Home Health Agency fully licensed in Wyoming.
Home Health Agencies providing occupational therapy services must assure individuals providing the service have a current license to practice occupational therapy by the Wyoming Board of Occupational Therapy per Wyoming Medicaid Rules, Chapter 45, Section 13.

Certificate *(specify):*

Other Standard *(specify):*

Home Health Agencies providing occupational therapy services must assure occupational therapists complete Central Abuse Registry Screenings and Criminal History Background checks, maintain current CPR and First Aid Certification, and have a current driver's license and automobile insurance if transporting participants. Occupational therapists must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new home health agency providing occupational therapy services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify a home health agency providing occupational therapy services for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor home health agencies certified to provide occupational therapy services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

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

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

Service Definition *(Scope):*

Physical Therapy services consist of the full range of activities provided by a licensed physical therapist. This service assists individuals to preserve and improve their abilities for independent function such as range of motion, strength, tolerance, and coordination. It may also prevent, insofar as possible, irreducible or progressive disabilities through the use of assistive and adaptive devices, positioning, and sensory stimulation. Physical Therapy Services through the waiver can be used for maintenance and the prevention of regression of skills. The units must be prior authorized and must be prescribed by a physician. State Plan Physical Services are limited to restorative therapy.

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

Services are provided under the state plan when they are restorative. Maintenance therapy may be provided under the waiver. These services are uniquely coded. Edits to MMIS prohibit both restorative and maintenance therapy from being billed on the same day.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified to provide physical therapy services
Agency	Home Health Agency certified to provide physical therapy services
Individual	Individual certified to provide physical therapy services

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Agency certified to provide physical therapy services

Provider Qualifications

License *(specify):*

Agencies providing physical therapy services must assure physical therapists have a current license to practice physical therapy by the Wyoming Board of Physical Therapy per Wyoming Medicaid Rules, Chapter 45, Section 15.

Certificate *(specify):*

Other Standard *(specify):*

Agencies providing physical therapy services must assure physical therapists complete Central Abuse Registry Screenings and Criminal History Background checks, maintain current CPR and First Aid Certification, and have a current driver's license and automobile insurance if transporting participants. Physical therapists must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new agency providing physical therapy services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The Division has the authority to monitor providers throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency certified to provide physical therapy services

Provider Qualifications

License *(specify):*

Medicare certified or state licensed Home Health Agency fully licensed in Wyoming.
Physical therapists must have a current license to practice physical therapy by the Wyoming Board of Physical Therapy per Wyoming Medicaid Rules, Chapter 45, Section 15.

Certificate *(specify):*

Other Standard *(specify):*

Home Health Agencies providing physical therapy services must assure physical therapists complete Central Abuse Registry Screenings and Criminal History Background checks, maintain current CPR and First Aid Certification, and have a current driver's license and automobile insurance if transporting participants. Physical therapists must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new home health agency providing physical therapy services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify a home health agency providing physical therapy services for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor home health agencies providing physical therapy services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Individual certified to provide physical therapy services

Provider Qualifications

License *(specify):*

Individuals certified to provide physical therapy services must have a current license to practice physical therapy by the Wyoming Board of Physical Therapy per Wyoming Medicaid Rules, Chapter 45, Section 15.

Certificate *(specify):*

Other Standard *(specify):*

In addition to having a current license to practice physical therapy, physical therapists are required to complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Physical therapists must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

Individuals certified to provide physical therapy services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide physical therapy services can be recertified for up to two years. Individuals certified to provide physical therapy services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide physical therapy services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The Division has the authority to monitor individuals certified to provide physical therapy services throughout their

recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Speech Therapy

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

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

Service Definition *(Scope):*

Speech Therapy services consist of the full range of activities provided by a licensed speech therapist. Services include screening and evaluation of participants with respect to speech function; development of therapeutic treatment plans; direct therapeutic intervention; selection, assistance, and training with augmentative communication devices, and the provision of ongoing therapy. Speech Therapy services through the waiver can be used for maintenance and the prevention of regression of skills. The units must be prior authorized and must be prescribed by a physician.

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

Services are provided under the state plan when they are restorative. Maintenance therapy may be provided under the waiver. These services are uniquely coded. Edits to MMIS prohibit both restorative and maintenance therapy from being billed on the same day.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual certified to provide speech therapy services
Agency	Agency certified to provide speech therapy services
Agency	Home Health Agency certified to provide speech therapy services

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Speech Therapy

Provider Category:

Individual

Provider Type:

Individual certified to provide speech therapy services

Provider Qualifications

License *(specify):*

An individual certified to provide speech therapy must have a current license to practice speech hearing and language services by the Wyoming Board of Speech Therapy per Wyoming Medicaid Rules, Chapter 45, Section 22.

Certificate *(specify):*

Other Standard *(specify):*

In addition to having a current license to practice speech therapy, speech therapists are required to complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Speech therapists must also complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

Individuals certified to provide speech therapy services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide speech therapy services can be recertified for up to two years. Individuals certified to provide speech therapy services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification,and individuals certified to provide speech therapy services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The Division has the authority to monitor individuals certified to provide speech therapy services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Agency certified to provide speech therapy services

Provider Qualifications

License *(specify):*

Agencies providing speech therapy services are required to assure staff providing speech therapy services have a current license to practice speech hearing and language services by the Wyoming Board of Speech Therapy per Wyoming Medicaid Rules, Chapter 45, Section 22.

Certificate *(specify):*

Other Standard *(specify):*

Agencies providing speech therapy services must assure speech therapists complete Central Abuse

Registry Screenings and Criminal History Background checks, maintain current CPR and First Aid Certification, and have a current driver's license and automobile insurance if transporting participants. Speech therapists must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new agency providing speech therapy services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency certified to provide speech therapy services

Provider Qualifications

License *(specify):*

Medicare certified or state licensed Home Health Agency fully licensed in Wyoming. Agencies providing speech therapy services are required to assure staff providing speech therapy services have a current license to practice speech hearing and language services by the Wyoming Board of Speech Therapy per Wyoming Medicaid Rules, Chapter 45, Section 22.

Certificate *(specify):*

Other Standard *(specify):*

Home Health Agencies providing speech therapy services must assure speech therapists complete Central Abuse Registry Screenings and Criminal History Background checks, maintain current CPR and First Aid Certification, and have a current driver's license and automobile insurance if transporting participants. Speech therapists must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new home health agency providing speech therapy services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify a home health agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor home health agencies providing speech therapy

services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Dietician Services

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

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

Service Definition *(Scope):*

Dietitian Services provided by a registered dietitian include menu planning, consultation with and training for caregivers, and education for the participant served. The service does not include the cost of meals. Dietitian Services are not available under the State Plan. Without this service certain individuals would receive inadequate nourishment and would require institutionalization. The Dietitian services are those services designated in the client's Individual Plan of Care (IPC). The clientele served by this service show a pattern of chronic and unusual need requiring Dietitian Services which is not provided by the State Plan.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency certified to provide dietician services
Agency	agency certified to provide Dietician Services
Individual	individual certified to provide Dietician Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietician Services

Provider Category:

Agency

Provider Type:
Home Health Agency certified to provide dietician services
Provider Qualifications
License *(specify):*
Medicare certified or state licensed Home Health Agency fully licensed in Wyoming. Agencies certified to provide dietician services are required to verify staff providing dietician services have a current license to practice as a dietician by the Commission on Dietetic Registration.
Certificate *(specify):*

Other Standard *(specify):*
Home Health Agencies must ensure all staff providing dietician services to participants complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Agency staff providing dietician services must also complete and document applicable participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The DD Division initially certifies a new home health agency providing dietician services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify a home health agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor home health agencies providing dietician services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietician Services

Provider Category:

Agency

Provider Type:
agency certified to provide Dietician Services
Provider Qualifications
License *(specify):*
Agencies certified to provide dietician services are required to verify staff providing dietician services have a current license to practice as a dietician by the Commission on Dietetic Registration.
Certificate *(specify):*

Other Standard *(specify):*
Agencies must ensure all staff providing dietician services to participants complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Agency staff providing dietician services must also complete and document applicable participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
The DD Division initially certifies a new agency providing dietician services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietician Services

Provider Category:
Individual

Provider Type:
individual certified to provide Dietician Services

Provider Qualifications

License *(specify):*
An individual certified to provide Dietician Services must have a current license to practice as a Dietician by the Commission on Dietetic Registration.

Certificate *(specify):*

Other Standard *(specify):*
In addition to having a current license to practice as a dietician, dieticians are required to complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR Certification and have a current driver's license and automobile insurance if transporting participants. Dieticians must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
Individuals certified to provide Dietician Services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide Dietician Services can be recertified for up to two years. Individuals certified to provide Dietician Services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide Dietician Services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The Division has the authority to

monitor providers throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Modifications

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

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

Service Definition *(Scope):*

A physical adaptation to the primary residence of a waiver participant that is functionally necessary, and either 1) contributes to a participant's ability to remain in or return to his/her home, and/or 2) is necessary to ensure the health, welfare and safety of the participant.

Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electrical and plumbing adaptations that accommodate the medical equipment necessary for the welfare of the participant.

Environmental modification requests shall support the needs identified within the plan of care and meet criteria as defined in Wyoming Medicaid rules, Chapter 44, Section 6 and 7. The DD Division shall determine if the environmental modification request is necessary for the participant before prior authorizing the service on the plan of care.

Exclusions: An environmental modification, which adds to the total square footage of the home, is excluded from this benefit, except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). An accessibility modification to adapt living arrangements in a home, which is owned or leased by providers of waiver services, is not eligible for reimbursement. Adaptations or improvements to the home that are of general utility, primarily for the convenience of persons other than the participant, or not of direct medical or remedial benefit to the participant are excluded from this service. Scope and Limitations of this service are found in Wyoming Medicaid rules, Chapter 44, Environmental Modifications and Specialized Equipment, Section 6.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	agency certified to provide environmental modification services
Individual	individual certified to provide environmental modification services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

agency certified to provide environmental modification services

Provider Qualifications

License *(specify):*

Agencies certified to provide environmental modification services are required to assure they have the applicable building, electrical, plumbing contractor's license as required by local or state regulations.

Certificate *(specify):*

If an agency providing environmental modification services is also providing residential and/or day habilitation services to three or more participants it is required to obtain and maintain CARF accreditation per Wyoming Medicaid Rules, Chapter 45, Section 23. If an agency providing environmental modification services is not serving three or more participants in residential habilitation and/or day habilitation it is required to adhere to the standards covered under independent providers.

Other Standard *(specify):*

Providers must meet all applicable CARF Standards and maintain CARF accreditation. In addition, all staff providing environmental modification services must complete and document complete and document general trainings on recognizing abuse and neglect, incident reporting, and HIPAA & Confidentiality requirements. In addition to the policies and procedures required by the CARF standards, providers must also have policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

Providers are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, providers can be recertified for up to two years. Providers who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and providers who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The DD Division has the authority to monitor providers throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual
Provider Type:
individual certified to provide environmental modification services
Provider Qualifications
License *(specify):*
Individuals certified to provide environmental modification services must have the applicable building, electrical, plumbing contractor's license as required by local or state regulations.
Certificate *(specify):*

Other Standard *(specify):*
In addition to having the applicable building, electrical, plumbing contractor's license as required by local or state regulations, individuals certified to provide environmental modification services must also complete training on incident reporting, recertification, and HIPAA & Confidentiality.
Verification of Provider Qualifications
Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
Individuals certified to provide environmental modification services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide environmental modification services can be recertified for up to two years. Individual certified to provide environmental modification services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide environmental modification services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The DD Division has the authority to monitor individuals certified to provide environmental modification services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
In Home Support - Phased out Year 1

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

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

Service Definition *(Scope):*
This service will be phased out in Year 1 of the waiver renewal.

The provision of habilitation services to individuals who reside with their family or independently. In-home support services includes conducting a designed program to allow the individual with a developmental disability to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in the community. Individuals are trained in techniques to address functional deficits in self-help, daily living skills, mobility, learning, communication, self-sufficiency, survival skills, reduction of maladaptive behaviors, community access and other necessary skills.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	individual certified to provide in home support services
Agency	Agency certified to provide in home support services
Agency	CARF Accredited agency certified to provide in home support services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: In Home Support - Phased out Year 1

Provider Category:
Individual

Provider Type:
individual certified to provide in home support services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Individuals certified to provide in home support services must be 18 years of age or older, complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Individuals certified to provide in home support services must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition, individuals certified to provide in home support services serving people in a facility they own or lease must also have policies and procedures in place addressing emergency situations and drills, external

and internal inspections, weapons, smoking , pets, incident reporting, restraint usage, and conflicts of interest. They must also complete Central Abuse Registry screenings and Criminal History Background checks on all people 18 years of age or older living in the home. Individuals certified to provide in home support services who are not serving people in a home or facility they own or lease must have policies and procedures in place addressing, as applicable, emergency situations and drills, weapons, smoking , pets, incident reporting, restraint usage, and conflicts of interest. They must also complete Central Abuse Registry screenings and Criminal History Background checks on all people 18 years of age or older participating in the delivery of services.

If a person living in the home does not meet the background check requirements the individual certified to provide in home support services is not be approved to provide services in that home. The individual certified to provide in home support services is also required to sign a "Not In My Home" form stating that under no circumstances will services be provided in their home or they may be decertified as a waiver provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

Individuals certified to provide in home support services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide in home support services can be recertified for up to two years. Individuals certified to provide in home support services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide in home support services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The Division has the authority to monitor individuals certified to provide in home support services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: In Home Support - Phased out Year 1

Provider Category:

Agency

Provider Type:

Agency certified to provide in home support services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies providing in home support services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 24, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing in home support services upon hire, maintaining current CPR and First Aid Certification for all direct care staff, and assuring staff transporting participants have a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must post emergency plans, complete emergency drills, complete internal and external inspections, adhere to

documentation standards, and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new agency providing in home support services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: In Home Support - Phased out Year 1

Provider Category:

Agency

Provider Type:

CARF Accredited agency certified to provide in home support services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The DD Division requires providers certified to provide in-home support services who are serving three or more participants in Residential Habilitation Services or Day Habilitation Services to maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 23 of the Wyoming Medicaid rules.

Other Standard *(specify):*

Agencies must meet all applicable CARF Standards and maintain CARF accreditation. These standards cover leadership, strategic planning, health and safety, human resources, rights of participants, quality improvement within the agency, employment services, community services, and individualized services and supports. In addition, all staff providing in-home support services to participants must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Provider staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition to the policies and procedures required by the CARF standards, providers must also have policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards, including standards

on employment services. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accreditation report and corresponding quality improvement plans.

In addition to the CARF accreditation, the DD Division initially certifies a new agency providing in-home support services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a two year recertification.

The DD Division has the authority to monitor agencies services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Skilled Nursing

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

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

Service Definition *(Scope):*

Services listed in the plan of care that are within the scope of the State's Nurse Practice Act. Skilled nursing services under the waiver differ in provider type (including provider training and qualifications) from skilled nursing services in the Medicaid State plan.

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

Skilled nursing on the Adult DD Waiver may be provided by provider agencies and independent nurses as long as they meet the provider qualifications. The Wyoming Medicaid State Plan requires that skilled nursing services be provided by home health agencies that provide a minimum of two medically necessary services.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified to provide skilled nursing services
Individual	Individual certified to provide skilled nursing services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Agency
Provider Type:
Agency certified to provide skilled nursing services
Provider Qualifications
License *(specify):*
Agencies certified to provide skilled nursing services are required to assure individuals providing skilled nursing services have a current license to practice nursing by the Wyoming State Board of Nursing per Wyoming Medicaid Rules, Chapter 45, Section 19.
Certificate *(specify):*

Other Standard *(specify):*
Agencies certified to provide skilled nursing services must assure nurses providing skilled nursing services have completed and documented applicable participant specific training before serving a participant, and completed and documented general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements. Agencies must also assure skilled nursing services are prescribed by a medical professional.
Verification of Provider Qualifications
Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The DD Division initially certifies a new agency providing skilled nursing services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Individual
Provider Type:
Individual certified to provide skilled nursing services
Provider Qualifications
License *(specify):*
Individuals providing skilled nursing services must have a current license to practice nursing by the Wyoming State Board of Nursing per Wyoming Medicaid Rules, Chapter 45, Section 19. Individuals providing skilled nursing services must be a registered professional nurse, or licensed practical or

vocational nurse under the supervision of a registered nurse, licensed to practice in the State.
Certificate *(specify):*

Other Standard *(specify):*
In addition to having a current license to practice nursing, skilled nurses are required to complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR Certification and have a current driver's license and automobile insurance if transporting participants. Skilled nurses must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, and HIPAA & Confidentiality requirements. Skilled nurses can only provide skilled nursing services as prescribed by a medical professional.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
Individuals certified to provide skilled nursing services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide skilled nursing services can be recertified for up to two years. Individuals certified to provide skilled nursing services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide skilled nursing services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The Division has the authority to monitor individuals certified to provide skilled nursing services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Specialized Equipment

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

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

Service Definition *(Scope):*
Specialized equipment includes: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live (c) items necessary for life support or to address physical conditions along with ancillary supplied and equipment necessary to the proper functioning of such items.(d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary

medical supplies not available under the State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limitations of this service are found in Medicaid Rule Chapter 44.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	agency certified to provide specialized equipment services
Individual	individual certified to provide specialized equipment services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Equipment

Provider Category:
Agency

Provider Type:
agency certified to provide specialized equipment services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Agencies certified to provide specialized equipment services are required to assure staff providing service is 18 years of age or older and are adhering to Wyoming Medicaid rules, Chapter 44.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
Providers are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, providers can be recertified for up to two years. Providers who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and providers who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The DD Division has the authority to monitor providers throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Equipment

Provider Category:
Individual

Provider Type:
individual certified to provide specialized equipment services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Individuals certified to provide specialized equipment services must be 18 years of age or older and provide specialized equipment services pursuant to Wyoming Medicaid Rules, Chapter 44.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
Individuals certified to provide specialized equipment services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide specialized equipment services can be recertified for up to two years. Individuals certified to provide specialized equipment services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide specialized equipment services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The Division has the authority to monitor individuals certified to provide specialized equipment services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

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

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

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case managers are not employed by the state. They are either employed by a Medicaid Waiver provider organization certified to provide case management services, or independently certified as a Medicaid Waiver provider to provide case management services. Case managers are responsible for developing and submitting a service plan for a participant once a year. The case manager must coordinate at least two team meetings a year related to a participant's service plan, once to develop the annual plan of care, and a six-month plan review meeting. Case managers must make a monthly home visit to the participant's home.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The DD Division manages the provider background check process and requires all Adult DD Waiver providers and Adult DD Waiver provider staff who provide services to participants to complete a Federal Bureau of Investigation (FBI) fingerprint background check and State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check per Wyoming Medicaid rules, Chapter 45. The only exceptions are Adult DD Waiver providers certified to provide environmental modifications or specialized equipment, who are not required to complete a background check since they are not providing direct services.Any time a provider chooses to add a direct service, the DD Division requires the provider to complete a background screening before the provider is approved to provide the service.

The background check must verify the provider or provider staff has not been convicted of an Offense Against the Person or an Offense Against Morals, Decency and Family, including:
Homicide (W.S. § 6-2-101 et seq.)
Kidnapping (W.S. § 6-2-201 et seq.)
Sexual assault (W.S. § 6-2-301 et seq.)
Robbery and blackmail (W.S. § 6-2-401 et seq.),
Assault and battery (W.S. § 6-2-501 et seq.),
Bigamy (W.S. § 6-4-401)
Incest (W.S. § 6-4-402)
Abandoning or endangering children (W.S. § 6-4-403)
Violation of order of protection (W.S. § 6-4-404), and
Endangering children; controlled substances (W.S. § 6-4-405), or
Similar laws of any other state or the United States relating to these crimes.

The DD Division requires provider applicants to complete a background check before they are certified to provide services. To assure the background check is completed the DD Division submits the background check paperwork to the Wyoming Division of Criminal Investigation and receives the results of the background check verifying the provider applicant has no convictions which disqualify him/her to provide waiver services. The results are maintained in the provider file. Provider agency staff are required to submit to the background check upon hire and to maintain verification of the results of the background check in the individual staff's personnel file. The DD Division completes a staff file review of provider agencies during the provider recertification process to assure background checks have been completed and to verify that staff meet the background check

requirements to provide waiver services.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Wyoming Department of Family Services maintains the Central Registry of child and disabled adult protection cases, as authorized in Wyoming State Statute W.S. § 7-19-201. All Adult DD Waiver providers and Adult DD Waiver provider staff who provide services to participants are required to complete a Central Registry Screening per Wyoming Medicaid rules, Chapter 45. The only exceptions are Adult DD Waiver providers certified to provide environmental modifications or specialized equipment, who are not required to complete a Central Registry Screening since they are not providing direct services. Any time a provider chooses to add a direct service, the DD Division requires the provider to complete a Central Registry screening that verifies the person does not appear on a substantiated Wyoming Department of Family Services Central Registry, per Wyoming Medicaid rules, Chapter 45, Provider Certification and Sanctions.

The DD Division requires Adult DD Waiver provider applicants to complete the Central Registry Screening before they are certified to provide services. To assure the Central Registry Screening is completed the DD Division submits the screening paperwork to the Wyoming Department of Family Services and receives the results of the screenings, which are maintained in the provider file. Adult DD Waiver Providers employing staff are required to complete the Central Registry Screening for all staff providing direct services at the time of hire. The provider submits the screening paperwork to the Wyoming Department of Family Services and receives the results of the screenings, which are maintained in the individual staff's personnel file. The DD Division completes a staff file review of provider agencies during the provider recertification process to assure the Central Registry Screenings have been completed and to verify that staff meet the screening requirements to provide waiver services.

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- ○ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar

services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- (●) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

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

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

- ( ) **Other policy.**

Specify:

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

The DD Division within the state Medicaid Agency has continuous open enrollment of Adult DD Waiver service providers. Information on how to become an Adult DD Medicaid Waiver provider is available on the DD Division's website. When contacted by interested provider applicants, DD Division staff reviews the process and requirements of becoming an Adult DD Waiver provider, including the requirements that the provider sign a Medicaid Provider Agreement, complete background checks, and complete a central registry screening. If DD Division staff meet with

the applicant in person the enrollment packet is given to them during the meeting. If the applicant contacts the DD Division by phone an enrollment packet is sent to them by mail. The application is currently not available on-line. DD Division staff work with the applicant throughout the enrollment process, keep the applicant informed of what is still pending, and are available to answer questions. After all requirements of certification have been met, the DD Division forwards the enrollment packet to Affiliated Computer Services Inc. (ACS), the Medicaid billing representative. ACS reviews the enrollment packet to assure the applicant has completed all the required paperwork, including the Medicaid Provider Agreement, and verifies the applicant meets the requirements to become a Medicaid provider. ACS then generates the provider number and notifies the DD Division that the applicant has been assigned a provider number. All providers certified to provide Adult DD Waiver services are required to have a current provider agreement in place with the State Medicaid Agency.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Proportion of Adult DD waiver providers meeting all state certification requirements (the number of waiver providers initially certified who meet all the requirements divided by the number of providers initially certified to provide waiver services)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Initial provider applicant's information entered into IMPROV, the Division's provider management system verifying provider applicant has met the requirements to be certified as a provider.

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

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Results of Adult DD provider application by category (granted initial certification, denied certification – standards not met, denied certification – application incomplete) measured by the number of applicants in each category divided by the total number of waiver provider applicants)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider recertification information entered into IMPROV, the Division's provider management system verifying the provider has completed the recertification process

Responsible Party for	**Frequency of data**	**Sampling Approach**

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

Data Aggregation and Analysis:

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

Performance Measure:

Proportion of Adult DD waiver providers completing recertification process by end certification date (the number of providers recertified by end certification date divided by the number of providers certified to provide services on waiver)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Completion date of recertification is tracked in IMPROV, the Division's provider management system

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

Data Aggregation and Analysis:

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

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of Adult DD waiver providers who have implemented approved quality improvement plans according to Division standards (the number of waiver providers who have implemented approved quality improvement plans according to Division standards divided by the total number of providers who were required to submit a quality improvement plan)

Data Source (Select one):
Other
If 'Other' is selected, specify:
IMPROV, the DD Division's provider management system

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

Data Aggregation and Analysis:

Responsible Party for data	**Frequency of data aggregation and**

aggregation and analysis *(check each that applies):*	**analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of Adult DD waiver providers found to be non-compliant with certification standards, by standard area and type of provider (the number of providers that received citations resulting in recommendations, by standard area divided by the total number of providers reviewed by Survey Certification Unit)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Areas of provider non-compliance is tracked in IMPROV, the DD Division's provider management system

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of Adult waiver providers sanctioned due to noncompliance with rules by type of sanction – suspension, civil monetary penalty etc. (the number of providers sanctioned due to noncompliance with rules divided by the total number of providers)

Data Source (Select one):
Other
If 'Other' is selected, specify:
IMPROV, the DD Division's provider management system

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of Adult DD participants interviewed who report that they are familiar with the process for filing a grievance and/or complaint regarding a provider (the number of Adult DD participants who affirm knowing the complaint process divided by the total number of participants interviewed)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 4.1%
☑ **Other** Specify: Contractor for National Core Indicators	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute aggregates the data and generates a preliminary report and a final report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Wyoming does not allow payment to non-certified providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
DD Division's provider management system, IMPROV

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

Data Aggregation and Analysis:

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

Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Proportion of Adult DD waiver providers initially certified who complete initial provider training (the number of new providers receiving training divided by the of new providers initially certified)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Initial provider training is tracked through IMPROV, the DD Division's provider management system

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

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of Adult DD waiver providers required to complete retraining in a specific area as specified in state requirements and the approved waiver (the number of providers required to complete retraining divided by total number of Adult DD Waiver providers)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider retraining is tracked in IMPROV, the DD Division's provider management system

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

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of Adult DD providers receiving recommendations due to provider training not being conducted in accordance with state requirements and approved waiver by type of provider -CARF, non-CARF, (Adult DD providers receiving recommendations due to provider training not being conducted in accordance with state requirements by type of provider divided by total number of Adult DD providers)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider recommendations are entered and tracked in the DD Division's provider management system called IMPROV.

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

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of Adult DD participants surveyed that report staff has adequate training to meet his/her needs (the number of Adult DD participants who affirm staff have adequate training divided by the total number of Adult DD participants interviewed)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 4.1%
☑ **Other** Specify: Contractor for National Core Indicators survey	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute aggregates the data and generates a preliminary report and	☑ **Annually**

a final report	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Subassurance 1: Qualified providers:

Initial provider certification process

Provider applicants must meet all requirements for the services they are requesting certification in before becoming a certified provider. This information, including results of background checks, CPR certification, First Aid certification, and training, is tracked in the DD Division's provider management system, IMPROV. No provider applicant is allowed to become certified until all required documentation and results of background checks have been received. Data from IMPROV is generated to report on trends within the provider certification process.

2. Provider recertification process

Providers are required to be recertified at least every two years, depending on the results of their current recertification. The recertification process includes verification the provider is complying with rules & regulations pertaining to qualifications for services, staff/provider training, policies, procedures and practices for incident reporting, restraint usage, documentation and billing standards, HIPAA/Confidentiality, emergency procedures, inspections, rights and rights restrictions, and appropriately implementing plans of care. The results of the recertification outline any specific issues of non-compliance, information for submitting quality improvement plans, and specific time lines to remedy non-compliance issues. The DD Division works with providers to ensure compliance is met including providing individual consultation and when necessary, sanctioning the provider due to not adhering to time lines or failure to meet compliance. The results of the recertifications are tracked in IMPROV, including areas of non-compliance resulting in recommendations, dates of submission and approval of quality improvement plans, and verification quality improvement plans have been implemented appropriately. Data is generated from IMPROV to track trends in areas of non-compliance, submissions of quality improvement plans, and completion dates of recertifications.

3. Complaint process

Participants, guardians, and providers can file a complaint against another provider. Complaints received by the DD Division are entered in IMPROV, and follow-up actions are determined based on priority levels according to the type of complaint. If the DD Division determines there is provider non-compliance with rules and regulations through a complaint, the complaint is substantiated and the provider is required to submit a quality improvement plan that is tracked through IMPROV. The Division provides notification to the complainant regarding if the complaint was found substantiated or not substantiated.

4. Incident reporting process

Incidents reported to the Division are tracked through IMPROV, and may result in a criminal case through law enforcement, an investigation by DFS, and/or an investigation by the DD Division. Follow-up actions by the DD Division are based on priority levels and type of incident. If the DD Division determines there is provider non-compliance with rules and regulations through complaints or incidents the complaint or incident is "substantiated" and the provider is required to submit a quality improvement plan that is tracked through IMPROV.

5. Internal referral process

Division staff who attend team meetings or review and approve plans of care may identify provider non-compliance with rules and regulations through one of these processes. When this occurs, DD Division staff

submit an internal referral through IMPROV, and follow-up actions are determined based on priority levels type of the internal referral. If the DD Division determines there is provider non-compliance with rules and regulations, the internal referral is substantiated and the provider is notified by the Division to submit a quality improvement plan that is tracked through IMPROV.

If a provider repeatedly fails to submit an acceptable quality improvement plan the Division has the authority to sanction the provider. Sanctioning can include freezing a provider's admissions, suspending a provider, imposing a monitor, imposing a civil monetary penalty, removing participants at significant risk, requiring additional training, decertifying a provider, as well as other sanctions. Information on providers who have been sanctioned is tracked in IMPROV and data generated on sanctions. Providers can also be decertified if they are convicted of a crime against a person or if they are listed on the Abuse Central Registry.

Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.
The DD Division assesses providers' adhering to training requirements through the same processes listed above. A provider applicant is not certified as a provider until they have completed the required training. All certified providers are then responsible for ensuring that they have had participant specific training prior to working with a participant for all waiver participants they are providing services to. If concerns with provider training are found through one of these processes discussed previously, the provider is required to submit a quality improvement plan addressing the non-compliance with in regards to training. The provider is responsible for receiving training within the time frames specified in the quality improvement plan. In addition, the Division also has the authority to require a provider to complete retraining in a specific area when concerns continue to be identified. This information is tracked through IMPROV and reports are generated on the number of providers requiring retraining, the number of providers receiving recommendations concerning training, and the number of new providers who completed the required training.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
Effective July 1, 2009 the Survey/Certification unit of the DD Division will also review a representative sample of documentation for participants across all providers who may be involved in the participant's care. The representative sample size will have a 95% confidence level and a margin of error of 5%. The sample will be identified in July of every two years and the review of the implementation of the plan and documentation of

services will be completed throughout two fiscal years.

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

- ○ **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

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

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

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

The DD Division limits the maximum dollar amount of waiver services authorized for each ABI Waiver participant using a prospective individual budget amount. The prospective individual budget amount is based upon historical annual plan units multiplied by the posted service rates. The rates for all ABI Waiver services are posted on the DD Division website. For new participants, the limit is based upon core services multiplied by projected units as determined using the ICAP assessment and information from the case manager to determine service needs.

Participants, guardians and case managers are notified by letter of a participant’s individualized budget amount when the participant is provided a funding opportunity on the ABI Waiver, and whenever there are changes to the individualized budget amount. The budget limit methodology may be adjusted over the course of the waiver period due to increases or decreases in posted rates and/or increases or decreases in funding appropriations.

Once the individualized budget is first determined or is changed, the participant, the case manager and the team work together to develop or revise the plan of care so that needed waiver services are allocated within the individualized budget and non-waiver services are identified. The individualized budgeted amount does not limit specific waiver services. If the participant and/or guardian, with support from the team, identifies that the plan of care developed within the budgeted amount will not meet the participant’s health and

welfare needs the case manager can request additional funding on behalf of the participant through the DD Division's Extraordinary Care Committee.

The DD Division's Extraordinary Care Committee has the authority to evaluate and approve requests for additional funding above a participant's individualized budget amount due to emergency requests, a material change in circumstance, a potential emergency or other condition justifying an increase in funding. The Extraordinary Care Committee's membership includes the Waiver Manager, the DD Division's Fiscal Manager, and a representative of the State Medicaid Agent. The committee reviews the ECC request and information compiled by the participant's case manager, which must detail the reasons for the needed increase in funding and an explanation for the person's specific health and welfare needs not being adequately addressed within the individualized budgeted amount or through other non-waiver resources or supports. In some instances, the participant may be denied additional funding but may be directed to enroll in other available programs or resources to meet his/her needs in lieu of waiver funding. In these cases the participant and/or guardian is notified by letter they have a right to request a fair hearing.

The process for determining a participant's individualized budgeted amount is made available through a memorandum to stakeholders, which includes participants, guardians, and providers. An ECC database is maintained by the DD Division, which summarizes the decision of all requests, including if the decision and funding is time-limited. The ECC policy, procedure and forms for requesting additional funds are available on the Division's website for public viewing and use.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Individualized Plan of Care

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:
- ☐ **Social Worker.**
  Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The DD Division reviews and approves 100% of plans of care developed and submitted by case managers. Part of this review and approval process is assuring the plan has been developed in the best interests of the participant and identifies appropriate services and supports based on the input from the participant, guardian and family. Participants and guardians are required to sign each plan of care verifying they agree with the services, supports in the plan and have had the opportunity to have informed choice of providers.

In addition to these safeguards, the DD Division is implementing new policies to address conflict of interest when case managers are providing other services on the plan.

1) The DD Division is currently working with Medicaid to develop the process for certifying case management providers working with organizations under their own provider number. This process begins in July 2009 and will be completed by December 31, 2009. This staggered approach will allow the DD Division to work individually with each case manager on the specific changes, the reasons for the changes, the impact of the changes, and to assure the case manager is given the support and training needed to make this a successful transition. DD Division staff will work directly with case managers to assure the process is completed by December 31, 2009.

2) Enhance education of participants/families and guardians initially applying for services and develop a participant handbook to be distributed to all participants/families and guardians by December 31, 2009. This handbook will explain the role of the case manager in assuring participants have choice of providers, as well as the responsibilities case managers have in assuring the development of the plan of care is in the best interest of the participant and how the case manager is responsible for monitoring the implementation of the plan of care to assure it is implemented in the best interest of the participant. The handbook will also include information on actions the participant and guardian can take if there are concerns with a case manager who is also providing other services on the plan of care.

3)Develop continued training of participants/families and guardians on the Adult DD Waiver, including:
*available services both in the institution and on the Adult DD Waiver
*using a person-centered approach to plan for services and to make changes when needed
*what a plan of care team meeting is
*freedom of choice of providers including case managers
*responsibilities of case managers in developing the plan of care, monitoring implementation of the plan of care, and the conflict of interest that occurs when a case manager is providing other services on the plan of care
*participants and guardians roles and responsibilities in development of the plan of care, including participating in plan of care team meetings

The trainings will be developed by December 31, 2009 and trainings will be offered twice an year and upon

request.
4) The changes to the plan of care effective July 1, 2009 include a conflict of interest statement that summarizes how conflict will be addressed, how the best interest of the participant is assured, how monitoring will be enhanced, and what actions the participant/guardian should take if he or she has concerns with any aspects of the case manager's roles and responsibilities. DD Division staff will serve as a resource to case managers' and the participants' teams to educate them on conflicts of interest, and the responsibilities the case manager has in choice, development of the plan of care, and monitoring implementation of the plan of care, beginning with team meetings being held for plans of care effective July 1, 2009. This will assure everyone whose plan of care is effective July 1st through December 1st has been given information on the conflict of interest. For those participants whose plan of care is not effective until after December 1, 2009 the DD Division will develop a one page summary of the conflict of interest areas to be discussed and covered during team meetings and will require case managers to cover this topic during the next team meeting scheduled, which could be a six month team meeting or special team meeting. Case managers will be required to submit this one page summary to the DD Division with the participant's or guardian's signature verifying they have been provided information on the conflict of interest.

5) Require agencies providing case management, case managers employed by agencies, and self employed case managers providing other services on plans of care to develop and implement a comprehensive conflict of interest policy that addresses the areas of choice, development of the plan of care and implementation of the plan of care by December 31, 2009.

6) Require comprehensive case management policies on how agency or self-employed case manager will follow up and provide feedback on concerns identified during development or monitoring of plan of care by December 31, 2009.

7) Develop a web-based complaint process so participants, guardians and families can file a complaint easily with the DD Division if they have concerns by December 31, 2009. The web-based system will provide another avenue for participants, families and guardians to file a complaint at any time as long as they have access to the Internet.

The DD Division will continue to review 100% of annual plans of care and has revised its review and approval process for plans of care effective July 1, 2009 to assure that conflicts of interest are identified in the plan of care and all aspects of the conflict of interest are addressed adequately in the plan.

The DD Division has regional case management training scheduled from May through October 2009 and will include training on the safeguards being put in place to address the conflicts of interest.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The DD Division requires and promotes a person centered approach to services. This support begins when a person applies for the Adult DD Waiver and continues through choice of providers, development of the plan of care, and implementation of the plan of care. The DD Division contacts each Adult DD Waiver applicant in person or by telephone to explain the application process and to provide information on both waiver and institutional services available so the applicant can make an informed choice of institution or community based services. DD Division staff also provide applicants with an overview of the person centered process, emphasizing the person has choice of who participates on their plan of care team, which providers they choose, and which waiver and non-waiver services are identified in the plan of care. This information is also summarized in a handbook distributed to applicants either in person or by mail.

If the person chooses community based services and once there is a funding opportunity, the DD Division generates the individualized budget amount and notifies the participant and/or guardian of the funding opportunity and of their budgeted amount. The case manager reviews the array of services on the Adult DD waiver and the list of providers in the community that provide these services. The participant and guardian inform the case manager of the people they would like to have involved in the participant's team, including providers, and of times they are available to meet to

develop the plan of care. The case manager then schedules the meeting, notifying the team members.

If the participant and/or guardian are not certain of which services are the most appropriate, the case manager will schedule a team meeting to begin developing the plan allowing the participant to understand the waiver and non-waiver service options.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Once an applicant on the Adult DD Waiver receives funding, the DD Division generates the individualized budget amount and notifies the participant and/or guardian of the funding opportunity and of their budgeted amount. The case manager reviews the array of services on the Adult DD waiver and the list of providers in the community that provide these services. The participant and guardian inform the case manager of the people they would like to have involved in the participant's plan of care team, including providers, and of times they are available to meet to develop the plan of care. The case manager then schedules the meeting, notifying the team members.

During the team meeting the participant, the case manager and the team work together to develop a plan of care that will allocate the individualized budget amount for needed waiver services and that identifies non-waiver services available and appropriate for the participant. These non-waiver services may include Medicaid State Plan Services, housing, community services offered through grants or other programs, and natural supports.

During the team meeting the case manager reviews information, as appropriate, from the psychological evaluation, ICAP, medical history, recent medical appointments or assessments, and other assessments completed. This information is used throughout the plan of care to assure health, welfare and other needs are addressed in the plan.

The plan of care begins with an "About Me" section, which specifically asks questions to actively engage the participant to develop the integral components of the plan of care. Their responses to the questions gather input on the participant's accomplishments, progress, wishes, wants, dreams, likes, dislikes, plans for the future, etc. The participant's team assists the participant in selecting appropriate services, developing meaningful goals and objectives, constructing individualized daily service schedules, tailored and developing realistic, positive behavioral and or medical treatment plans as needed.

The next section of the plan of care covers functional limitations, and rights and rights restrictions. If rights restrictions are imposed, the team is required to identify the reason for the restriction, how it is imposed, and how the participant can exercise their rights more fully. The team is also required to identify when the rights restrictions will be reviewed for continued appropriateness. The maximum time frame between reviews is six months.

The plan of care also contains a section on medical information that includes a list of the participant's medical specialists, current medications, information on seizures, current adaptive or specialized equipment, and any other health information pertinent to the delivery of services. It is noted in this section that the case manager must update this information in the plan of care as needed, and distribute the revised information to the plan of care team, including all providers. Examples of changes may include a change in medication, purchasing a new piece of specialized equipment, a change in seizure activity requiring a revised seizure protocol.

The next sections of the plan of care cover specific support needs the participant has in different settings, including at home, in the community, and at work. These sections also cover the participant's supervision needs and level of assistance needed with activities of daily living, measurable and meaningful objectives the participant has chosen to work on and behavior support needs. A Positive Behavior Support Plan is required if the individual exhibits a

behavior of moderate or above on the ICAP report or if the team identifies any significant behavioral issues. Throughout these sections the plan identifies specific risks and safety plans to address the risks.

A final signature page concludes the plan of care, and all parties signing the form confirm that the plan of care has been carefully planned and coordinated with the active involvement of the participant and guardian. The signatures also assure the plan has been individually tailored, identifying appropriate waiver and non-waiver services, and establishing schedules, activities, and objectives that incorporate the participant's unique needs and preferences. The plan specifically states "I have been present, encouraged, and involved at every possible level during the development of my plan of care."

The case manager is responsible for completing the initial plan of care based on the input from the participant, guardian and team. The initial plan of care must be submitted to the DD Division for review and approval within 45 days of receiving notification of funding.

Once the plan is approved by the DD Division, case managers have specific monitoring responsibilities to assure the plan of care is being implemented appropriately and to identify possible changes needed in the plan. These responsibilities include:

- Completing a monthly home visit with the participant present to monitor the participant's health and welfare, as well as to discuss satisfaction with both waiver and non-waiver services and needed changes to the plan of care with the participant.
- Observing the delivery of services to the participant quarterly
- Reviewing critical incidents that have occurred monthly to identify trends and concerns
- Reviewing progress on objectives monthly
- Reviewing implementation and effectiveness of the positive behavior support plan monthly
- Reviewing restraint usage and restrictive interventions monthly
- Reviewing utilization of services and documentation of service delivery monthly
- Reviewing health and welfare information quarterly to identify possible changes in health status

If the case manager identifies concerns with either the existing plan of care meeting the needs of the participant or with the implementation of the plan of care, the case manager is responsible for working with the participant, guardian and team, including holding a team meeting, to address the concerns and revise the plan of care as needed.

In addition to the specific responsibilities listed above, the case manager is also required to coordinate a six month plan of care review meeting where the participant, guardian and team formally review the effectiveness of the implementation of the plan of care and identify changes needed. The case manager is required to review specific information from implementation of the plan of care over the past six months, including a summary of progress on objectives, changes in health status, restraint and restrictive interventions occurring over the past six months, utilization of services, and other health or welfare concerns. The team identifies possible changes to the plan of care and the case manager is responsible for updating the plan based on this information.

Team members can also request a team meeting at any time to review the plan of care, request changes, or discuss concerns. If a participant is denied a service they are requesting or is denied choice of providers, they are notified of the opportunity of a Fair Hearing.

Rules for the plan of care development process are found in Wyoming Medicaid Rules, Chapter 41, Adult DD Waiver rules, and DD Division Rules, Chapter 1, Case Management rules.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The individualized plan of care (IPC) developed by the participant's team must have input from the participant in the "About Me" section on things the participant likes, wants in their life, and does not want in their life. Through these series of questions, the plan of care form has cues for the case manager to facilitate conversation about unhealthy habits, risky behavior, and important changes the person wants to make in their life.

To further expand upon the input from the participant and guardian on risks in the "About Me" section, the DD Division uses the Supports, Medical Information, and Positive Behavior Support plan sections of the IPC to address risks and construct support plans. The functional limitations, identified risks and support needs of the participant are outlined in the areas of Communication, Self-Advocacy, Transportation, specific safety supports needed, Near Water, Community Outings, Mobility, Monitoring needed during sleeping, Money transactions, Mealtime guidelines, Dietary, Emergency situations, Toileting, Personal Hygiene, Home Supervision, Positioning, and Day Site Supervision. Special protocols for any critical medical, safety, or behavioral need is expanded upon through a separate attached protocol.

For behaviors identified as potentially risky or historically risky to a person's health or safety, a carefully designed positive behavior support plan is required to mitigate risk. It is based on a functional behavior analysis of the participant's specific behaviors, antecedents, communication style and obstacles, stressors, rewards, and environmental factors. The requirements for developing and implementing a positive behavior support plan are in Chapter 45, Section 29 of the Medicaid Rules for Provider Certification.

To address the need for backup plans and the arrangements used for backup, the DD Division has revised the plan of care to include a section on "Backup support plans". In this section, the participant's team will review the circle of support the participant has to identify the first line of communication when the participant is in an emergency or in need of quick assistance to resolve an issue or conflict. The team will also identify who the main contact people are in the person's routine activities and environments, in case an incident arises. For individuals who live semi-independently or independently with monitoring, the plan will include a more detailed action plan for on-call or emergency situations.

In order to develop an on-call system of both natural and provider supports, the participant's team will evaluate the person's unique needs and circumstances to determine the situations that may arise where the participant may need to call someone in their "circle" for back up. These situations may include: housing issues, police involvement, money concerns, food shortages, transportation problems, witnessing criminal behavior, staff/provider problems, behavioral concerns, medical concerns and/or medical emergencies, and any other identified potential risky situations. After identifying the situations pertinent to the participant, the team will develop a contact person for the situation, and the criteria for which the situation will rise to the "on-call response" level. The backup support plan will be implemented by training all on-call contacts on the plan, teaching the participant the plan and reviewing/reteaching it as needed, posting it in a visible area for the participant, and revising it as needed. The plan will be reviewed at least every six months at the semi-annual review of the plan of care meeting, and at the annual plan of care development meeting

Case managers must complete the new plan of care that includes the backup support plans beginning with plans dated July 1, 2009 and for all people new to the waiver. For participant’s whose plan of care does not come due until after September 30, 2009, the case manager will work with the participant and the team to establish the Circle of Support and incorporate this into the participant’s current plan of care by September 30, 2009. The DD Division will review the plan during the annual plan review.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Adult DD Waiver participants and guardians have free choice of providers and can request a change of providers, except case managers, at anytime during the plan year. The DD Division reviews information on provider choice when a person first applies for services on the Adult DD Waiver. When an applicant receives a funding opportunity, the case manager is required to review the list of service providers and choice of providers with the applicant. The case manager is also required to review choice of providers during each six month plan of care review meeting and before the annual plan of care meeting, so the participant has an opportunity to change providers before the new plan is developed.

The current provider list is available through the participant’s case manager and is on the DD Division’s website in a searchable format so people can search for providers certified to provide a specific service in a geographic area. The individual plan of care includes a check box where the participant or guardian signs verifying they understand they have free choice of providers. DD Division staff review 100% of the annual plans of care, including this section, to

assure it is signed and dated.

Once a participant chooses to change providers, they notify their case manager, who is required to follow a specific transition process, including scheduling a team meeting that includes the participant, guardian, other chosen team members, and both the current and future provider. This is to ensure the future provider is given all the pertinent information on the participant and the plan of care, and is involved in revisions to the plan of care as needed.

Adult DD Waiver participants can choose to change their case manager during the six month plan of care review process or the annual plan of care development process. This restriction to changing case managers is in place to assure there is consistent monitoring of the implementation of the plan of care and changes are made to the plan of care as needed. However, participants or guardians can request that the Division permit a change of case manager at other times if there is a significant conflict between the participant and case manager, evidence of unethical conduct, non-performance of duties, resignation of the case manager, or other unusual circumstances. If the participant or guardian is denied the request to change, they may request a Fair Hearing. In cases where there is evidence of unethical conduct or non-performance of duties, a referral is made to the Survey/Certification unit within the DD Division to investigate the "complaint." If the complaint is substantiated, the case manager is required to complete a quality improvement plan addressing the non-compliance with case management requirements.

The DD Division maintains a listing of all providers that can be searched by town or by service type on its website. The Notice of Choice form, Transition Checklist, and listing of providers can be found on the DD Division's website http://www.health.wyo.gov/ddd

Information about choice can also be found in Medicaid Rule Chapter 41, Section 11. Information on participant transitions can be found in Medicaid Rule Chapter 41, Section 11 and Chapter 45 Section 32.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The DD Division is a part of the state Medicaid Agency, so it is not necessary to fill this section out.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☐ **Operating agency**

- [x] **Case manager**
- [ ] **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The first line of monitoring the implementation of the plan of care is the participant's case manager, who is responsible for completing the following monitoring activities:

• Completing a monthly home visit with the participant present to monitor the participant's health and welfare, as well as to discuss satisfaction with both waiver and non-waiver services and needed changes to the plan of care with the participant.
• Observing the delivery of services to the participant quarterly
• Reviewing critical incidents that have occurred monthly to identify trends and concerns
• Reviewing progress on objectives monthly
• Monitoring back up plans monthly
• Reviewing implementation and effectiveness of the positive behavior support plan monthly
• Reviewing restraint usage and restrictive interventions monthly
• Reviewing utilization of services and documentation of service delivery monthly
• Reviewing health and welfare information quarterly to identify possible changes in health status

The case manager is required to document these monitoring activities, completing follow-up on concerns, document the follow-up actions completed, and make appropriate changes to the plan of care with team involvement when needed.

The Survey/Certification unit of the DD Division is also responsible for monitoring the implementation of the individual plan of care, including monitoring participant health and welfare. The unit completes this monitoring through the following processes:

1) Provider recertification process:
Providers are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, providers can be recertified for up to two years. Providers who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and providers who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The recertification process for providers serving three or more participants in residential habilitation or day habilitation includes review of the implementation of plans of care for a sample of participants receiving services from the organization. These providers are also required to be certified by CARF. The recertification of providers serving less than three participants in residential habilitation and day habilitation currently does not include a review of the implementation of the plan of care but does include review of documentation of services to assure services are being provided in accordance with the plan of care.

Effective July 1, 2009 the review of the implementation of plans of care for Adult DD Waiver participants will be changed to include all providers. The representative sample size will have a 95% confidence level and a margin of error of 5%. The sample will be identified in July each year and the review of the implementation of the plans of care will be completed throughout two fiscal years, and will focus on the implementation of the entire plan of care, including non-waiver services, not just on specific providers.

The review will include, when applicable and appropriate, observations of all waiver services, review of non-waiver services, review of adequacy of backup plans, interviews with the participant, provider staff, and guardians, walk-through of service areas, review of case management documentation, and review of all other pertinent documentation. The focus of these reviews will be to assure participants have access to the services in their plan, services meet the needs of the participants, participants have access to non-waiver services in their plans, and participants' health and welfare needs are being met.

In addition to the DD Division's review of implementation of plans of care described above, effective July 1, 2009 the Survey/Certification unit of the Division will also review a sample of case management documentation of Adult DD participants for a six month period to verify the case manager is consistently monitoring the implementation of plans of care and updating the plan as needed. The representative sample size will have a 95% confidence level and a margin of error of 5%. The sample will be identified in July each year and the review of the implementation of the plans of care will be completed throughout two fiscal years, and will focus on the implementation of the entire plan of care, including non-waiver services, not just on specific providers.

2) Incident reporting process:
The Survey/Certification unit of the DD Division requires providers report specific categories of incidents as described in the incident reporting section of this application. The unit reviews each incident reported within one business day to determine if there are significant health, safety or rights concerns. These are considered level one incidents and require follow-up within ten business days. The review also includes verification the provider reported the incident to all appropriate entities and completed the appropriate follow-up actions based on the incident. If there are concerns with the incident and/or follow-up completed by the provider Survey/Certification staff complete follow-up actions to assure the concerns are addressed. If the complaint is not considered a level one complaint, Survey/Certification staff complete an investigation and/or other follow-up actions to determine if the complaint is substantiated, following the time lines below:

Level 2 – Medium Consideration: Person's health or safety is of significant concern and provider compliance needs to be ensured. This requires follow-up actions by the DD Division within two weeks.

Level 3 – Lower Consideration: Although no substantial health and safety concerns, the incident may impact the care of the person and provider compliance needs to be ensured. This requires follow-up actions by the DD Division within 2 weeks-1 month.

NAN – No Action Necessary: Adequate information and follow up have been provided. No concerns with health/safety and no compliance must be ensured.

3) Complaint process:
The Survey/Certification unit of the DD Division manages the complaint process, described in the Grievance/Complaint section of this application. Anyone can file a complaint with any DD Division staff, and the complaint is referred to the appropriate Survey/Certification staff who first determines if the complaint identifies significant health, safety or rights concerns. These are considered level one complaints and require initial follow-up within two business days. If the complaint is not considered a level one complaint, Survey/Certification staff complete an investigation and/or other follow-up actions to determine if the complaint is substantiated, following the time lines below:

• Level 2 – Medium Consideration. Complaint identifies potential provider non-compliance that may be impacting the quality of services participant is receiving. Investigation must be completed with 30-60 days
• Level 3 – Lower Consideration: Complaint indicates potential provider non-compliance that does not appear to be directly impacting the quality of services to the participant. Investigation must be completed within 90 days
• NAN – No Action Necessary: Complaint is either outside the scope of the Division and the complainant is notified of who may have authority to investigate or the complaint does not identify any compliance issues that can be investigated

4) Internal DD Division referrals:
Other DD Division staff, including Waiver Specialists who review and approve plans of care, and Area Resource Specialists, who attend team meetings, can make a referral to the Survey/Certification unit if there are concerns with a participant's health, welfare or rights or any concerns with non-compliance with current rules or regulations. DD Division staff first work with the provider to resolve these concerns, unless there are significant health or safety concerns, which results in an immediate referral to the Survey/Certification unit. The unit completes the appropriate

follow-up actions or investigation to assure the situation is addressed appropriately. Significant health or safety concerns are considered level one internal referrals and require initial follow-up within two business days. If the internal referral is not considered a level one referral, Survey/Certification staff complete an investigation and/or other follow-up actions to determine if the internal referral is substantiated, following the time lines below:

• Level 2 – Medium Consideration. Internal referral identifies potential provider non-compliance that may be impacting the quality of services participant is receiving. Investigation must be completed with 30-60 days
• Level 3 – Lower Consideration: internal referral indicates potential provider non-compliance that does not appear to be directly impacting the quality of services to the participant. Investigation must be completed within 90 days
• NAN – No Action Necessary: internal referral is either outside the scope of the Division and the DD Division staff is notified of the reason no action is being taken on the referral.

When significant health or safety concerns are identified through any of the above processes, the Survey/Certification unit of the Division completes initial contact with the provider within two business days to assure the immediate health and safety risks are addressed by the provider and the significant health and safety concerns have been abated. This initial contact may include an on-site visit and/or review of documentation from the provider.

If non-compliance with rules and regulations is substantiated through any of the above processes, including situations where significant health and safety concerns have been identified, the provider is required to submit a quality improvement plan that includes specific action steps, responsible parties, and time frames for completing each step. If health, safety or rights concerns are substantiated the provider must submit the plan within 15 business days. All other plans must be submitted within 30 calendar days. The DD Division must approve the plan, and monitors the implementation of the plan to assure it has adequately addressed the area of non-compliance.

If the DD Division determines a participant or participants are in imminent danger, or if there is evidence of abuse or neglect, the Division can require the provider to make accommodations to protect the participant(s), up to and including moving the participant(s) to a different provider of the the participant's choice. In these cases, an emergency team meeting is held and participants are provided with a list of current providers that they may choose from.

Failure to address areas of non-compliance can result in sanctioning by the DD Division, including suspending the provider, freezing admissions, or decertifying the provider.

The Survey/Certification unit of the DD Division enters and tracks information on these monitoring processes in IMPROV, the Division's provider management system. All DD Division staff, the Medicaid Liaison, and Medicaid's Program Integrity Manager have access to IMPROV and can view incident reports, complaints, internal referrals, as well as results of providers' recertification, so they can track the follow up on specific situations and add information as appropriate. The DD Division reviews data on these processes generated from IMPROV monthly and quarterly to identify significant trends that may need action before the formal annual data analysis is completed as described in Section H of this application.

The Adult DD Waiver Manager and Adult DD Waiver Specialist are notified of all incidents and complaints involving Adult DD Waiver participants so they are aware of what has occurred, can provide input and guidance on the follow-actions, and can track the follow-up on the incidents and complaints through IMPROV. The Medicaid Program Integrity Manager, who reports directly to the State Medicaid Agent, is notified of all level one complaints or incidents and is involved as appropriate on identifying follow-up actions to be taken. The Medicaid Program Integrity Manager is also notified of providers who are at the point of being sanctioned, and tracks the sanctioning process to assure all appropriate steps have been taken with the provider.

b. Monitoring Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The DD Division monitors case managers through the processes described in D-2-a. These processes include the recertification process, incident reporting process, complaint process and internal referral process.

The case manager is responsible for completing the following monitoring activities on a monthly basis: a

monthly home visit, observation of services, review of documentation/billing from all service providers on the plan, review of incidents and restraints, review of progress on training objectives, review of implementation of the positive behavior support plan, and interviews with the participant and guardian that include specific questions on satisfaction of services, identification of what is going well and what concerns exist. The case manager is required to complete a quarterly review of all of the above information to identify trends, and to respond to specific questions on whether significant changes have occurred relating to the participant's health, behavior needs, or any other significant changes. The case manager is also required to interview the participant and/or guardian to assess satisfaction with where they live, where they work, or, if they don't work, if they would like to work. The case manager is responsible for documenting these monitoring activities, completing follow-up on concerns, documenting the follow-up actions completed, and making appropriate changes to the plan of care with team involvement when needed.

The Survey/Certification unit of the DD Division reviews case management documentation to assure these monitoring activities are being completed and concerns addressed.

In addition to these safeguards, the DD Division is implementing new policies to address conflict of interest when case managers are providing other services on the plan.

1) The DD Division is currently working with Medicaid to develop the process for certifying case management providers working with organizations under their own provider number. This process begins in July 2009 and will be completed by December 31, 2009. This staggered approach will allow the DD Division to work individually with each case manager on the specific changes, the reasons for the changes, the impact of the changes, and to assure the case manager is given the support and training needed to make this a successful transition. DD Division staff will work directly with case managers to assure the process is completed by December 31, 2009.

2) Enhance education of participants/families and guardians initially applying for services and develop a participant handbook to be distributed to all participants/families and guardians by December 31, 2009. This handbook will explain the role of the case manager in assuring participants have choice of providers, as well as the responsibilities case managers have in assuring the development of the plan of care is in the best interest of the participant and how the case manager is responsible for monitoring the implementation of the plan of care to assure it is implemented in the best interest of the participant. The handbook will also include information on actions the participant and guardian can take if there are concerns with a case manager who is also providing other services on the plan of care.

3) Develop continued training of participants/families and guardians on the Adult DD Waiver, including:
*available services both in the institution and on the Adult DD Waiver
*using a person-centered approach to plan for services and to make changes when needed
*the purpose of the plan of care team meeting
*freedom of choice of providers including case managers
*responsibilities of case managers in developing the plan of care, monitoring implementation of the plan of care, and the conflict of interest that occurs when a case manager is providing other services on the plan of care
*participants and guardians roles and responsibilities in development of the plan of care, including participating in plan of care team meetings

The trainings will be developed by December 31, 2009 and trainings will be offered twice a year and upon request.

4) The changes to the plan of care effective July 1, 2009 include a conflict of interest statement that summarizes how conflict will be addressed, how the best interest of the participant is assured, how monitoring will be enhanced, and what actions the participant/guardian should take if he or she has concerns with any aspects of the case manager’s roles and responsibilities. DD Division staff will serve as a resource to case managers’ and the participants’ teams to educate them on conflicts of interest, and the responsibilities the case manager has in choice, development of the plan of care, and monitoring implementation of the plan of care, beginning with team meetings being held for plans of care effective July 1, 2009. This will assure everyone whose plan of care is effective July 1st through December 1st has been given information on the conflict of interest. For those participants whose plan of care is not effective until after December 1, 2009 the DD Division will develop a one page summary of the conflict of interest areas to be discussed and covered during team meetings and will require case managers to cover this topic during the next team meeting scheduled, which could be a six month team meeting or special team meeting. Case managers will be required to submit this one page summary to the DD Division with the participant's or guardian's signature verifying they have been provided information on the conflict of interest.

5) Require agencies providing case management, case managers employed by agencies, and self employed case managers providing other services on plans of care to develop and implement a comprehensive conflict of interest policy that addresses the areas of choice, development of the plan of care and implementation of the plan of care by December 31, 2009.

6) Require comprehensive case management policies on how agency or self-employed case manager will follow up and provide feedback on concerns identified during development or monitoring of plan of care by December 31, 2009.

7) Develop a web-based complaint process so participants, guardians and families can file a complaint easily with the DD Division if they have concerns by December 31, 2009. The web-based system will provide another avenue for participants, families and guardians to file a complaint at any time as long as they have access to the Internet.

The DD Division will continue to review 100% of annual plans of care and has revised its review and approval process for plans of care effective July 1, 2009 to assure that conflicts of interest are identified in the plan of care and all aspects of the conflict of interest are addressed adequately in the plan.

The DD Division has regional case management training scheduled from May through October 2009 and will include training on the safeguards being put in place to address the conflicts of interest.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Service Plan Assurance/Sub-assurances**
   i. **Sub-Assurances:**
      a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Proportion of Adult DD Plans of Care in which the individual's assessed needs align with the services and supports (the number of plans in which the individual's assessed needs align with the services and supports divided by the total of plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult DD Plan of Care Excel spreadsheet

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of Adult DD Plans of Care in which identified risks align with appropriate supports and accommodations (the number of plans in which

identified risks align with appropriate supports and accommodations divided by the total number of plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult DD Plan of Care excel spreadsheet

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

Data Aggregation and Analysis:

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

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of Adult DD Plans of Care that reflect the individual's personal goals (the number of plans that reflect the individual's personal goals divided by the total number of plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Plan of Care excel spreadsheet

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

Data Aggregation and Analysis:

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

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of Adult DD Plans of Care with participant and/or guardian signature verifying they participated in the development of the plan (the number of plans with signature affixed divided by the number of plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult DD Plan of Care excel spreadsheet

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

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of Adult DD participants with restraint usage authorized in the plan of care (the number of participants with restraint usage in the plan divided by the number of plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult DD Waiver access database

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of Adult DD participants who report their case manager is accessible, responsive, and supports their participation in service planning (the number of participants who report their case manager is accessible, responsive, and supports their participation in service planning divided by the number of participants interviewed)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 4.1%

☑ **Other** Specify: contractor for National Core Indicators	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute aggregates the data and generates a preliminary report and a final report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of Adult DD participants interviewed who report that they were involved in the development of the plan of care (the number of participants interviewed who affirm in response to this question divided by the number of participants interviewed)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 4.1%
☑ **Other** Specify: Contractor for National Core Indicators	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute aggregates the data and generates a preliminary report and a final report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance

measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Proportion of Adult DD Plans of Care requiring correction to be consistent with state policies and procedures by category (approved with no changes, correction needed by type of correction)(measured by the number of plans in each results category divided by the total number of plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Plan of Care excel datasheet

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

Data Aggregation and Analysis:

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

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Proportion of Adult DD Plans of Care that were updated/revised within 365 days of the last plan (the number of plans updated or revised within 365 days of the last plan divided by the total number of plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult DD Waiver Access Database

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of Adult DD participants who report that they are getting the services they need (the number of participants who affirm in response to this question divided by the number of participants interviewed)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 4.1%
☑ **Other** Specify: Contractor for National Core Indicators	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute aggregates the data and generates a preliminary report and a final report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of Adult DD Plans of Care updated when changes are warranted (the number of plans updated when needed divided by the of participants' case managers' documentation reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Results of case management file review tracked in IMPROV, the DD Division's provider management system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: The case management file reviews are completed over a two year period to obtain a representative sample. A preliminary report is compiled in the first year so significant trends can be identified.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

	☐ **Continuously and Ongoing**
	☑ **Other** Specify: A preliminary report is compiled the 1st year so significant trends can be identified. A final report is completed the 2nd year identifying significant trends based on the representative sample.

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Proportion of Adult DD Plans of Care in which services and supports are provided in the type, scope, amount, duration, and frequency specified in the plan (the number of plans in which services and supports are provided in the type, scope, amount, duration, and frequency specified in the plan divided by the total number of plans reviewed)

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe

		Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: The record reviews and interviews are completed over a two year period to obtain a representative sample. A preliminary report is compiled in the first year so significant trends can be identified.
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: The record reviews and interviews are completed over a two year

		period to obtain a representative sample. A preliminary report is compiled in the first year so significant trends can be identified.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: The record reviews and interviews are completed over a two year period to obtain a representative sample. A preliminary report is compiled in the first year so significant trends can be identified.

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Proportion of approved Adult DD Plans of Cares that verify the participant and guardian had choice offered - both choice of institution and provider choice (the number of plans with verification divided by the total number of plans approved)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult DD Plan of Care excel spreadsheet

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

Data Aggregation and Analysis:

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

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of Adult DD participants interviewed stating they were given choice of providers and services (the number given choice divided by the number interviewed)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 4.1%
☑ **Other** Specify: Contractor for National Core Indicators	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute aggregates the data and generates a preliminary report and a final report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Sub-Assurance #1 & 2:

DD Division staff review 100% of plans of care, following detailed plan of care instructions that are available to all providers on the Division's website. The plan of care includes sections on health and safety risk assessments, safety plans to address risks, personal goals, non-waiver services, medical information, behavior plans, and other supports needed either by the provision of waiver service's or through other means. The DD Division's review and approval process includes verification that the plan adequately addresses these areas, the participant and guardian actively participated in the development of the plan, and the plan was developed in accordance with state policy and procedures. The case manager is required to correct incomplete or incorrect sections of the plan of care before receiving DD Division approval. DD Division staff enters information on the incomplete or incorrect sections of the plan into a plan of care spreadsheet, and this data is reviewed quarterly and analyzed for trends.

Sub-Assurance #3:

The DD Division requires in rule that all plans of care are:

• Approved annually by the DD Division,

• Updated as warranted by changes in the participant's needs

Changes to the plan of care primarily occur through the team meeting process and case managers are required to maintain team meeting notes for each meeting. If a change is requested by the participant, guardian or other team member at a time other than at the annual or six month review, a team meeting must be held to discuss the change. If the change is agreed upon, the case manager modifies the plan of care, and when required, submits the modification to the DD Division. The DD Division conducts case management record reviews during the provider recertification process. If it is discovered that the participant did not have a six month review meeting or a team meeting as needed for a specific change in the plan, it will be noted in the recertification report and a Quality Improvement Plan will be required.

Case managers are required to complete a review of the implementation of the service plan monthly, and a more in depth review quarterly, to ensure a participants needs, wants, health, safety, and satisfaction with services are being assessed for possible service plan changes. Record review of the case manager's monthly and quarterly case notes are performed during the recertification process or as warranted by incident reports or complaints. If the case manager is not meeting the monitoring and documentation requirements they must submit a Quality Improvement Plan to address the identified concerns.

The DD Division keeps track of participants' plans that are due each month to assure plans are updated

annually. If a plan is not submitted on time, the case manager is notified within two days to inquire about the tardiness of the plan submission and work with the case manager on a deadline for submission. Late plan submission by a case manager is noted in the person's provider file, and if the problem continues, it is a certification issue with the provider, which requires a Quality Improvement Plan.
The date the plan is approved is noted by the DD Division in a plan of care spreadsheet and in the waiver access database. If a lapse in services occurs due to the delayed start date, then the DD Division works with the case manager to assure the health and safety of the participant until the plan is approved and services can be reimbursed.

Sub-Assurance #4:
The DD Division assesses the implementation of plans of care by completing a thorough assessment of services received by a representative sample of Adult DD participants. This review includes a review of provider documentation of services, observations of service delivery to assure it meets the requirements in the plan of care, review of utilization and claims for services, and provider compliance with the state rules and standards. Information on the results of the monitoring is tracked in IMPROV, including specific concerns that must be addressed by the case manager and/or provider. If a deficit is discovered, then a quality improvement plan is required by the provider to address the area of non-compliance.

Sub-Assurance #5:
Case managers are required to offer choice of providers, choice of waiver services and choice of institutional care to the participant and/or guardian at the time of the annual plan of care and six month review. The plan of care includes a section where the guardian and/or participant verify that they have reviewed their choices through a provider list,have reviewed the waiver services available, and they know they have a choice between home and community based services and the Wyoming Life Resource Center (the state ICF/MR). The DD Division tracks when and if choice was offered and discussed prior to or during the annual plan of care development meeting using the plan of care spreadsheet.
The state monitors this sub-assurance through participant and guardian interviews during the recertification process with providers and through participant National Core Indicator interviews. If it is discovered that the participant did not receive the opportunity to choose providers as requested or at a six month review or annual team meeting, the concern will result in a quality improvement plan by the provider to address this area of non-compliance.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

○ **No**

◉ **Yes**

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

Case Management Safeguards:

1) The DD Division is developing the process for certifying case management providers working with organizations under their own provider number. This process begins in July 2009 and will be completed by December 31, 2009. This staggered approach will allow the DD Division to work individually with each case manager on the specific changes, the reasons for the changes, the impact of the changes, and to assure the case manager is given the support and training needed to make this a successful transition. DD Division staff will work directly with case managers to assure the process is completed by December 31, 2009.

2) Enhance education of participants/families and guardians initially applying for services and develop a participant handbook to be distributed to all participants/families and guardians by December 31, 2009. This handbook will explain the role of the case manager in assuring participants have choice of providers, the responsibilities case managers have in assuring the development of the plan of care is in the best interest of the participant and how the case manager is responsible for monitoring the implementation of the plan of care. The handbook will also include information on actions the participant and guardian can take if there are concerns with a case manager who is also providing other services on the plan of care.

3)Develop continued training of participants/families and guardians on the Adult DD Waiver, including:
*available services both in the institution and on the Adult DD Waiver
*using a person-centered approach to plan for services and to make changes when needed
*what a plan of care team meeting is
*freedom of choice of providers including case managers
*responsibilities of case managers in developing the plan of care, monitoring implementation of the plan of care, and the conflict of interest that occurs when a case manager is providing other services on the plan of care
*participants and guardians roles and responsibilities in development of the plan of care, including participating in plan of care team meetings

Training will be developed by December 31, 2009 and offered twice a year and by request.

4) The changes to the plan of care effective July 1, 2009 include a conflict of interest statement that summarizes how conflict will be addressed, how the best interest of the participant is assured, how monitoring will be enhanced, and what actions the participant/guardian should take if he or she has concerns with any aspects of the case manager’s roles and responsibilities. For those participants whose plan of care is not effective until after December 1, 2009 the DD Division will develop a one page summary of the conflict of interest areas to be discussed and covered during team meetings and will require case managers to cover this topic during the next team meeting scheduled, which could be a six month team meeting or special team meeting. Case managers will be required to submit this one page summary to the DD Division with the participant's or guardian's signature verifying they have been provided information on the conflict of interest.

5) Require agencies providing case management, case managers employed by agencies, and self employed case managers providing other services on plans of care to develop and implement a comprehensive conflict of interest policy that addresses the areas of choice, development of plan of care and implementation of plan of care by December 31, 2009.

6) Require comprehensive case management policies on how agency or self-employed case manager will follow up and provide feedback on concerns identified during development or monitoring of plan of care by December 31, 2009.

7) Develop a web-based complaint process so participants, guardians and families can file a complaint easily with the DD Division if they have concerns by December 31, 2009.

Monitoring Implementation of Plans of Care:

Effective July 1, 2009 the review of the implementation of plans of care for Adult DD Waiver participants will be changed to include all providers. The representative sample size will have a 95% confidence level and a margin of error of 5%. The sample will be identified in July of each year and the review of the implementation of the plans of care will be completed throughout two fiscal years, and will focus on the implementation of the entire plan of care, including non-waiver services, not just on specific providers.

The review will include observations of all waiver services, review of non-waiver services, review of adequacy

of backup plans, interviews with the participant, provider staff, and guardians, walk-through of service areas, review of case management documentation, and review of all other pertinent documentation. The focus of these reviews will be to assure participants have access to the services in their plan, services meet the needs of the participants, participants have access to non-waiver services in their plans, and participants' health and welfare needs are being met.

In addition to the DD Division's review of implementation of plans of care described above, effective July 1, 2009 the Survey/Certification unit of the Division will also review a sample of case management documentation of Adult DD participants for a six month period to verify the case manager is consistently monitoring the implementation of plans of care and updating the plan as needed. The representative sample size will have a 95% confidence level and a margin of error of 5%. The sample will be identified in July of each year and the review of the implementation of the plans of care will be completed throughout two fiscal years.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices

referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Individuals are notified and afforded the opportunity to request a Fair Hearing when the following occurs:
• An applicant does not meet the eligibility requirements for the waiver
• An applicant is not provided the choice of home and community-based services as an alternative to institutional care:
• A participant is denied the service(s) of their choice or the provider(s) of their choice
• A participant's services are denied, suspended, reduced or terminated
When any of these situations occur, the applicant or participant is notified in writing with specific information on how to request a Fair Hearing, in accordance with Wyoming Medicaid Rules, Chapter 34, Section 15 and Chapter 1, Section 9, including the time frames and procedures. The person is also informed that he/she may have an attorney, relative, friend, or other spokesperson represent them at the hearing if he/she chooses. The person has 30 days to request a fair hearing in writing to the Administrator of the Developmental Disabilities Division within the State Medicaid Agency. This information is also included in the Application Packet all applicants and guardians receive when applying for the Adult DD Waiver, and is explained by DD Division staff when reviewing the application process to the applicant or guardian.

If a participant is receiving waiver services, he/she is notified that services are not terminated or reduced pending the results of the Fair Hearing, unless otherwise authorized as specified in 42 CFR §431.230. This information is included in the letter sent to the participant or guardian.

Notices of adverse actions and the opportunity to request a fair hearing are kept on file at the DD Division for 6 years.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

Developmental Disabilities Division

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the

mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Participants, guardians, providers, and other interested parties can file complaints with the DD Division. Complaints can be filed anonymously. All DD Division staff are responsible for receiving complaints and entering complaints in IMPROV, the DD Division's provider management system.

The DD Division receiving the complaint first assesses the information to determine if there is any suspicion of abuse, neglect, exploitation, intimidation or self-neglect which by state law must be reported to the Protective Services unit of the Department of Family Services (DFS). In these cases, the DD Division completes the report the DFS and collaborates with DFS to determine the appropriate follow-up as described Section G -1 of this application.

If the DD Division staff receiving the complaint believes there are significant health and welfare concerns but the complaint does not identify suspected abuse, neglect, exploitation, intimidation, or self-neglect the staff is required to contact their manager and the Survey/Certification manager immediately to determine appropriate follow-up actions. These are classified as Level One Complaints. The managers coordinate the follow-up on Level One complaints to assure the immediate health and welfare issues are addressed and to oversee completion of the complaint investigation.

If the DD Division staff receiving the complaint does not identify significant health or welfare concerns they enter the complaint in IMPROV, which electronically adds the complaint review to the appropriate Survey/Certification's work queue for follow up. Survey/Certification staff review complaints entered into IMPROV within one business day to assign the priority level, the category of complaint, and to identify the appropriate investigation or follow-up actions that need to be completed. Below is more information on the priority level system in place to identify the time frame for investigating a complaint.

Level One complaints are those that indicate there are significant concerns with health, safety or rights and requires follow-up within one business day to assess and address the immediate health and safety concerns. The investigation must be completed within ten business days.

Level Two complaints are those that identify potential provider non-compliance that may be impacting the quality of services participant is receiving. The investigation must be completed within 30 days.

Level Three complaints indicate potential provider non-compliance that does not appear to be directly impacting the quality of services to the participant. Investigation must be completed within 90 days.

The final level is NAN – no action necessary. Complaint is either outside the scope of the Division and the complainant is notified of who may have authority to investigate or the complaint does not identify any compliance issues that can be investigated.

Complaints that involve waiver policies and procedures, waiver staff, or other specific waiver issues are referred to the appropriate DD Division Waiver Manager for investigation and/or follow-up. Complaints that involve provider non-compliance are referred to the appropriate Survey/Certification staff for investigation. Complaints that identify concerns with the overall service system are reviewed by the DD Division’s management team and, when appropriate, the DD Division’s Advisory Council to determine if changes to rules, regulations, policies or procedures need to be made.

Action steps that may be taken to investigate a complaint include:
- On-site investigation, including interviews with participant(s),staff and guardian/family members and review of provider documentation
- Requesting copies of documentation/records
- Contacting providers, staff, participants or guardians/family by telephone to gather information

DD Division staff update IMPROV on the results of the complaint investigation, and notify the provider whether the complaint has been substantiated, which requires the provider to submit a quality improvement plan to address the area(s) of non-compliance. The complainant is also notified of the results of the investigation following HIPAA and confidentiality laws.

If the complaint is substantiated Survey/Certification staff track the submission and approval of the quality improvement plan through IMPROV to assure the area of non-compliance is adequately addressed.

The DD Division’s complaint process is not a prerequisite or substitution for a Fair Hearing. If complaints are

received that relate to situations where a Fair Hearing can be requested, the complainant is reminded of their right to request a Fair Hearing, and the complaint process does not replace that right or delay the time lines to request a Fair Hearing.

The requirements for the DD Division's compliant process are found in Wyoming Medicaid Rules, Chapter 45, Section 31.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Per the Wyoming Adult Protective Services Act (WS 35-20-103): “Any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, exploited, intimidated, abandoned or is committing self neglect, shall report the information immediately…”

Per Wyoming Medicaid Rules, Chapter 45, Waiver Provider Certification and Sanctions, Section 30, all ABI Waiver providers and provider staff are required to report incidents to the DD Division, the Wyoming Department of Family Services - Protective Services Unit, Protection & Advocacy Systems Inc., the case manager, the guardian as required by law, and to law enforcement if a crime may have been committed. Reports must be filed immediately after assuring the health and safety of the participant and other individuals, and include the following categories:

Suspected abuse, including intimidation
Suspected neglect
Suspected self-neglect
Suspected self-abuse
Suspected abandonment
Suspected exploitation
Police involvement
Injuries caused by restraints, including drugs used as restraints, physical restraints, and mechanical restraints
Serious injury to the participant
Death
Elopement

In addition to the categories above, all Adult DD providers and provider staff are required to report medication errors and emergency restraint usage to the DD Division only, using the web based incident reporting system, unless the medication error is a result of suspected abuse, neglect or other reportable category listed above. In these cases the incident must also be reported to the Wyoming Department of Family Services - Protective Services Unit (DFS), Protection & Advocacy Systems Inc., the case manager, the guardian as required by law, and to law enforcement if a crime may have been committed.

Providers filing incident reports must file them through the DD Division's web-based system or faxed to the DD Division using the standardized "Notification of Incident" form. Participants, guardians, and families may contact the DD Division to report an incident, although they are also encouraged to report directly to the Department of Family Services Protective Services unit so DFS can gather pertinent information for their investigation. If the participant, guardian or family does not want to contact DFS, the DD Division will file the report with DFS on their behalf.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The DD Division requires case managers to educate participants and guardians on the person's right to be free from abuse, neglect and exploitation. The DD Division uses a "Right, Restrictions, and Responsibilities" publication as a tool (available on the Division's website) for case managers, participants, and guardians to learn and understand these rights in simple to read language. A review of these rights is required by the case manager to the participant and/or guardian at least every six months.

To train participants, families and providers on recognizing and reporting instances of abuse, neglect and exploitation, Wyoming Protection & Advocacy Systems Inc. (P&A) holds trainings throughout the state. P & A is a federally funded program, whose mission is to establish, expand, protect and enforce the human and civil rights of persons with disabilities through administrative, legal, and other appropriate remedies. It is the official non-profit corporation in Wyoming authorized to implement certain mandates of several federal laws. Enacted by Congress, these laws provide various protection and advocacy services. They provide protection of the rights of persons with disabilities through legally based advocacy. P & A's were established to address public outcry in response to the abuse, neglect, and lack of programming in institutions for persons with disabilities.

The DD Division currently does not provide statewide standardized training and education to participants or involved family members in the areas of abuse, neglect and exploitation. The lack of DD Division sponsored training is recognized as a gap. To alleviate this gap, the DD Division will form a working group comprised of DD Division staff and stakeholders, which include participants and families, to develop a statewide training curriculum on abuse, neglect and exploitation by the end of September 2009. This statewide training will include handbooks that participants and involved families can use as a resource and to keep emergency and important phone numbers. Training will begin in October 2009 and will be offered a minimum of twice a year.

In the interim, DD Division will coordinate training on abuse, neglect and exploitation with the Victim's Services unit of the Attorney General's office, Adult and Child Protection Services and with Protection and Advocacy. This training will be offered to participants and families/guardians one time a month through the months of July and September via a webinar. The training will include but not limited to: how to recognize and report abuse, neglect and exploitation. DD Division staff will also have pamphlets produced by the Attorney General's office to distribute after a team meeting and at the time of application to a waiver.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Per Wyoming Medicaid Rules, Chapter 45, Section 30, Adult DD Waiver providers and provider staff are required to report incidents to the DD Division, the Wyoming Department of Family Services - Protective Services Unit, Protection & Advocacy Systems Inc., the case manager, the guardian as required by law, and to law enforcement if a crime may have been committed. Reports must be filed immediately after assuring the health and welfare of the participant and other individuals.

If a potential crime has been committed law enforcement is involved and, when appropriate, works directly with the Wyoming Department of Family Services Protective Services Unit to coordinate investigations. If criminal charges are filed against an Adult DD Waiver provider the DD Division immediately suspends the provider pending the outcome of the criminal case. If the provider is convicted they are immediately decertified as provider.

DFS investigates suspected abuse, neglect, exploitation, self-neglect or abandonment and has an intake and referral process when incidents are reported. DFS has the statutory authority to substantiate cases, resulting in a person be listed on the Abuse Central Registry and informs the DD Division when a substantiation occurs involving an Adult DD Waiver provider. Per Chapter 45, providers appearing on the Central Registry are immediately suspended from providing services and decertified within 60 days unless they submit a new Central Registry Screening verifying they are not listed on the registry. The 60 day delay in decertification is required so the provider can appeal the DFS

decision before being decertified as a provider.

Protection and Advocacy, Systems Inc. (P & A) has federal authority under the Developmental Disabilities Assistance and Bill of Rights (DD) Act of 1975 and is required by the Act to pursue legal, administrative and other appropriate remedies to protect and advocate for the rights of individuals with developmental disabilities under all applicable federal and state laws. As part of this authority P & A receives and reviews all critical incident reports involving Adult DD Waiver providers and participants. P & A has a separate intake and investigation process for incidents, but does collaborate with the DD Division when there are concerns with the health and welfare of participants and/or when P & A identifies potential non-compliance with rules and regulations by an Adult DD Waiver provider.

The DD Division investigates incidents and, when appropriate, substantiates provider non-compliance with Medicaid rules and regulations, including concerns with participants' health and welfare. If through follow up on incident reports a provider is found to be non-compliant with rules, regulations or policies it is required to submit a quality improvement plan that identifies the area of non-compliance, the action steps to be taken by the provider to address the non-compliance, the time frame for addressing each action step, and the responsible party for each action step. Quality Improvement plans are due to the DD Division within 15 business days if the recommendation identifies concerns with health, safety or participant rights and within 30 calendar days for all other concerns. The participant, guardian and, when appropriate the case manager are notified by letter of the non-compliance if it directly relates to the participant receiving services, adhering to HIPAA and confidentiality laws.

The DD Division's incident intake process is separate from the Department of Family Service's process. Incident reports are submitted by providers and other stakeholders through a web-based system. Survey/Certification staff within the DD Division have access to the incident database via IMPROV, the DD Division's web based provider management system, and are required to check for incidents throughout the day, with the requirement that they review incidents within one business day. The Survey/Certification Manager or designee reviews the status of reported incidents in IMPROV to assure incidents are reviewed within this time frame.

Upon receipt of an incident that identifies suspected abuse, neglect, exploitation, self-neglect or abandonment, DD Division staff contact the Wyoming Department of Family Services (DFS), Protective Services Unit to determine if DFS is going to open a case or if there is police involvement. If there is police involvement, or if DFS determines a reported incident is within their statutory authority to investigate, the DD Division cannot complete follow-up on the specific incident until the investigations are completed.

The DD Division does complete immediate follow-up with the provider if there is a potential that the participant involved in the incident and/or other participants are at risk due to the provider's non-compliance with rules, regulations and policies. These are classified as Level One Incidents. The DD Division notifies DFS follow-up is going to be completed and the results of the investigation are shared with DFS as appropriate. If participants continue to be at significant risk the DD Division requires the provider to immediately alleviate the risks, can remove the participants if the risks are not alleviated, and can sanction the provider.

The DD Division uses a priority level system to identify the appropriate follow-up to be taken. Below is a summary of the levels:

Level One – Highest Consideration: Person's health or safety appears to be at immediate risk and provider compliance needs to be ensured. This requires follow-up actions by the DD Division within 1 business day.
Level Two – Medium Consideration: Person's health or safety is of significant concern and provider compliance needs to be ensured. This requires follow-up actions by the DD Division within two weeks.
Level Three – Lower Consideration: Although no substantial health and safety concerns, the incident may impact the care of the person and provider compliance needs to be ensured. This requires follow-up actions by the DD Division within 2 weeks-1 month.
NAN – No Action Necessary: Adequate information and follow up have been provided. No concerns with health/safety and no compliance must be ensured.

The DD Division must review and approve the quality improvement plan, and monitor implementation of the plan. The type of monitoring completed on the implementation of the quality improvement plan may include an on-site visit, request for documentation, follow-up interviews with participants, provider and/or provider staff, or follow-up during the next provider recertification.

All pertinent information on the review and follow-up completed on incident reports is maintained in IMPROV, the DD Division's provider management system, including the status of quality improvement plans. Information on sanctioned providers is also maintained in IMPROV.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible

for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department of Family Services, Protective Services unit (DFS) is responsible for overseeing and responding to critical incidents that identify suspected abuse, neglect, exploitation, self-neglect, intimidation or abandonment. DFS has the authority to pursue criminal charges per Wyoming State Statute 35-20-111, which states, "any person or agency who knows or has sufficient knowledge which a prudent and cautious man in similar circumstances would have to believe that a vulnerable adult is being or has been abused, neglected, exploited, intimidated or abandoned, or is committing self neglect, and knowingly fails to report in accordance with this act is guilty of a misdemeanor punishable by imprisonment for not more than one (1) year, a fine of not more than one thousand dollars ($1,000.00), or both."

When an Adult DD provider delays in reporting an incident, the provider is required to explain the reason for the delay in the incident report being filed. DFS reviews this information to determine if the provider knowingly failed to report the incident,and determines if further action is needed by DFS.

The DD Division, per Wyoming Medicaid Rules, Chapter 45, requires a provider reporting late incidents to submit a quality improvement plan addressing the non-compliance. If participants continue to be at significant risk the DD Division requires the provider to immediately alleviate the risks, can remove participants if the risks are not alleviated, and can sanction the provider.

The DD Division conducts monitoring activities to assure providers are reporting incidents as required. These activities include:

Provider certification process – Providers must be recertified at least every two years. Part of the recertification process includes assessment of providers and provider staff knowledge of reportable incidents to assure they are aware of the categories of reportable incidents and how to report. All providers are required to have an incident reporting policy that includes the requirements in the DD Division's Notification of Incident process and this policy is reviewed during each provider recertification. Participant specific documentation is reviewed to determine if a critical incident occurred that was not reported to the Division.

Incident Reporting Process – providers are required to report critical incidents to the appropriate authorities immediately after assuring the health and welfare of the participant. The DD Division reviews each incident report to assure that it was reported within the required time frame to the appropriate entities. The DD Division does follow-up to assure that the provider has responded appropriately to the incident and is taking appropriate action to assure the health and welfare of participants and to minimize risk. When appropriate the DD Division also completes follow-up on incidents during provider recertifications as a double check to assure that the follow-up has been completed and to assess how the participant is doing.

Complaint process – The DD Division's complaint process can and has identified situations where a reportable incident occurred but was not reported as required. When this occurs, the DD Division requires that the provider report the incident and also requires that they submit a quality improvement plan to address their failure to report incidents.

If a provider is found to be non-compliant with rules, regulations or policies it is required to submit a quality improvement plan that identifies the area of non-compliance, the action steps to be taken by the provider to address the non-compliance, the time frame for addressing each action step, and the responsible party for each action step. Quality Improvement plans are due to the DD Division within 15 business days if the recommendation identifies concerns with health, safety or participant rights and within 30 calendar days for all other concerns. The DD Division must review and approve the quality improvement plan, and monitor implementation of the plan. The type of monitoring completed on the implementation of the quality improvement plan may include an on-site visit, request for documentation, follow-up interviews with participants, provider and/or provider staff, or follow-up during the next provider recertification.

All pertinent information on the review and follow-up completed on incident reports is maintained in IMPROV, the DD Division's provider management system. Recommendations and quality improvement plans are tracked through IMPROV as well, including verification the quality improvement plan has been implemented appropriately.

In addition to completing follow-up on individual incidents the DD Division reviews data on incidents on a quarterly basis to identify significant trends and to determine appropriate actions to take to prevent the recurrence of incidents. Actions taken may include retraining of participants, Adult DD providers, and provider staff on recognizing and reporting abuse and neglect, exploitation and self-neglect, distributing information to participants,

guardians,and providers on causes of serious injuries that can be avoided, such as assuring participants have proper footwear in the winter to avoid falls, working with a specific provider who has an increase in incidents identifying specific concerns with services, and/or completing participant and provider training on any other specific trend identified in the data. The goal is to minimize the occurrences and recurrences of incidents.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

○ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

◉ **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Safeguards for restraint usage are written into Wyoming State Statute 35-1-625 and 626, which mandate participants must be free from physical restraints and isolation except for emergency situations or when isolation or restraint is a part of a treatment program; and isolation or restraint of a client may be used only when less restrictive measures are ineffective or not feasible for the welfare of the client and shall be used for the shortest time possible.

The DD Division has specific safeguards in place concerning use of restraints in Wyoming Medicaid Rules, Chapter 45, which prohibits the use of seclusion in home and community based waiver services. In Chapter 45, Section 28, restraints are defined as:

• Drugs used as a restraint: Any drug that is administered to manage a participant's behavior in a way that reduces the safety risk to the participant or others, and 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.
• Mechanical restraints: 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.
• Personal restraints: The application of physical force or physical presence without the use of any device, for the purposes of restraining the free movement of the body of the participant. The term personal restraint does not include briefly holding, without undue force, a participant 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.
• Emergency restraints: A restraint used in an emergency due to significant concerns with the health and welfare of the participant or others, which is not authorized in the participant's plan of care.

Any restraint usage, must be ordered by a physician or qualified behavioral health practitioner, written in the participant's plan of care, and reviewed and approved by the participant, guardian, and the DD Division. Least restrictive measures must be attempted first and, when restraint usage is identified in the plan of care, a positive behavior support plan must be developed that focuses on positive interventions. Providers are required to document that the participant has been consulted regarding alternatives he or she prefers prior to the development of the behavior support plan that includes the use of restraint, when possible.

All providers are required to have policies on restraint usage, including a policy on whether they will use

emergency restraints, such as a personal restraint, as a time-limited emergency measure until the appropriate law enforcement, safety or other emergency service providers arrive on site. When an emergency restraint occurs, providers are required to notify the guardian and case manager so the case manager can convene a team meeting to assess the use of the emergency restraint and to work with the participant and team on identifying appropriate changes to the plan of care. These changes may include authorization of restraint usage, but the team is encouraged to consider less intrusive methods if appropriate.

Providers are required to document the use of restraints as an incident following the provider's internal incident reporting policy. Restraint usage must be reported to the DD Division when an injury results from the use of restraints. Effective July 1, 2009 providers will also be required to notify the DD Division, through the incident reporting process, of use of emergency restraints. The DD Division will complete follow-up monitoring to assure the team meets and the plan of care is revised appropriately.

All rights restrictions in the plan of care, including restraint usage, have to identify the following:

1) Why the restriction is imposed
2) How it is imposed
3) A plan to restore rights
4) A date to review restrictions

Providers using restraints must assure less restrictive intervention techniques are used prior to the use of restraint, assure the individual plan of care includes limitations or specific descriptions of the proper restraint to use or not use on the participant, and identify the designated provider staff to provide face-to-face evaluation of the participant within one hour of the use of restraint to assure there are no injuries or other concerns and to assure the provider staff are following the participant's plan of care and restraint standards, including using the least restrictive approach first.

Providers are required to obtain and maintain restraint training from entities that are certified to conduct such training before agreeing to provider services for any participant who has restraint use in the plan of care. Staff involved in the direct administration of restraints must also receive initial and annual competency-based training in the following:

1) The contributing factors or causes of threatening behavior.
2) The use of alternative interventions, such as mediation, de-escalation, self-protection, and time out, which still permits the participant the freedom to leave the time-out area
3) Recognizing signs of physical distress in the person who is being restrained.
4) The re-establishment of communication after a person has been restrained.
5) The prevention of threatening behaviors
6) When and how to restrain safely

Removal from restraint must occur as soon as the threat of harm has been safety minimized. Restraint cannot be used as coercion, discipline, convenience, or retaliation by staff.

Analysis of restraint usage occurs on the participant level, provider level and at the state level as described below:
1. Providers are required to review and discuss each use of restraint. The participant, the guardian and staff are included in the discussion, which should address:
- The incident.
- Its antecedents
- The reasons for the use of restraint.
- The person's reaction to the intervention.
- Actions that could make future use of restraint unnecessary.

When applicable, modifications should be made to plan of care to address issues or behaviors that impact the need to use restraint.

2. The chief executive or designated management staff member is required to review and sign off on all uses of restraint after every occurrence. The review must include:
- Verification that the provider's policies and procedures regarding restraints were followed
- Verification that the behavior support plan for the participant was followed
- Determination if modifications to the treatment plan are needed

• Determination if staff involved in the restraint had received appropriate training and utilized this training appropriately when using a restraint
• Verification that recommendations identified during the review of the restraint usage are appropriate and are being implemented
3. Case managers are required to complete an analysis of restraint usage monthly for each participant to identify trends and to work with the team to make appropriate changes to the plan of care as needed.
4. The use of restraint must be recorded in the provider's information system and reviewed for:
• Analysis of patterns of use
• History of use by personnel
• Environmental contributing factors
• Assessment of program design contributing factors
If the frequency of use of restraint, including physical restraint, mechanical restraint, and chemical restraint changes, the chief executive or a designee must investigate the pattern of use and take action to continuously reduce or eliminate the use of restraint.
5. The DD Division oversees the use of restraints or seclusion and ensures that State safeguards concerning their use are followed as described in G-2-a-ii.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The DD Division monitors compliance with restraint rules through the plan of care approval process, provider recertification process, incident-reporting process, and complaint process. The focus of this monitoring is to assure restraint usage is only occurring when necessary as a last resort, is authorized as required in state rules, is approved in the plan of care, and to assure staff have appropriate training in both restraint usage and in de-escalation techniques and other non-evasive approaches to working with participants.

Plan of Care Approval Process
DD Division staff review and approve each plan annually. This review includes a review of authorized restraints written in the plan of care to assure the restraint is ordered by a physician or qualified behavioral health practitioner, has been approved by the guardian and participant, that least restrictive measures were attempted first, and a positive behavior support plan is included in the plan of care that focuses on positive interventions. The review also includes assuring seclusion is not listed in the plan as a restriction.

Provider Recertification Process
Providers are certified for a period of up to two years. The recertification process includes monitoring the use of restraints to ensure that state requirements are being followed and to detect unauthorized, inappropriate or ineffective use of restraints and use of seclusion. This monitoring includes:

• A review of provider/provider staff files to verify the provider has current training from an entity certified to conduct the training, such as MANDT or CPI.

• Interviews with providers and provider staff about restraint usage to assure restraints are only used when absolutely necessary and it is written into the participant's plan of care, and to verify seclusion is not being used.

• A review of the provider's information system and results of the analysis of restraint use to assure trends are being identified and areas of concern are addressed at the provider level.

• Effective July 1, 2009 the review of the implementation of plans of care for Adult DD Waiver participants will be changed to include all providers. The representative sample size will have a 95% confidence level and a margin of error of 5%. The sample will be identified in July of each year and the review of the implementation of the plans of care will be completed throughout two fiscal years, and will include a review of restraint and restrictive intervention usage and tracking

• In addition to the DD Division's review of implementation of plans of care described above, effective July 1, 2009 the Survey/Certification unit of the Division will also review a sample of case management documentation of Adult DD participants for a six month period to verify the case manager is consistently monitoring use of restraints and restrictive interventions, including completing follow-up when concerns are found and updating the plan as needed. The representative sample size will have a 95% confidence level and a margin of error of 5%. The sample will be identified in July of each year and the review of

the implementation of the plans of care will be completed throughout two fiscal years.

A review of a representative sample of Adult DD Waiver participant files to assess the documentation of restraint usage, including the documentation of the review and discussion required after each use of restraints. This includes a review of case management documentation for the random sample of Adult DD Waiver participants to verify the case manager has completed the monthly evaluation and trend analysis of restraint usage and has completed appropriate follow-up on concerns.

• A review of each provider's policies and procedures on restraint usage and on emergency restraints, including verification the policy states seclusion will not be used.

Incident and Complaint Processes
When restraint usage is reported through incidents or complaints the DD Division reviews the participant's plan of care to assure that restraint usage is authorized and that a positive behavior support plan is in place and was followed. Incidents and complaints are reviewed to verify seclusion is not being used.

The unauthorized or inappropriate use of restraints and the use of seclusion can be uncovered through any of the processes listed above. If the unauthorized use of restraints is found, the provider is required to immediately put safeguards in place to assure there are no more restraints used until the team is able to evaluate the reason for the unauthorized restraint and to identify appropriate follow up actions. If the use of seclusion is found, the provider is notified to immediately stop the practice and the DD Division completes an on-site investigation to assure seclusion is not being used.

If a provider is found to be non-compliant with rules, regulations or policies, including the unauthorized use of restraints, it is required to submit a quality improvement plan that identifies the area of non-compliance, the action steps to be taken by the provider to address the non-compliance, the time frame for addressing each action step, and the responsible party for each action step. Quality Improvement plans are due to the DD Division within 15 business days if the recommendation identifies concerns with health, safety or participant rights and within 30 calendar days for all other concerns. The DD Division must review and approve the quality improvement plan, and monitor implementation of the plan. The type of monitoring completed on the implementation of the quality improvement plan may include an on-site visit, request for documentation, follow-up interviews with participants, provider and/or provider staff, or follow-up during the next provider recertification.

However, the DD Division has not completed the system for collecting data on restraints and restrictive interventions (covered in section G-2-b) on a statewide basis. The DD Division has developed an action plan to have the data collection in place by July 1, 2009, including collecting baseline data. This data will be collected over fiscal year 2010 and will be analyzed following the system outlined in the Quality Improvement Strategy section of this application.

Restraint and restrictive intervention data:
In order to collect baseline data, case managers will be asked to submit to the DD Division by June 30, 2009 all participants on their caseloads that have restraints and restrictive interventions included in the plan of care, including the type of restraint and/or restrictive intervention. The Adult DD Waiver Manager will add several fields to the Waiver Database to collect this data on restraints and restrictive interventions. These fields will be in place by July 1, 2009 and DD Division staff will enter the information from the case managers into the Waiver Database.

The DD Division is also revising the Case Management Quarterly Report by July 1, 2009 to include a breakdown of the restraints and restrictive interventions used during that time period. The DD Division is adding the requirement that emergency restraint usage be reported on this form as well. This information will be faxed or emailed to the DD Division and entered into a database starting September 30, 2009. This is a short term solution for data collection while the DD Division is developing the electronic plan of care. Once the electronic plan of care is in place, which is anticipated by July 1, 2010, this data will be collected through that system.

In addition to monitoring restraint and restrictive intervention data on the participant and provider level, the DD Division will also be reviewing aggregate data quarterly to identify systemic trends in this area that may need addressing before the annual review of data and information as outlined in the Quality Improvement Strategy section of this application (Section H.) Examples of how trends may be addressed by the DD Division include, enhancing training in this area, releasing a bulletin clarifying a standard or

rule, and/or revising the plan of care approval process to assure restraint or restrictive interventions are appropriately approved during the plan review. The goal is to assure restraint and restrictive interventions are only used when necessary and per rules and standards.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The DD Division has specific safeguards in place concerning use of restrictive measures in Wyoming Medicaid Rules, Chapter 45.

Restrictive interventions include:
• limits on a participant's movement
• limits on a participant's access to other individuals, locations or activities
• the use of other aversive techniques (not including restraint or seclusion) that are designed to modify the participant's behavior.

Restrictive interventions must be included in the plan of care and reviewed and approved by the participant, guardian and the DD Division. The plan of care must also include a plan to restore rights and periodic reviews of the restrictions. The DD Division has specific safeguards in place concerning use of restrictive interventions, which include least restrictive measures must be attempted first; and, when restrictive interventions are identified in the plan of care, a positive behavior support plan must be developed that focuses on positive interventions. Providers are required to document that the participant has been consulted regarding alternatives he or she prefers prior to the development of the behavior support plan that includes the use of restrictive interventions, when the participant can express preferences.

All rights restrictions in the plan of care, including restrictive interventions, have to identify the following:

1) Why the restriction is imposed
2) How it is imposed
3) A plan to restore rights
4) A date to review restrictions

Providers and provider staff are required to receive participant specific training, including training on rights restrictions and restrictive interventions.

Providers are required to document the use of restrictive interventions as an incident following the provider’s internal incident reporting policy.

Analysis of use of restrictive interventions occurs on the participant level, provider level and at the state level as described below:
1. Providers are required to document each use of restrictive interventions and to review the use of the restrictive intervention to assure it was authorized in the participant's plan of care and implemented appropriately
2. Case managers are required to complete an analysis of restrictive interventions monthly for each participant to identify trends and to work with the team to make appropriate changes to the plan of care as needed.
3. The DD Division oversees the use of restrictive interventions and ensures that State safeguards concerning their use are followed as described in G-2-b-ii.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The DD Division monitors compliance with restrictive interventions through the plan of care approval process, provider recertification process, incident-reporting process, and complaint process. The focus of this monitoring is to assure restrictive interventions occur only when necessary as a last resort, are authorized as required in state rules, are approved in the plans of care, and to assure staff have appropriate training in approved restrictive interventions for each participant.

Plan of Care Approval Process:
DD Division staff review and approve each plan annually. This review includes a review of restrictive interventions written in the plan of care to assure the restrictive intervention has been approved by the guardian and participant, least restrictive measures were attempted first, and a positive behavior support plan is included in the plan of care that focuses on positive interventions.

Provider Recertification Process:
Adult DD Waiver providers are certified for up to two years. The provider recertification process includes monitoring the use of restrictive interventions to ensure that state requirements are being followed and to detect unauthorized, inappropriate or ineffective use of restrictive interventions. This monitoring includes:

• Review of provider/provider staff files to verify the provider has current training on restrictive interventions written into each participant's plan of care
Interviews with providers and provider staff about use of restrictive interventions to assure they are only used when necessary and are written into the participant's plan of care.
• Review of the provider's information system and results of the analysis of restrictive intervention use to assure trends are being identified and areas of concern are addressed at the provider level
• Review of a representative sample of Adult DD Waiver participant files to assess the documentation of use of restrictive interventions. The representative sample size will have a 95% confidence level and a margin of error of 5%. This includes a review of case management documentation for the random sample of Adult DD Waiver participants to verify the case manager has completed the monthly evaluation and trend analysis of use of restrictive interventions and has completed appropriate follow-up on concerns.

Incident and Complaint Processes:
When use of restrictive interventions is reported through incidents or complaints the DD Division reviews the participant's plan of care to assure that the use of restrictive interventions authorized and that a positive behavior support plan is in place and was followed.

The unauthorized or inappropriate use of restrictive interventions can be uncovered through any of the processes listed above. When this occurs the provider is required to immediately put safeguards in place to assure there are no more restrictive interventions used until the team is able to evaluate the reason for the unauthorized restrictive intervention and to identify appropriate follow up actions.

If a provider is non-compliant with rules, regulations or policies, including the unauthorized use of restrictive interventions, it is required to submit a quality improvement plan that identifies the area of non-compliance, the action steps to be taken by the provider to address the non-compliance, the time frame for addressing each action step, and the responsible party for each action step. Quality Improvement plans are due to the DD Division within 15 business days if the recommendation identifies concerns with health, safety or participant rights and within 30 calendar days for all other concerns. The DD Division must review and approve the quality improvement plan, and monitor implementation of the plan. The type of monitoring completed on the implementation of the quality improvement plan may

include an on-site visit, request for documentation, follow-up interviews with participants, provider and/or provider staff, or follow-up during the next provider recertification.

The DD Division has not completed the system for collecting data on restraints and restrictive interventions (covered in section G-2-b) on a statewide basis. The DD Division has developed an action plan to have the data collection in place by July 1, 2009, including collecting baseline data. This data will be collected over fiscal year 2010 and will be analyzed following the system outlined in the Quality Improvement Strategy section of this application.

Restraint and restrictive intervention data:
In order to collect baseline data, case managers will be asked to submit to the DD Division by June 30, 2009 all participants on their caseloads that have restraints and restrictive interventions included in the plan of care, including the type of restraint and/or restrictive intervention. The Adult DD Waiver Manager will add several fields to the Waiver Database to collect this data on restraints and restrictive interventions. These fields will be in place by July 1, 2009 and DD Division staff will enter the information from the case managers into the Waiver Database.

The DD Division is also revising the Case Management Quarterly Report by July 1, 2009 to include a breakdown of the restraints and restrictive interventions used during that time period. The DD Division is adding the requirement that emergency restraint usage be reported on this form as well. This information will be faxed or emailed to the DD Division and entered into a database starting September 30, 2009. This is a short term solution for data collection while the DD Division is developing the electronic plan of care. Once the electronic plan of care is in place, which is anticipated by July 1, 2010, this data will be collected through that system.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

First line monitoring: The participant's physician, psychiatrist, or other licensed medical professional who prescribes medications to the participant shall be the first line monitor of the participant's medication regimen. The first line monitor shall be accessed by the participant, guardian, case manager and designated team member(s) to conduct regular assessments of medication regimens, side effects, or when concerns arise regarding a participant's treatment plan, health condition or potentially harmful contraindicated medications are used.

Second line monitoring: Medication regimens shall have a second line of monitoring conducted by the participant's case manager, in conjunction with designated members of the participant's team. Case Managers shall monitor medication regimens by:
1) Ensuring all medications, medical treatments, and medication assistance are described accurately and fully in the plan of care and updated as needed.
2) Ensuring providers receive training on the participant's plan of care.
3) Conducting reviews of events as defined in the state's medication assistance policy.
4) Ensuring professional medical assessments are performed at least annually, or as needed by responsible

parties, to include:
a) Medication reviews to prevent the concurrent use of contraindicated medications
b) Blood tests and liver function tests to monitor the effects of psychotropic or seizure medications on one's body
c) Any follow up medical visits needed to monitor the participant's health post-injury, post-surgery, or after any significant change in treatment plan
5) Documenting review of the participant's health, medical condition, medication regimen, incident reports, PRN usage, and pertinent health risks at least quarterly on the case management quarterly form, or as deemed appropriate for the participant by the participant's medical professional. At least quarterly, or as health or safety risks arise, the case manager must monitor the participant for significant health changes, including:
a) Significant changes in weight (either weight gain or loss)
b) Increase in seizure activity or changes in type or duration of seizures
c) Unplanned changes in diet and/or food intake
d) Changes in adaptive equipment needs or in condition of equipment
e) Significant changes in type or frequency of behaviors
f) Changes in medication
g) Use of PRN medications
h) Any other significant health changes
i) Follow up actions taken on Incident Reports, PRN usage, or other identified health risks or concerns

Monitoring of PRN usage:
A qualified person, in accordance with state standards, who a provider deems responsible for analyzing the patterns of PRN usage, will work in conjunction with the participant's case manager to assure an appropriately trained medical professional continually assesses, monitors, and re-evaluates the participant to determine if the PRN medication is still needed or is still appropriate for the participant's medical condition.

The frequency of the monitoring, which shall be done at least quarterly by the case manager but may be needed more frequently for some participants or types of medication.

Monitoring Behavioral Modifying Medication:
First line monitoring of behavioral modifying medication shall be the responsibility of the participant's physician, psychiatrist, or other licensed medical professional who prescribes medications to the participant. The first line monitor shall be accessed by the participant, guardian, case manager and designated team member(s) to conduct regular assessments of medication regimens, side effects, or when concerns arise regarding a participant's treatment plan, health condition or potentially harmful contraindicated medications are used.

Second line monitoring of behavioral modifying medication shall be conducted by the participant's case manager, in conjunction with designated members of the participant's team.

When a medication is given for the purposes of modifying a behavior, including prescribed medications and non-prescription sedating medications, the provider shall have policy and procedures for assisting and monitoring medication in compliance with the state's standards. The policy and procedures shall include:
1) The qualified person(s) responsible for assisting the participant with medications.
2) The qualified person on the participant's team who will be designated to assure an appropriately trained medical professional continually assesses, monitors, and re-evaluates the participant to determine if the behavioral modification medication is still needed, is having adverse effects on the participant, or is still appropriate for the participant's medical condition.
3) How the medication will be used in accordance with the type, frequency, duration, route, and specific instructions as prescribed by the participant's licensed medical professional involved in his/her treatment plan.
4) Specific PRN instructions for behavioral modifying medication, including:
a) Documentation of the PRN as an internal incident report
b) The qualified person evaluating the participant face-to-face within one hour after the PRN is taken and documenting the participant's reaction to the PRN.
c) The types of incidents relating to PRN usage or administration that would be deemed "critical incidents" and reportable to the Division, DFS, Protection & Advocacy Systems Inc, the participant's case manager and guardian, if applicable.
d) The responsible person for reviewing the use of the PRN medication for behavioral modification purposes.
e) The requirements of the review, including:
i) Verification that the provider's policies and procedures regarding medication assistance and the participant's PRN protocols in the plan of care were followed.
ii) Verification that the positive behavior support plan for the participant was followed, including less

restrictive techniques.
iii) Determination if modifications to the treatment plan or medication regimen are needed or should be requested to the participant's medical professional.
iv) Determination if staff involved in the use and administration of the PRN had received appropriate training in accordance with the Division standards and utilized this training appropriately when assisting with the PRN medication.
f) Recording the review of each PRN used in the provider's information system and reviewed for:
i) Analysis of patterns of use.
ii) History of use by personnel.
iii) Environmental contributing factors.
iv) Assessment of program design contributing factors.
5) If PRN usage is suspicious or raises concerns regarding the participant's health and safety, then the provider shall investigate the pattern of use and take action to continuously reduce or eliminate the PRN usage, change medications, or otherwise address the medication regimen under the direction of the participant's licensed medical professional.
6) Any concerns or incidents that qualify as a critical incident according to the Division's state requirements shall be filed with the DD Division as described in Appendix G-1-d.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

To ensure appropriate medication management by providers, all providers assisting participants with medication regimens must comply with the state requirements for medication assistance, including:
1) The development and implementation of internal medication assistance policies and procedures that meet the Division's standards.
a) Through implementation of the provider's policies and procedures, the provider ensures:
i) Only prescribed medication, or medications specified through consent of the participant or guardian and deemed appropriate by the participant's medical professional, shall be included in the participant's medication regimen.
ii) Only qualified persons, as dictated by Division's standards, assist a participant with medications.
iii) The participant receives consistent and appropriate assistance with the medication as described by the prescription and instructions from the participant's medical professional.
2) The participant, or guardian if applicable, gives consent to allow a provider to assist with the participant's medication.
3) Only qualified persons, which is a licensed medical professional or a state Approved Medication Assistant, assist a participant with medication. To become an Approved Medication Assistant, the provider or provider staff must complete the required training.
4) The participant's case manager, in conjunction with designated member(s) of the participant's team, oversees the ongoing monitoring of the participant's medication regimen as described in the plan of care.
5) The assistance needed by the participant is accurately reflected in the plan of care, including any other special instructions or participant education needed for assisting with the medication, and providers must be trained on the participant's plan of care.

The DD Division is responsible for overseeing and monitoring provider compliance with the Division's medication assistance policy and standards, potentially harmful practices and the provider's own policies and procedures.

The DD Division oversees provider compliance with state standards and requirements through the Area Resource Specialists attending team meetings, the Survey/Certification unit completing recertifications, waiver specialists approving each plan of care, and as needed through follow up to critical incidents reported. Through these regular channels of communication and monitoring, the State ensures that participant medications are managed appropriately and monitors for potentially harmful practices.

The case manager and all providers are responsible for reporting unsafe practices to the DD Division through the critical incident reporting process and reporting critical medication errors to the DD Division. Through critical incident reports, complaints, provider certification or recertification processes, the Division completes follow up on any identified health or safety concerns regarding medication assistance. During follow up of a medication assistance concern the Division may review the provider's:
1) Medication assistance policies and procedures
2) Medication error policies and procedures

3) Medication-related forms, including
a) Incident Reports
b) Medication Assistance Records (MARs)
c) Medication Error forms
d) Medication and/or PRN reviews
e) Case management documentation of follow up

If the Division identifies health or safety concerns regarding medication assistance, such as unsafe practices or non-compliance with the Division's standards and requirements, then the provider must:
i) Rectify the situation as quickly as possible, subject to approval by the Division
ii) Receive re-education on the Division's standards, policy and procedures on Medication Assistance,
iii) Train or retrain personnel as needed to safely assist participant's with medication, and
iv) Address the areas of non-compliance before the next recertification is completed.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State Policy: The Division ensures participant medications are managed and monitored in accordance with the State's standards by requiring all home and community-based waiver providers, who assist participants with medications, to develop and implement policies and procedures in accordance to the standards listed herein.

STANDARDS
Providers assisting participants with medication regimens must comply with the state requirements for medication assistance as listed in this policy.
1) The participant or guardian must give consent to allow a specific provider or providers to be recognized as "friends" in accordance with the Wyoming Nursing Practice Act, Title 22, Chapter 21, 33-21-154, (iii) which allows for "the incidental health care by members of the family and friends." This allows the DD Division to get medical consent from participants and families to permit providers to assist with medications.

2) During waiver services, only qualified persons can assist a participant with medication. Qualified persons include licensed medical professionals who can administer medications within the scope of the medical licensure, or Approved Medication Assistants who completed and passed the state approved curriculum and competency based test. Retraining is required at least every two (2) years.

3) If an Approved Medication Assistant has a medication error, the DD Division will review the error to possibly require retraining contingent upon the findings of the investigation.
i) Retraining includes an overview of the original curriculum, observation of medication assistance tasks by an approved medication assistant trainer or licensed medical professional and satisfactory completion of a competency-based test approved by the Division.

4) The participant's case manager, in conjunction with designated member(s) of the participant's team, oversees the ongoing monitoring of the participant's medication regimen as described in the plan of care.

5) The assistance needed by the participant must be accurately reflected in the plan of care, including any

other special instructions or participant education needed for assisting with the medication.

6) The provider must comply with the Division's standards for medication assistance and the provider's own internal medication assistance policies and procedures, which cover:
i) Medication Consent
ii) Qualified Persons to assist with medications
iii) PRN protocol
iv) Behavioral Modifying Medications
v) Medication Storage and Labeling
vi) Medication Records
vii) Medication Assistance Records
viii) Medications Off-site
ix) Medication Error Reporting

7) The policies and procedures must also include verification that:

i) Only prescribed medication, or medications specified through consent of the participant or guardian and deemed appropriate by the participant's medical professional, are included in the participant's medication regimen.
ii) Only qualified persons assist a participant with medications.
iii) The participant receives consistent and appropriate assistance with the medication as prescribed by the participant's medical professional.

8) The Division oversees provider medication management and assistance and potentially harmful practices by monitoring providers' compliance with these standards through critical incident reports, complaint follow-up, certification and recertifications, or as the need of a participant arises. Requirements of State monitoring is detailed in Appendix G-3-c-iv of this application.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Developmental Disabilities Division

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

All providers are required to develop policies and procedures to comply with the following Division's standards for recording, reporting and tracking medication errors.
Medication errors that providers are required to record include:
Medication errors that providers are required to record include:
i) Wrong medication
ii) Wrong dosage
iii) Wrong participant
iv) Wrong route
v) Wrong Time – Deviation from accepted standard time frame for the medication assistance
(1) Standard Medication Assistance Time frame is one hour before or after the scheduled time of medication assistance or as prescribed due to special circumstances, i.e. mealtimes.

Also, providers have additional medication errors or incidents reportable within their organization, but not reportable to the Division. These categories include:
i) Refusals or missed medications,
ii) Dropped medication,
iii) Expired or damaged medication,
iv) Lost or missing medication,
v) Other medication events determined to need action

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

Medication errors reportable to the DD Division include any occurrence of the following:
* Wrong medication
* Wrong dosage
* Wrong participant
* Wrong route
* Wrong Time – Deviation from accepted standard time frame for the medication assistance (Standard Medication Assistance Time frame is one hour before or after the scheduled time of medication assistance or as prescribed due to special circumstances, i.e. mealtimes).

Medication Errors reported to the Division do not have to be reported to Protection & Advocacy Systems, Inc., Department of Family Services, or police unless a crime has been committed, such as medication diversion or other misuse of medication. The Division will review the medication error and determine if the incident must be reviewed by other investigative parties for further follow up.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Responsible entity:
The DD Division is responsible for monitoring the performance of Adult DD Waiver providers who assist participants with medications. Monitoring occurs through regular contact with providers. DD Division staff attending team meetings monitor the medication regimen being written in the plan and follow up that is discussed with team members. DD Division staff review and approve each plan of care to assure the participant's assessed needs and medical information align with the medication and medical treatment outlined in the plan. The Survey/Certification unit of the Division completes participant file reviews and various participant and staff interviews during certification and recertification processes, and conducts investigations and follow up for critical incidents or complaints reported to the Division's critical incident reporting system, managed in IMPROV. Through these regular channels of communication and monitoring, the State ensures that participant medications are managed appropriately and monitored for potentially harmful practices.

How monitoring is performed:
Monitoring compliance with the state standards occurs during regular contact with providers, such as team meetings, site surveys during recertifications, plan of care review, and incident report or complaint follow up.

Medication errors reported through the DD Division's critical incident reporting system are tracked through the IMPROV database daily by DD Division staff. If a medication error is reported through a critical incident report, the DD Division will investigate the incident to ensure the necessary follow up is conducted to rectify the situation and prevent further occurrences. Follow up may include requiring re-training for the provider or provider employee associated with the medication error. In these cases, the provider will have to pass the competency based test for medication assistance with 100% accuracy before continuing to assist with medications.

When any member of the DD Division notices a problem with a provider's medication assistance practices, an internal referral is made through the Division's provider management system, IMPROV. Survey/Certification staff within the Division are responsible for completing follow up as needed on the referral. Examples of problematic medication assistance are any medication error, misuse of a participant's medication, or unsafe practices that are not in compliance with the state standards. IMPROV tracks the details of the referral and the follow up actions taken by DD Division Survey/Certification staff to remediate the problem with the provider. If changes are made to medications or treatment plans as a result of the meeting or follow up medical appointments, then changes to the plan of care are made by the case manager and distributed to team members.

Follow up requirements vary depending upon the concern identified, but the monitoring may include a review of the provider's:

1) Medication assistance policies and procedures
2) Medication error policies and procedures
3) Medication-related forms, including
   a) Incident Reports
   b) Medication Assistance Records (MARs)
   c) Medication Error forms
   d) Medication and/or PRN reviews
4) Case management documentation of follow up

If the Division identifies health or safety concerns regarding medication assistance, such as unsafe practices or non-compliance with the Division's standards and requirements, then the provider must:
1) Rectify the situation as quickly as possible, subject to approval by the Division
2) Receive re-education on the Division's standards, policy and procedures on Medication Assistance,
3) Train or retrain personnel as needed to safely assist participant's with medication, and
4) Address the areas of non-compliance within the timeline specified by the Division and always before the next recertification is completed.

Frequency of Monitoring:
The DD Division monitors provider compliance in various frequencies depending on the type of monitoring. Monitoring will occur at team meetings attended by DD Division staff, but frequency depends on staff availability for attendance. Monitoring occurs annually through annual review of the plan of care by waiver specialists at the DD Division. The DD Division also monitors provider compliance with medication management at least every two years, depending on provider recertification dates. During the certification/recertification process, a statistically valid sample of the number of the waiver participants served at the time of monitoring will be used. Secondly, the ratio of those needing medication assistance to the total sample will be used to estimate the universe of those requiring medication assistance. Then a statistical sample of participants requiring med assist will be reviewed. The records reviewed are listed in the next paragraph.

The DD Division is responsible for monitoring provider compliance with the DD Division's medication assistance policy and standards. The DD Division reviews a sample of 1) provider personnel files to ensure qualified persons are assisting participants with medications and 2) provider's participant files who receive medication assistance. Sampling and process described below.

1) The DD Division maintains a registry for all providers and provider personnel who have completed the Medication Assistance curriculum requirements. During an initial certification or a recertification of a provider, which occurs at least every two years, the DD Division reviews the provider's training records for persons who are Approved Medication Assistants. A statistically valid sample of Approved Medication Assistant personnel employed by a provider are reviewed based upon the number of persons trained for that provider according to the DD Division's registry.

2) Effective July 1, 2009 the review of the implementation of plans of care for Adult DD Waiver participants will be changed to include all providers. The DD Division will also review a representative sample waiver participant files will be reviewed to verify if the participant is receiving the monitoring, medication management, and assistance with medication in a healthy and safe manner according to the State standards. The representative sample size will have a 95% confidence level and a margin of error of 5%. The sample will be identified in July of each year and the review of the implementation of the plans of care will be completed throughout two fiscal years.
• In addition to the DD Division's review of implementation of plans of care described above, effective July 1, 2009 the Survey/Certification unit of the Division will also review a sample of case management documentation of Adult DD participants for a six month period to verify the case manager is consistently monitoring medication assistance, including completing follow-up when concerns are found and updating the plan as needed. The representative sample size will have a 95% confidence level and a margin of error of 5%. The sample will be identified in July of each year and the review of the implementation of the plans of care will be completed throughout two fiscal years.

The results of this monitoring activities will be maintained in IMPROV, the DD Division's provider management system, to identify trends and make changes as needed in this area. Changes could include enhancing the training modules for Approved Medication Assistants, increasing monitoring activities to assure compliance with the standards, and/or releasing general bulletins in specific areas to remind providers of the standards.

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Number and percent of critical incidents to Adult DD participants, by type of incident and substantiated or unsubstantiated (the number of incidents of each type substantiated and unsubstantiated divided by the total number of reported critical incidents)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of Adult DD participants injured while being restraints (the number of Adult DD participants injured while being restrained divided by the total number of Adult DD participants with restraint usage written in plan of care)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult DD Waiver Database

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of medication errors by type (the number of each type of medication error divided by the total number of medication errors for Adult DD participants.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medication errors reported to the DD Division are entered and tracked in the DD Division's provider management system called IMPROV.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of Adult DD participants interviewed who report they feel safe in their home, neighborhood, workplace and day program (the number of participants interviewed who affirm they feel safe in these areas divided by the number of participants interviewed)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

		Confidence Interval = 95% +/- 4.1%
☑ **Other** Specify: Contractor for National Core Indicators	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute aggregates the data and generates a preliminary report and a final report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of Adult participants interviewed who report having someone to go to for help when they feel afraid (the number of participants interviewed who affirm in response to this question divided by the number of participants interviewed)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 4.1%
☑ **Other** Specify: Contractor for National Core Indicators	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute aggregates the data and generates a preliminary report and a final report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of Adult DD participants interviewed who report they are receiving preventative medical services by category (the number of participants reporting yes in each category divided by the number of participants interviewed)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation	**Frequency of data collection/generation**	**Sampling Approach***(check each that applies):*

(check each that applies):	*(check each that applies):*	
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 4.1%
☑ **Other** Specify: Contractor for National Core Indicators	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute aggregates the data and generates a preliminary report and a final report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number of deaths of Adult DD participants by category of death (the number of deaths by category divided by the number of deaths of Adult DD participants)

Data Source (Select one):
Record reviews, off-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Methods of Discovery - Health and Welfare:

Critical incidents are sent to the DD Division via the Division's website. These incidents are automatically recorded in the Division's provider management system, IMPROV. All providers are also required to send a copy of the critical incident to the guardian, case manager, DFS, and Protection and Advocacy. DD Division staff are responsible for assigning a category for the incident depending on the severity and what it entails. DFS and Protection and Advocacy review all critical incidents that are filed and complete full investigations when it is suspected that abuse, neglect, or exploitation might have occurred, or when restriction of rights might have been violated.

Providers are also required to report to the Division any restraint that results in an injury using the same website. Injuries that are a result of a restraint must also be reported to DFS, Protection and Advocacy, the guardian, and the case manager. If a restraint is used on a participant that does not result in an injury, it still must be reported to the Division at the same website; however, this does not need to be reported to DFS or Protection and Advocacy. This includes any emergency restraints that are used on a participant. Division staff are responsible for reviewing all restraint usage to ensure provider compliance.

Medication errors must be reported to the Division so that the Division can provide the required re-training to providers. These errors need to be reported to the Division at the same website but do not need to be reported to DFS or Protection and Advocacy unless they meet the category of a critical incident. Division staff are responsible for reviewing all instances of medication errors for provider compliance.

When Division staff identify individual problems concerning health, safety and rights are discovered through an incident report or complaint, providers receive a "recommendation" from the Division. A recommendation identifies the specific area of non-compliance and providers are required to submit a quality improvement plan within a specified time frame to address the area of non-compliance. All recommendations and any follow up completed by the Division are documented in the Division's provider management system, IMPROV. The quality improvement plan must include specific action steps, responsible parties, and time frames for completing each action step. The quality improvement plan template is on the DD Division's website at http://health.wyo.gov/ddd/ddd/carfpiforms.html and providers can go to the website if they need assistance with writing a quality improvement plan, or they can contact the Division for more clarification and guidance. The quality improvement plan must be submitted to the DD Division within 15 business days if the recommendation identified concerns with health, safety or rights, and within 30 calendar days otherwise. The DD Division must review and approve the quality improvement plan for each recommendation. The DD Division must also monitor the implementation of the quality improvement plan to assure the area of non-compliance has been addressed. This monitoring may include on-site visits, review of documentation, and interviews with providers, provider staff, participants, guardians and/or case managers. The type of monitoring completed depends on the type of non-compliance and severity of the situation. In addition, all recommendations are reviewed by the Division during the provider's next recertification to assure the area of non-compliance continues to be addressed.

If a provider fails to submit an acceptable quality improvement plan after several attempts working with the DD Division, the DD Division can impose a sanction. Sanctions include suspending admissions, suspending the provider, decertifying the provider, requiring additional training, imposing civil monetary penalties, and/or imposing a monitor within the provider organization.

When providers receive a recommendation, which can occur through the recertification process, complaint process, or incident reporting process, the information is entered into the DD Division's provider management system (IMPROV). IMPROV is a web based system that automatically tracks the category of recommendation, due date for the provider to submit the quality improvement plan for each recommendation, and the status of the recommendation. IMPROV includes letters/information sent to the provider identifying the area of non-compliance and the results of the review of the quality improvement plan. Overdue quality improvement plans are listed as "overdue" in a work queue that both the Survey/Certification Unit and Survey/Certification Manager have access. This process assures the DD Division is able to track the status of all quality improvement plans.

The Survey/Certification Manager reviews the status of quality improvement plans on a weekly basis, and completes a quality assurance check within IMPROV to assure staff have entered the information on the quality improvement plan into IMPROV, have sent the appropriate notifications, have reviewed the submitted quality improvement plans, and are monitoring the implementation of the plan.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

○ **No**

◉ **Yes**

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

Restraint, Seclusion, and Restrictive Interventions:

The DD Division has not completed the system for collecting data on restraints and restrictive interventions (covered in section G-2-b) on a statewide basis. The DD Division has developed an action plan to have the data collection in place by July 1, 2009, including collecting baseline data. This data will be collected over fiscal year 2010 and will be analyzed following the system outlined in the Quality Improvement Strategy section of this application.

Restraint and restrictive intervention data:

Case managers will submit information on all participants on their caseloads that have restraints and restrictive interventions included in the plan of care, including the type of restraint and/or restrictive intervention, by June 30, 2009. The Adult DD Waiver Manager will add several fields to the Waiver Database and enter this data by July 30, 2009.

The DD Division will revise the Case Management Quarterly Report by July 1, 2009 to include a breakdown of the restraints and restrictive interventions used during that time period. Emergency restraint usage must be reported on this form as well. This information will be faxed or emailed to the DD Division and entered into a database starting September 30, 2009. This is a short term solution for data collection while the DD Division is developing the electronic plan of care.

Medication Management:

The DD Division has developed a state policy and standards for provider medication management and administration, with a working group that included various stakeholders. The working group developed a thorough action plan that includes:

1) Writing medication assistance standards,
2) Developing policies and procedures for medication assistance by providers.
3) Developing and implementing Medication Assistance Curriculum to train providers and provider staff to be Approved Medication Assistants,
The DD Division will have the core training curriculum for Medication Assistance developed by July 1, 2009. Provider training for the curriculum will begin in July with a statewide training for all providers who can attend, using a train-the-trainer approach. The providers will return to their agencies and begin training the staff they choose on the curriculum and establishing core staff to be Approved Medication Assistants. The training will be held once a month by the DD Division after July for three months, then quarterly thereafter. The state's training can certify an Approved Medication Assistant, or with additional training, certify a person to be an Approved Medication Assistant trainer. The providers will have until December 31, 2009 to certify enough staff necessary to comply with the state's policy, so each participant has an Approved Medication Assistant or other qualified person assisting with medications according to their medication regimens.
Medical Consent for assisting participants with medications will be required for every participant to which the policy is applicable by September 30, 2009. Providers must have policies, procedures, standardized forms, and practices developed and implemented in accordance to the state policy and standards by September 30, 2009. The requirement for providers to become Approved Medication Assistants will be completed by December 31, 2009.

Training Participants - abuse and neglect:
To alleviate the gap in training participants, guardians and families on recognizing and reporting abuse and neglect, the DD Division will form a working group comprised of DD Division staff and stakeholders, which include participants and families, to develop a statewide training curriculum on abuse, neglect and exploitation by the end of September 2009. This statewide training will include handbooks that participants and involved families can use as a resource and to keep emergency and important phone numbers. Training will begin in October 2009 and will be offered a minimum of twice a year.

In the interim, DD Division will coordinate training on abuse, neglect and exploitation with the Attorney General's office and with Protection and Advocacy. This training will be offered to participants and families/guardians one time a month through the months of July and September via a webinar. The training will include how to recognize and report abuse, neglect and exploitation. DD Division staff will also have pamphlets produced by the Attorney General's office to distribute after a team meeting and at the time of application to a waiver.

Assessing Implementation of Plans of Care, including use of Restraint and Restrictive Interventions:

Effective July 1, 2009 the review of the implementation of plans of care for Adult DD Waiver participants will be changed to include all providers. The representative sample size will have a 95% confidence level and a margin of error of 5%. The sample will be identified in July of each year and the review of the implementation of the plans of care will be completed throughout two fiscal years, and will include a review of restraint and restrictive intervention usage and tracking.

• In addition to the DD Division's review of implementation of plans of care described above, effective July 1, 2009 the Survey/Certification unit of the Division will also review a sample of case management documentation of Adult DD participants for a six month period to verify the case manager is consistently monitoring use of restraints and restrictive interventions, including completing follow-up when concerns are found and updating the plan as needed. The representative sample size will have a 95% confidence level and a margin of error of 5%. The sample will be identified in July of each year and the review of the implementation of the plans of care will be completed throughout two fiscal years.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and

requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The DD Division within the State Medicaid Agency has 9 major processes that provide information or data on how the six major waiver assurances are being met. These processes include:
1. Waiver Applicant Process: Level of Care. Data collected in Adult DD Application Referral Database.
2. Attendance at Team Meetings: Level of Care, Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. Data collected in Team Meeting Database.
3. Plan of Care Approval: Level of Care, Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. Data collected in Plan of Care Database.
4. Extraordinary Care Review: Service Plan, Qualified Providers, Health and Welfare, Financial

Accountability. Data collected in ECC Database.
5. Provider Recertification: Service Plan, Qualified Providers, Health and Welfare, Administrative Authority, Financial Accountability. Data collected in IMPROV.
6. Complaint Process: Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. Data collected in IMPROV.
7. Incident Reporting: Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. Data collected in IMPROV.
8. Satisfaction Surveys: Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. Data collected by contracted entity and reported in National Core Indicator Reports.
9. Mortality Review: Service Plan, Qualified Providers, Health and Welfare, Administrative Authority, Financial Accountability. Data collected in Mortality Review Database.

Data collected from these processes are compiled and reviewed quarterly by the DD Division's management team, Office Medicaid Waiver Liaison, and Office of Medicaid Program Integrity Manager to identify significant trends that need to be addressed before the annual trend analysis is completed on each performance measure. Data from the most recent quarter for each performance measure will be compared to data from the two previous quarters.

When significant trends are found that require follow-up actions, the DD Division's management team works with the State Medicaid Agent to identify the appropriate steps to take to address the gap in a timely manner, the responsible party for completing the follow-up, and the performance measures to be tracked to verify the trend has been addressed appropriately. This information is shared with the DD Advisory Council, and the Division reports the results of the steps taken to the Council to assure the gap has been addressed.

A formal analysis of the data for each of the six assurances is completed annually within three months after the close of the waiver year. Results of the trend analysis, including strengths and areas needing improvement, are compiled into a report and presented to both the State Medicaid Agent and the DD Advisory Council within six months after the close of the waiver year.

The DD Advisory Council consists of representatives from the following:
• Governor's Planning Council for People with Developmental Disabilities
• Wyoming Protection & Advocacy Systems, Inc.
• Regional Service Providers
• Family members/participants from each of the waivers
• Self-employed case manager
• Wyoming INstitute for Disabilities
• Wyoming Department of Education

The Council provides recommendations to the DD Division based on the results of the review. These recommendations may include:
• A change in rule, policy and/or procedure to address the gap
• Forming a working group to further analyze the data and recommend changes
• Developing/enhancing training in specific areas
• Other recommendations to identify a specific gap

The DD Division along with the State Medicaid Agent has final authority on what recommendations are implemented.

ii. System Improvement Activities

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

Specify: DD Advisory Council	

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

System design changes may be identified during the quarterly review of the performance measures or during the annual trend analysis completed in conjunction with the DD Division's Advisory Council, both described in Section H-1-a. Once system design changes have been agreed upon, the DD Division with the State Medicaid Agent identifies the following:
• Who will oversee the systems change, which depends on the assurances impacted by the change
o The State Medicaid Agent or designee will take the lead on the changes impacting Administrative Authority and/or Financial Accountability
o The DD Division will take the lead on changes impacting Level of Care, Service Plan, Qualified Providers, and Health and Welfare
• Identification of other agencies or stakeholders who should be involved in system design changes
• Major action steps to implement the change
• The timeline for the change, including time lines for each major action step
• Identification of performance measures and appropriate data collection to track the results of the systems change
• Timeline for assessing impact of change
The DD Division, the Office of Medicaid Waiver Liaison, and the Medicaid Program Integrity Manager review implementation of systems changes quarterly to review process on the system changes, to identify potential barriers, and to make changes as needed to the action plan to implement system changes. The DD Advisory Council is updated semi-annually on the implementation of the system improvements through a written report and formal presentation.

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

The DD Division presents information on the effectiveness of the quality improvement strategy, including the effectiveness of the performance measures, processes used by the DD Division to gather data, changes to databases or data analysis, and issues with data reliability, annually to the DD Division's Advisory Council. The DDD Advisory Council makes recommendations on changes to the quality improvement system, and the DD Division works with the State Medicaid Agent to identify appropriate changes based on these recommendations. A timeline is developed to implement changes that includes responsible parties, action steps, and deadlines for each major step. The DD Division's Advisory Council is updated on the progress of the changes, and the changes are reported to CMS in an annual report.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Through Wyoming Medicaid Rules, Chapter 45, Adult DD Waiver providers who are required to obtain CARF accreditation must have an annual independent financial audit. The audit is submitted to the State Medicaid Agency each year.

Adult DD Waiver providers are required to follow documentation standards in Wyoming Medicaid rules, Chapter 45, Provider Certification and Sanctions. There are various methods that Medicaid employs to ensure the integrity of payments for waiver services. Medicaid has written requirements governing provider audits. A requirement of

participation grants Medicaid the authority to conduct routine audits and on-site provider visits. Medicaid has a specific Program Integrity unit that is responsible for overseeing and auditing provider activities. Audits monitor compliance with program requirements. Audits and on-site visits may include, but are not limited to:

- Examination of records
- Interviews of providers, associates, and employees
- Interviews of program clients
- Verification of the professional credentials of providers, their associates, and their employees
- Examination of any equipment, stock, materials and other items used in or for the treatment of program clients
- Audit of facility financial records for reimbursement
- Determination of whether the health care provided is medically necessary and/or
- Statistically valid sampling of claims submitted by and payments made to providers

Medicaid's Program Integrity Unit also ensures the integrity and accuracy of Medicaid payments by utilizing sophisticated information technology that integrates databases containing provider, beneficiary, and claims information. This technology includes the Medicaid Management Information System (MMIS), ad hoc reporting tools, and fraud and abuse software. This auditing process includes Adult DD waiver claims and other claims that process through the MMIS. The auditing of claims is done quarterly by statistically valid sampling as well as select claims which meet certain criteria. The Wyoming policies for Medicaid's Program Integrity Unit are outlined in Wyoming Medicaid Rules (Chapters 4 and 16). Medicaid also participates in the Payment Error Reporting Measurement program to ensure accuracy of the claims reimbursement process.

The State of Wyoming's Auditor's Office is responsible for ensuring that the State's financial reporting and transactions are completed in accordance with state law and has an independent audit annually.

The MMIS maintains required audit trails for all processing. The information is maintained and output may be in a variety of media and formats such as manual logs, imaged copies of documents, and computer-generated process summaries and control totals. Through the life of a claim in the MMIS, the system retains in the claim record all exception codes posting to the claim, the adjudicator ID of the person who forced or denied any exceptions to the claim, and the date and the adjudicator ID of the last person who worked on the claim. These features provide an audit trail to support the claim's payment process.

Medicaid's Program Integrity Unit reviews a statistically valid sample of provider waiver claims. Providers are required to submit all documentation of services within an identified time period. If it is found that documentation is not complete, re-education or recoveries will be completed. Any concerns with documentation are reported to Medicaid's Utilization Review Committee (CURT), which includes representation from the DD Division, as well as Medicaid Fraud. The committee determines the appropriate response to the documentation concerns, which can include re-education of the provider, recovery of funds, and/or referral to the Medicaid Fraud Control Unit.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.
   i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Number and percentage of Adult DD Waiver providers referred to the Medicaid Program Integrity Unit or the Medicaid Fraud Control Unit for recovery of funds or investigation. Percentage=number of Adult DD waiver providers referred to Program Integrity Unit or MFCU/number of Adult DD waiver providers reviewed by Waiver Program.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid referral data entered and tracked through IMPROV, the DD Division's provider management system.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: The DD Division reviews a minimum of a 3 month period of documentation for each service a provider has billed for over the past year
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Reports on Medicaid referrals from IMPROV are generated & a higher level review is completed at least quarterly to identify significant trends that may need addressing before the formal annual review

Performance Measure:
Percentage of recoveries from Adult DD waiver providers for which the federal portion was paid back to CMS timely. Percentage=number of times CMS was paid back federal portion timely following recovery/number of recoveries from Adult DD waiver providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS report, Excel spreadsheet of recoveries, and CMS-64

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of Adult DD waiver claims paid for services not included in the service plan. percentage=number of waiver claims paid for services not included in the service plan/number of Adult DD waiver claims.

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

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The DD Division's re-certification process and complaint process can identify billing errors or potential fraud.

The status of recoveries and investigations are shared and discussed at monthly CURT meetings and through on-going communication directly with the Waiver Manager.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When a problem is found, the DD Division may offer re-education to the provider and/or may refer the cases to Medicaid or MFCU for possible recovery of funds and/or investigation for fraud.

If preliminary investigation by the Medicaid Program Integrity Unit appears to show that the concern was unintentional on the part of the provider, provider education is given. Provider education needed due to poor documentation is done by the Waiver Program. Provider education needed due to a billing problem is done by the Program Integrity Unit and/or the Provider Relations section of the MMIS contractor. Additionally, if provider documentation is found to be inadequate, funds paid to the provider are recovered by the Medicaid Program Integrity Unit. If preliminary investigation by the Medicaid Program Integrity Unit raises suspicion of fraud or abuse by a provider, the Program Integrity Manager refers the case to the Medicaid Fraud and Control Unit for further investigation.

Starting July 1, 2009, recoveries and investigations will be tracked through E-FADS, an enhancement to the Program Integrity Unit's tracking system.

ii. Remediation Data Aggregation

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

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

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
See Brief Waiver Description for Workplan and Timeline details.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

In 2008 the DD Division within the State Medicaid Agency was required by state statute (W.S. 42-4-120 (g)) to establish by rule and regulation a cost based reimbursement system to pay providers of services and supplies under home and community based waiver programs for persons with developmental disabilities or acquired brain injury.

The DD Division established the following objectives in its rate determination:
• Rate standardization and equity – Rates are standardized, and based on the reported costs of providing services. Rates are consistent for similar services, regardless of which provider is providing the service.
• Reflect participant needs – the rates provide sufficient definition to reflect participant need as measured by the Inventory for Client and Agency Planning (ICAP) Service Score and other needed interventions, for services with tiered rates.
• Facilitate regular updates – the methods and data used to establish rates are formula-driven, which should facilitate updates to rates in future periods.
• Increased transparency - the methods and data used to establish rates are publicly available, easily understood and established through an open and public process.
• Fiscal stability for providers and for the State of Wyoming – the rate methodology is prospective in nature, and rates

should be known in advance of services being provided. Enhanced predictability will allow for providers to better manage the costs of their operations. It will also allow the State to more easily project and budget for appropriate funding levels for services provided under the waivers managed by the Division.

Based on these objectives, the DD Division, assisted by a consultant, developed standardized rates state-wide for the services provided under the Adult, Child and ABI Waivers that are tied to variables in participants' ICAP needs assessments. To achieve this goal, the consulting firm used an independent rate model development approach that incorporates data related to wages, overhead, productivity, staffing ratios and other factors to create a proposed rate for each service and service level. The assumptions made for each proposed rate are based on data reported by the HCBS providers in Wyoming through a cost and wage survey process, and through other public sources of cost information. The standardized rates established for services under this approach achieved all of the objectives described above. Furthermore, the rates are to be re-based every two to four years.

As a result of the rate methodology the Wyoming legislature passed house bill 52 in 2008 to phase in the methodology as individual plans of care renew or begin July 1, 2008 with full implementation beginning July 1, 2009 (SFY-2010). This house bill added section g to Wyoming Statute 42-4-120.

The DD Division, assisted by a consultant, established a service provider working group to guide the rate development; this included 4 CARF service providers. This working group had 5 meetings to review the process and provide input. On November 1, 2007, the Division and consultant held a meeting inviting the 20 largest DD Waiver service providers in the State to review the proposed rates and provided impact analysis. The service providers had the opportunity to ask questions and provide input. Furthermore, there were 4 legislative committee meetings in calendar year 2007 by the Select Committee on Developmental Programs in which the rate setting process and concepts were presented and the public, including service providers, families and guardians had the opportunity to comment on the rate setting process.

All rate determination methods and the resulting rates are reviewed and approved by the Wyoming Department of Health, Wyoming's Medicaid agency. In addition to the public process described above, the Medicaid Agency also solicits public comments by means of a public notice when changes in methods and standards for establishing payment rates under the Waiver are proposed. The notice is published in accordance with federal requirements at 42 CFR 447.205, which prescribes the content and publication criteria for the notice. Whenever rates change, the Division makes listings of all covered services and corresponding rates available to clients and their families and service providers.

Information on payment rates are available to participants as part of the regular team meetings, are posted on the DD Divisions website and are available upon request.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The Wyoming Medicaid Management Information System (MMIS) is the system used to accept and process claims for services rendered by the Adult DD waiver providers. Providers will directly submit electronic claims using an electronic software system or via web online entry, which are both direct input tools to the Wyoming MMIS. Once a provider submits a claim, the claim enters the MMIS and is processed through the processing cycle, which includes all edits and audits.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All service requests are reviewed and pre-approved by a waiver specialist in the Developmental Disabilities Division. The specialist reviews the service descriptions, units, rates, and quantity to see that the total amount of services requested is within the IBA. The specialist verifies the provider is certified for the requested service and that the units requested do not exceed the specified methodology.

All services must receive a prior authorization number that is assigned through the MMIS. All billing for waiver services is submitted electronically through MMIS and all providers are paid through that system. There are many edits built into the MMIS that do not allow payment for more units or dollar requests above the amount approved. System edits include service codes with set rates, limits on number of days that can be billed in a month, number of hours that can be billed in a day, and other time specific rules which limit the amount of services that can be billed.

Since all claims are submitted electronically using a Prior Authorization number, the MMIS utilizes edits to assure that payments never exceed authorization. No waiver services are authorized without a Prior Authorization number.

An individual must be an active Medicaid recipient enrolled in the Adult DD Waiver program in order for services to be processed and paid for. This assurance is an integral component managed by the Wyoming Medicaid Management Information System (MMIS).
The MMIS requires an individual to be:
- Enrolled in Medicaid
- Enrolled in a Adult DD program (in this case, the Adult DD Waiver program)

Additional checks regarding services rendered, including appropriate provider type, no duplicate claims submitted, etc. are also performed.
The Wyoming Claims Processing Subsystem uses a Recipient Master File to verify recipient eligibility for services billed by a provider. Once an individual becomes eligible for services, the participant's eligibility information is updated in the MMIS. Only services in the client’s plan will be covered based on limits established by the prior authorization number assigned to the service. The MMIS posts exceptions if a recipient is not eligible on the service date or is restricted from the service (as indicated in the service restrictions on the Recipient Master File). Service restrictions may include restricting the recipient to a particular provider for treatment or placing the recipient on

review.

The MMIS checks other service limitations by referencing recipient Medicaid eligibility, TPL, and by various benefit plan specific limits established by the Utilization Review (UR) Criteria File.

Each claim processed by the Wyoming Claims Processing cycle (regardless of the entry method) has to pass the provider eligibility edit module. The Provider Master File verifies that the provider is actively enrolled and licensed according to the benefit plan for the category of service and dates of service. It also verifies any special restrictions for the provider for the service date on the claim. For each test that fails, the MMIS posts an exception code. The claim is adjudicated according to the exception disposition codes maintained on the Exception Control File.
The Claims Processing Subsystem also uses several edits to verify the reasonableness of provider charges. First the system performs internal balancing of claim charges. Second, the system edits and checks each service charge against pricing information on the reference files.
Medicaid determines the disposition of the exception codes posting to claims and the system maintains this information on line in the Exception Code File. The Claims Processing Subsystem has the capability of allowing the force payment of services on an exceptional basis, as directed in writing by Medicaid.

Through the life of a claim, the system retains in the claim record all exception codes posting to the claim, the adjudication ID of the person who forced or denied any exceptions to the claim, and the date and adjudication ID of the last person who worked on the claim. These features provide an audit trail to support the claim's payment process.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health**

plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

- [ ] **Applicable**
  Check each that applies:
  - [ ] **Appropriation of Local Government Revenues.**

    Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

  - [ ] **Other Local Government Level Source(s) of Funds.**

    Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**
  Check each that applies:
  - [ ] **Health care-related taxes or fees**
  - [ ] **Provider-related donations**
  - [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the**

personal home of the individual.

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Costs related to room and board for clients, as well as facility maintenance, upkeep and improvement related to residential program services are not covered by the Adult DD waiver. These costs were excluded from the total costs collected for the rate determination and are therefore excluded from the payment rates.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/MR

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	65680.89	6471.00	72151.89	207740.00	937.00	208677.00	136525.11
2	65724.92	6471.00	72195.92	207740.00	937.00	208677.00	136481.08
3	65627.91	6471.00	72098.91	207740.00	937.00	208677.00	136578.09
4	65694.88	6471.00	72165.88	207740.00	937.00	208677.00	136511.12
5	65825.12	6471.00	72296.12	207740.00	937.00	208677.00	136380.88

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/MR
Year 1	1353	1353
Year 2	1369	1369
Year 3	1385	1385
Year 4 (renewal only)	1401	1401
Year 5 (renewal only)	1417	1417

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay estimate is calculated by taking the total number of days waiver recipients received waiver coverage during the waiver year divided by the number of unduplicated recipient count. Total days of waiver

coverage = last-date-of-service - first-date-of-service + 1. If a recipient becomes institutionalized during the time of waiver coverage, those days are excluded from the calculation. The average length of stay reported in the SFY-2007 CMS-372 increased by 2% for SFY-2008, based upon reports generated from the Medicaid Management Information System (MMIS), which is the report used to complete the CMS-372. The SFY-2008 MMIS data will be used for each year of the waiver.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The Factor D is calculated by multiplying the estimated number of users/service by the units/user and cost/unit. This calculation results in a total estimated expenditure for each service. All of the estimated component costs are totaled to get a total estimated expenditure for the wavier. Finally, the total estimated figure is divided by the total number of unduplicated recipients to arrive at an average cost per recipient, Factor D.

The Factor D reported in the SFY-2007 CMS-372 increased by 6% for SFY-2008, based upon reports generated from the Medicaid Management Information system (MMIS), which is the report used to complete the CMS-372. Additional changes to Factor D in the forthcoming waiver years are estimated as follows:
- Estimated number of users:
Step 1: Use the SFY-2008 MMIS report data.
Step 2: Adjust the total estimated unduplicated count for any additional participants due to additional funding provided to reduce the waiting list, if applicable.
Step 3: Apply a percentage of participants who utilize a service based upon the ratio in the SFY-2008 MMIS report data.
- Estimated units/user:
Step 1: Use the SFY-2008 MMIS claims data to calculate the average units/user and round up to the next whole number.
Step 2: Convert any services that have a unit change from the SFY-2008 MMIS data, if applicable.
- Estimated cost/unit:
Step 1: Use the published rates current to the wavier year.
Step 2: For those services that have multiply rates based upon level of care, calculate an average cost/unit/service.
Step 3: Apply an inflation/deflation factor to the cost/unit due to increases or decreases in funding provided for service rates by waiver year, if applicable.
Step 4: Convert any services that have a unit change from the SFY-2008 MMIS data, if applicable.
Step 5: For those services with an event unit, utilize the average paid amount in the SFY-2008 MMIS data.

Service changes:
In – Home Support Service – Phase out in year one. The phasing out of this service in the first year estimates that 20% of the annualized units/user in SFY-2008 will be utilized in the transition year.

Prevocational – Phase out in year one. The phasing out of this service in the first year estimates that 20% of the annualized units/user in SFY-2008 will be utilized in the transition year.

Day Habilitation:
Estimated number of users: Estimates that those receiving prevocational services will transition to the Day Habilitation.
Estimated units/user: Estimate the average units/user will equal the number of units/user for day habilitation in SFY-2008. For those that choose the 15 minute unit option, the day unit is multiplied by 15 (3.75 hours) to convert to the estimated 15 minute units.
Estimated cost/unit: Utilize the posted rates.

New Services:

Supported Living –
Estimated number of users: Estimates that those receiving In-Home Support will transition to the Supported Living service.
Estimated units/user: Estimate the average units/user will equal the number of units/user for residential habilitation.
Estimated cost/unit: Utilize the posted rates.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is the estimated annual average per capita Medicaid cost for all services that are furnished in addition to waiver services while the individual is in the waiver.

Step 1: The Factor D' reported in the SFY-2007 CMS-372 increased by 9% for SFY-2008, based upon reports generated from the Medicaid Management Information system (MMIS), which is the report used to complete the CMS-372.
Step 2: Use the SFY-2008 MMIS report data.
Step 3: Increase the estimated cost by 6% for year 1 of the waiver due to inflation. In subsequent years the estimate remains unchanged from year 1.

The prescribed drugs furnished to Medicare/Medicaid dual eligibles under the provisions of Part D are not processed through the State's MMIS and are therefore excluded from the MMIS reporting and from Factor D'.

Factor D' includes institutional costs when a person leaves the waiver for the institution and returns to the waiver in the same waiver year.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor G value must reflect the average per capita cost for the level(s) of institutional care that would otherwise be furnished to waiver participants.

Step 1: The Factor G reported in the SFY-2007 CMS-372 decreased by 1% for SFY-2008, based upon reports generated from the Medicaid Management Information system (MMIS), which is the report used to complete the CMS-372.
Step 2: Use the SFY-2008 MMIS report data
Step 3: Increase the estimated cost by 4% for year 1 of the waiver due to inflation. In subsequent years the estimate remains unchanged from year 1.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' includes the average per capita cost of all other Medicaid services furnished while the individual is institutionalized (including State plan and expanded EPSDT services) and the cost of short term hospitalization (furnished with the expectation that the person would return to the institution).

Step 1: The Factor G' reported in the SFY-2007 CMS-372 increase by $257 per capita for SFY-2008, based upon reports generated from the Medicaid Management Information System (MMIS), which is the report used to complete the CMS-372.
Step 2: Use the SFY-2008 MMIS report data
Step 3: Increase the estimated cost by 6% for year 1 of the waiver due to inflation. In subsequent years the estimate remains unchanged from year 1.

The prescribed drugs furnished to Medicare/Medicaid dual eligibles under the provisions of Part D are not processed through the State's MMIS and are therefore excluded from the MMIS reporting and from Factor G'.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are

reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Prevocational Services - phased out Year 1
Physical Therapy
In Home Support - Phased out Year 1
Specialized Equipment
Supported Employment
Personal Care
Skilled Nursing
Supported Living
Case Management
Residential Habilitation
Occupational Therapy
Dietician Services
Environmental Modifications
Respite
Speech Therapy
Day Habilitation

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services - phased out Year 1 Total:						**471249.91**
Prevocational Services - phased out Year 1	day	199	31.00	76.39	**471249.91**	
Physical Therapy Total:						**76939.20**
Physical Therapy	15 minute	30	117.00	21.92	**76939.20**	
In Home Support - Phased out Year 1 Total:						**262288.84**
In Home Support - Phased out Year 1	hour	191	44.00	31.21	**262288.84**	
Specialized Equipment Total:						**245015.72**
Specialized Equipment	event	43	2.00	2849.02	**245015.72**	
Supported Employment Total:						**3272965.20**
Individual Community Integrated Employment	15 minute	165	2144.00	7.14	**2525846.40**	

Group Supported Employment	15 minute	111	2370.00	2.84	**747118.80**	
Personal Care Total:						**589307.40**
Personal Care	15 minute	44	3307.00	4.05	**589307.40**	
Skilled Nursing Total:						**2633519.40**
Skilled Nursing	15 minute	626	222.00	18.95	**2633519.40**	
Supported Living Total:						**11204576.00**
Supported Living (daily)	day	314	310.00	93.40	**9091556.00**	
Supported Living (15 minute)	15 minute	78	4500.00	6.02	**2113020.00**	
Case Management Total:						**4807865.33**
case management	month	1353	12.00	282.90	**4593164.40**	
subsequent assessments	event	317	1.00	677.29	**214700.93**	
Residential Habilitation Total:						**45696273.44**
Residential Habilitation	day	818	310.00	177.04	**44893803.20**	
Intervention (Residential)	hour	88	351.00	25.98	**802470.24**	
Occupational Therapy Total:						**204800.40**
Occupational Therapy	15 minute	86	162.00	14.70	**204800.40**	
Dietician Services Total:						**31827.84**
Dietician Services	15 minute	22	96.00	15.07	**31827.84**	
Environmental Modifications Total:						**77592.00**
Environmental Modifications	event	6	1.00	12932.00	**77592.00**	
Respite Total:						**1698393.60**
Respite	15 minute	180	2564.00	3.68	**1698393.60**	
Speech Therapy Total:						**477922.88**
Speech Therapy	15 minute	178	173.00	15.52	**477922.88**	
Day Habilitation Total:						**17115709.86**
Day Habilitation (daily)	day	864	186.00	91.64	**14726914.56**	
Day Habilitation (15 minute)	15 minute	216	2790.00	3.12	**1880236.80**	
Intervention (Day)	hour	75	261.00	25.98	**508558.50**	
				GRAND TOTAL:		**88866247.02**
				Total Estimated Unduplicated Participants:		**1353**
				Factor D (Divide total by number of participants):		**65680.89**
				Average Length of Stay on the Waiver:		351

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services - phased out Year 1 Total:						**0.00**
Prevocational Services - phased out Year 1	day	0	1.00	1.00	**0.00**	
Physical Therapy Total:						**79503.84**
Physical Therapy	15 minute	31	117.00	21.92	**79503.84**	
In Home Support - Phased out Year 1 Total:						**0.00**
In Home Support - Phased out Year 1	hour	0	1.00	1.00	**0.00**	
Specialized Equipment Total:						**245015.72**
Specialized Equipment	event	43	2.00	2849.02	**245015.72**	
Supported Employment Total:						**3310312.32**
Individual Community Integrated Employment	15 minute	167	2144.00	7.14	**2556462.72**	
Group Supported Employment	15 minute	112	2370.00	2.84	**753849.60**	
Personal Care Total:						**589307.40**
Personal Care	15 minute	44	3307.00	4.05	**589307.40**	
Skilled Nursing Total:						**2662967.70**
Skilled Nursing	15 minute	633	222.00	18.95	**2662967.70**	
Supported Living Total:						**12185316.00**
Supported Living (daily)	day	318	330.00	93.40	**9801396.00**	
Supported Living (15 minute)	15 minute	80	4950.00	6.02	**2383920.00**	
Case Management Total:						**4864891.29**
case management	month	1369	12.00	282.90	**4647481.20**	
subsequent assessments	event	321	1.00	677.29	**217410.09**	
Residential Habilitation Total:						**46204461.42**
Residential Habilitation	day	827	310.00	177.06	**45392872.20**	

Intervention (Residential)	hour	89	351.00	25.98	**811589.22**	
Occupational Therapy Total:						**207604.62**
Occupational Therapy	15 minute	87	162.00	14.73	**207604.62**	
Dietician Services Total:						**31827.84**
Dietician Services	15 minute	22	96.00	15.07	**31827.84**	
Environmental Modifications Total:						**77592.00**
Environmental Modifications	event	6	1.00	12932.00	**77592.00**	
Respite Total:						**1717264.64**
Respite	15 minute	182	2564.00	3.68	**1717264.64**	
Speech Therapy Total:						**483915.60**
Speech Therapy	15 minute	180	173.00	15.54	**483915.60**	
Day Habilitation Total:						**17317429.80**
Day Habilitation (daily)	day	874	186.00	91.63	**14895739.32**	
Day Habilitation (15 minute)	15 minute	219	2790.00	3.12	**1906351.20**	
Intervention (Day)	hour	76	261.00	25.98	**515339.28**	
				GRAND TOTAL:		**89977410.19**
				Total Estimated Unduplicated Participants:		**1369**
				Factor D (Divide total by number of participants):		**65724.92**
				Average Length of Stay on the Waiver:		351

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services - phased out Year 1 Total:						**0.00**
Prevocational Services - phased out Year 1	day	0	1.00	1.00	**0.00**	
Physical Therapy Total:						**79503.84**
Physical Therapy	15 minute	31	117.00	21.92	**79503.84**	
In Home Support - Phased						

out Year 1 Total:						**0.00**
In Home Support - Phased out Year 1	hour	0	1.00	1.00	**0.00**	
Specialized Equipment Total:						**250713.76**
Specialized Equipment	event	44	2.00	2849.02	**250713.76**	
Supported Employment Total:						**3354390.24**
Individual Community Integrated Employment	15 minute	169	2144.00	7.14	**2587079.04**	
Group Supported Employment	15 minute	114	2370.00	2.84	**767311.20**	
Personal Care Total:						**602700.75**
Personal Care	15 minute	45	3307.00	4.05	**602700.75**	
Skilled Nursing Total:						**2696622.90**
Skilled Nursing	15 minute	641	222.00	18.95	**2696622.90**	
Supported Living Total:						**12277782.00**
Supported Living (daily)	day	321	330.00	93.40	**9893862.00**	
Supported Living (15 minute)	15 minute	80	4950.00	6.02	**2383920.00**	
Case Management Total:						**4921917.25**
case management	month	1385	12.00	282.90	**4701798.00**	
subsequent assessments	event	325	1.00	677.29	**220119.25**	
Residential Habilitation Total:						**46653154.20**
Residential Habilitation	day	836	310.00	176.85	**45832446.00**	
Intervention (Residential)	hour	90	351.00	25.98	**820708.20**	
Occupational Therapy Total:						**210561.12**
Occupational Therapy	15 minute	88	162.00	14.77	**210561.12**	
Dietician Services Total:						**31827.84**
Dietician Services	15 minute	22	96.00	15.07	**31827.84**	
Environmental Modifications Total:						**77592.00**
Environmental Modifications	event	6	1.00	12932.00	**77592.00**	
Respite Total:						**1736135.68**
Respite	15 minute	184	2564.00	3.68	**1736135.68**	
Speech Therapy Total:						**491347.68**
Speech Therapy	15 minute	183	173.00	15.52	**491347.68**	
Day Habilitation Total:						**17510407.74**

Day Habilitation (daily)	day	884	186.00	91.62	**15064526.88**	
Day Habilitation (15 minute)	15 minute	221	2790.00	3.12	**1923760.80**	
Intervention (Day)	hour	77	261.00	25.98	**522120.06**	
				GRAND TOTAL:		**90894657.00**
				Total Estimated Unduplicated Participants:		**1385**
				Factor D (Divide total by number of participants):		**65627.91**
				Average Length of Stay on the Waiver:		351

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services - phased out Year 1 Total:						**0.00**
Prevocational Services - phased out Year 1	day	0	1.00	1.00	**0.00**	
Physical Therapy Total:						**79503.84**
Physical Therapy	15 minute	31	117.00	21.92	**79503.84**	
In Home Support - Phased out Year 1 Total:						**0.00**
In Home Support - Phased out Year 1	hour	0	1.00	1.00	**0.00**	
Specialized Equipment Total:						**250713.76**
Specialized Equipment	event	44	2.00	2849.02	**250713.76**	
Supported Employment Total:						**3391737.36**
Individual Community Integrated Employment	15 minute	171	2144.00	7.14	**2617695.36**	
Group Supported Employment	15 minute	115	2370.00	2.84	**774042.00**	
Personal Care Total:						**616094.10**
Personal Care	15 minute	46	3307.00	4.05	**616094.10**	
Skilled Nursing Total:						**2726071.20**
Skilled Nursing	15 minute	648	222.00	18.95	**2726071.20**	
Supported Living Total:						**12460668.00**

Supported Living (daily)	day	325	330.00	93.40	**10017150.00**	
Supported Living (15 minute)	15 minute	82	4950.00	6.02	**2443518.00**	
Case Management Total:						**4978265.92**
case management	month	1401	12.00	282.90	**4756114.80**	
subsequent assessments	event	328	1.00	677.29	**222151.12**	
Residential Habilitation Total:						**47220998.58**
Residential Habilitation	day	846	310.00	176.89	**46391171.40**	
Intervention (Residential)	hour	91	351.00	25.98	**829827.18**	
Occupational Therapy Total:						**210561.12**
Occupational Therapy	15 minute	88	162.00	14.77	**210561.12**	
Dietician Services Total:						**33274.56**
Dietician Services	15 minute	23	96.00	15.07	**33274.56**	
Environmental Modifications Total:						**90524.00**
Environmental Modifications	event	7	1.00	12932.00	**90524.00**	
Respite Total:						**1755006.72**
Respite	15 minute	186	2564.00	3.68	**1755006.72**	
Speech Therapy Total:						**494350.96**
Speech Therapy	15 minute	184	173.00	15.53	**494350.96**	
Day Habilitation Total:						**17730757.44**
Day Habilitation (daily)	day	895	186.00	91.62	**15251981.40**	
Day Habilitation (15 minute)	15 minute	224	2790.00	3.12	**1949875.20**	
Intervention (Day)	hour	78	261.00	25.98	**528900.84**	
				GRAND TOTAL:		**92038527.56**
				Total Estimated Unduplicated Participants:		**1401**
				Factor D (Divide total by number of participants):		**65694.88**
				Average Length of Stay on the Waiver:		351

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services - phased out Year 1 Total:						**0.00**
Prevocational Services - phased out Year 1	day	0	1.00	1.00	**0.00**	
Physical Therapy Total:						**82068.48**
Physical Therapy	15 minute	32	117.00	21.92	**82068.48**	
In Home Support - Phased out Year 1 Total:						**0.00**
In Home Support - Phased out Year 1	hour	0	1.00	1.00	**0.00**	
Specialized Equipment Total:						**256411.80**
Specialized Equipment	event	45	2.00	2849.02	**256411.80**	
Supported Employment Total:						**3429084.48**
Individual Community Integrated Employment	15 minute	173	2144.00	7.14	**2648311.68**	
Group Supported Employment	15 minute	116	2370.00	2.84	**780772.80**	
Personal Care Total:						**616094.10**
Personal Care	15 minute	46	3307.00	4.05	**616094.10**	
Skilled Nursing Total:						**2755519.50**
Skilled Nursing	15 minute	655	222.00	18.95	**2755519.50**	
Supported Living Total:						**12583956.00**
Supported Living (daily)	day	329	330.00	93.40	**10140438.00**	
Supported Living (15 minute)	15 minute	82	4950.00	6.02	**2443518.00**	
Case Management Total:						**5035291.88**
case management	month	1417	12.00	282.90	**4810431.60**	
subsequent assessments	event	332	1.00	677.29	**224860.28**	
Residential Habilitation Total:						**47979430.96**
Residential Habilitation	day	857	310.00	177.44	**47140484.80**	
Intervention (Residential)	hour	92	351.00	25.98	**838946.16**	
Occupational Therapy Total:						**214617.60**
Occupational Therapy	15 minute	90	162.00	14.72	**214617.60**	
Dietician Services Total:						**33274.56**
Dietician Services	15 minute	23	96.00	15.07	**33274.56**	
Environmental Modifications Total:						**90524.00**

Environmental Modifications	event	7	1.00	12932.00	**90524.00**	
Respite Total:						**1773877.76**
Respite	15 minute	188	2564.00	3.68	**1773877.76**	
Speech Therapy Total:						**500367.90**
Speech Therapy	15 minute	186	173.00	15.55	**500367.90**	
Day Habilitation Total:						**17923677.72**
Day Habilitation (daily)	day	905	186.00	91.61	**15420711.30**	
Day Habilitation (15 minute)	15 minute	226	2790.00	3.12	**1967284.80**	
Intervention (Day)	hour	79	261.00	25.98	**535681.62**	
				GRAND TOTAL:		**93274196.74**
				Total Estimated Unduplicated Participants:		**1417**
				Factor D (Divide total by number of participants):		**65825.12**
				Average Length of Stay on the Waiver:		351