§1915(i) State plan HCBS

State: Wyoming TN: 13-007

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1915(i) State plan Home and Community-Based Services **Administration and Operation**

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

Services. (Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):

Family Care Coordination (FCC) Family Support Partner (FSP) Youth Support Partner (YSP) Youth and Family Training and Support Service Intensity Evaluation (CASII, ECSII, CANS) High Fidelity Wraparound (HFWA) Supervisor/Coach Respite Care

State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. (Select 2. one):

•	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program (<i>select one</i>):					
	•	The Medical Assistance Unit (name of unit):	Provider Services Unit, Behavioral Health Programs			
	0	Another division/unit within the SMA that is se	parate from the Medical Assistance Unit			
		(name of division/unit)				
		This includes				
		administrations/divisions				
		under the umbrella				
		agency that have been identified as the Single				
		State Medicaid Agency.				
0	The State plan HCBS benefit is operated by (name of agency)					
J						

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Distribution of State plan HCBS Operational and Administrative Functions. 3.

(By checking this box the state assures that): When the Medicaid agency does not directly conduct an administrative 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. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (check each that applies):

(Check all agencies and/or entities that perform each function).

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Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non- State Entity
1 Individual State plan HCBS enrollment	Ø			
2 State plan HCBS enrollment managed against approved limits, if any	Ø			
3 Eligibility evaluation	Ø		Ø	
4 Review of participant service plans	Ø		Ø	
5 Prior authorization of State plan HCBS	Ø		Ø	
6 Utilization management	Ø		Ø	
7 Qualified provider enrollment	Ø			
8 Execution of Medicaid provider agreement	Ø			
9 Establishment of a consistent rate methodology for each State plan HCBS	Ø		Ø	
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	Ø		Ø	
11 Quality assurance and quality improvement activities	Ø		Ø	

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

The contracted	Care Management	Entity (CME)
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(By checking the following boxes the State assures that):

4. Conflict of Interest Standards. The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. (If the state chooses this option, specify the conflict of interest protections the state will implement):
- **5. Example 2 Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
- **6. No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.
- 7. Non-duplication of services. State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

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Number Served

Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	То	Projected Number of Participants
Year 1	Jan. 1, 2014	Dec. 31, 2014	100
Year 2	Jan. 1, 2015	Dec. 31, 2015	150
Year 3	Jan. 1, 2016	Dec. 31, 2016	200
Year 4	Jan. 1, 2017	Dec. 31, 2017	300
Year 5	Jan. 1, 2018	Dec. 31, 2018	350

2. Annual Reporting. (By checking this box the state agrees to): annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

✓ Medicaid Eligible. (By checking this box the state assures that): Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act.)

2. **Income Limits.**

☑ In addition to providing State plan HCBS to individuals described in item 1 above, the state is also covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the federal poverty level, or who are eligible for HCBS under a waiver approved for the state under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate (as described in Supplemental Attachment 2.2A, Page 11 of the state plan). Choose one:

\checkmark	The state covers all individuals described in items 2(a) and 2(b) as described
in .	Attachment 2.2-A of the state plan.

or

☐ The state covers only the following group individuals described below as specified in Attachment 2.2-A of the state plan. Choose (a) or (b):

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	(a) Individuals not otherwise eligible for Medicaid who meets the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services.
	or
	(b) ☐ Individuals who would meet the criteria for a 1915(c) or 1115 waiver and whose income does not exceed 300% of the supplemental security income benefit rate. Complete (i) and/or (ii).
	i. (☐ Specify the 1915(c) Waiver/Waivers CMS Base Control Number/Numbers for which the individual would be eligible:
WY.0451	
	and/or
	ii. □ Specify the name(s) or number(s) of the 1115 waiver(s) for which the individual would be eligible:
NT/A	

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Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

O Directly by the Medicaid agency

By Other (*specify State agency or entity under contract with the State Medicaid agency*):

The State defines the eligibility parameters in agreement with CMS. The CME, under contract with the State Medicaid agency, is responsible for evaluation of eligibility as described in this section.

Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needsbased eligibility for State plan HCBS. (Specify qualifications):

Service Intensity Evaluators are required to have a bachelor's degree in a human service area or related field, or, two years work/personal experience in providing direct services or linking of services for youth with serious emotional disturbance.

Under employment or contract with the Care Management Entity and individually credentialed to administer the specific assessment tools they are administering.

The credentialing process includes training on administration and scoring of the specific tool(s) followed by scoring and submission of a standardized test vignette that is submitted to the State training team who then reviews the vignette process notes and scoring for accuracy. A formal letter is issued to the individual seeking credentialing indicating if the have successfully completed the credentialing process.

Recredentialing is completed annually after through recertification training and successful scoring of a standardized test vignettes. Individual technical assistance is provided by the State and CME trainers to service intensity evaluators to address quality issues or correct common errors associated with administering the tools.

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Initial Service Intensity Evaluations are part of the eligibility determination process for voluntary enrollment in the CME. After the CME benefit plan process, services, and supports are explained to an interested youth and family, they are required choose a Family Care Coordinator as part of the eligibility process to determine if they may enroll with the CME.

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The clinical eligibility process then begins with a review of the child/youth's clinical history, including gathering of pertinent diagnostic information from referral sources, claims data and other resources such as the Total Health Record's continuity of care document. Children and youth considered for the Care Management Entity (CME) benefit must have a DSM-IVR (or current edition) Axis 1 or ICD 9 (or current edition) behavioral health diagnosis determined by a qualified health care provider within the last year. If the child/youth is determined to be an appropriate referral for the CME, a service intensity instrument is administered (CASII/ECSII) by a credentialed service intensity evaluator to determine needs-based eligibility. This portion of the evaluation determines if the level of needed service intensity indicates that the child/youth could benefit from services and supports included in the CME benefit plan. An additional and complimentary component of the initial evaluation process includes the strengths, needs and cultural discovery (SNCD) narrative that the FCC compiles during the initial family and child interview. This is the first phase of the HFWA process (preparation and engagement). It is desirable and beneficial to families when the FCC and service intensity evaluator can work in concert and complete the SNCD and service intensity evaluations during the same initial interview. An interview guide has been developed to assist FCC's and service intensity evaluators with this coordinated process.

The service intensity instruments used to identify functional deficits and challenges to demonstrate clinical need for eligibility include the American Academy of Child and Adolescent Psychiatrist's Child and Adolescent Service Intensity Instrument (CASII) and Early Childhood Service Intensity Instrument (ECSII). These two instruments are the primary clinical needs assessment tools administered by the Care Management Entity to assist with determining program eligibility and need for HCBS services and supports. Children/youth ages six (6) to twenty (20) must have a minimum CASII composite score of twenty (20). Children aged four (4) & five (5) must have a minimum ECSII composite score of eighteen (18), or, a comprehensive evaluation of social and emotional deficits to illustrate level of service needs performed by a qualified health care provider.

The Child, Adolescent Needs and Strengths (CANS) is administered to determine if there are urgent safety or other issues that could be detrimental to the health and welfare of the participants. The CANS score is not part of the need-based eligibility process but is utilized to assist the child and family team members to focus on issues that require immediate or intensive action due to an immediate safety concern or priority for intervention vs. those issues indicate a need for action after a strategy is developed to address the problem/need vs. a need for watchful waiting, monitoring, or possibly preventive action.

Based on the child/youth's eligibility as described and CME availability, the child/youth can enroll in the CME. The Medicaid Management Information System will be updated to reflect participation in the program and a specific program eligibility code will be added to indicate eligibility for CME service benefit plan. If the child/youth does not meet criteria for the CME the family will be referred to the appropriate behavioral health resources and supports in their community.

Reevaluation of service intensity needs using the CASII or ECSII is conducted every six (6) months and the CANS is administered every three (3) months preceding any HFWA and clinical treatment plan updates to identify and prioritize issues that require services and

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supports to be included in the updated plans.

- **4. Reevaluation Schedule**. (By checking this box the state assures that): Needs-based eligibility reevaluations are conducted at least every twelve months.
- **5.** Needs-based HCBS Eligibility Criteria. (By checking this box the state assures that): Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: (Specify the needs-based criteria):

- A current DSM Axis 1 or ICD diagnosis
- Children and Youth must meet the definition for Serious Emotional Disturbance (SED) as described in the Federal Register, Volume 58, # 96.
- Children ages six (6) through twenty (20) years of age must have a minimum CASII composite score of twenty (20)
- Children ages four (4) & five (5) must have a minimum ECSII composite score of eighteen (18), or, the appropriate social and emotional assessment information provided to illustrate level of service needs
- **6.** Needs-based Institutional and Waiver Criteria. (By checking this box the state assures that): There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. (Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):

LOC waivers)	TT 1/ 1 T O O 1 \ \
LOC waivers)	Hospital LOC waivers)

*Long Term Care/Chronic Care Hospital

**LOC= level of care

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7. Target Group(s). The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C). (Specify target group(s)):

Children ages four (4) through twenty (20) years of age with a serious emotional disorder as evidenced by an a DSM (most current version) or ICD (most current version) Axis I behavioral health disorder and with a minimum CASII composite score of twenty (20). Or, for children four (4) through five (5) years of age, a minimum ECSII score of eighteen (18), or, the appropriate social and emotional assessment completed by a qualified health care provider that provides information to illustrate level of service needs may suffice until an ECSII evaluation can be completed before the first child and family team meeting (within 45 days of enrollment with the CME).

(By checking the following boxes the State assures that):

- **8.** Adjustment Authority. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).
- **9. Residence in home or community**. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The state attests that each individual receiving State plan HCBS:
 - (i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or
 - (ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health related treatment or support services, if such residence meets home and community-based setting requirements as defined by the state and approved by CMS. (If applicable, specify any residential settings, other than an individual's home or apartment, in which 1915(i) participants will reside. Describe the home and community-based setting requirements that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):

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Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

- 1. There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:
 - An objective face-to-face assessment with a person-centered process by an agent who is independent and qualified;
 - A person-centered process and guided by best practice and research on effective strategies that result in improved health and quality of life outcomes;
 - Consultation with the individual and if applicable, the individual's authorized representative, and
 includes the opportunity for the individual to identify other persons to be consulted, such as, but not
 limited to, the individual's spouse, family, guardian, and treating and consulting health and support
 professionals responsible for the individual's care;
 - An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the person-centered service plan;
 - An examination of the individual's physical, cognitive, and behavioral health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the person-centered service plan, a caregiver assessment;
 - If the state offers individuals the option to self-direct state plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
 - A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.
- 2. Based on the independent assessment, the individualized person-centered service plan:
 - Is developed with a person-centered process jointly with the individual and if applicable, the individual's authorized representative, and others chosen by the individual. The person-centered planning process:
 - Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
 - Is timely and occurs at times and locations of convenience to the individual.
 - Reflects cultural considerations of the individual:
 - Includes strategies for solving conflict or disagreement with the process, including clear conflict of interest guidelines for all planning participants;
 - Offers choices to the individual regarding the services and supports they receive and from whom;
 - Includes a method for the individual to request updates to the plan, as needed; and
 - Records the alternative home and community-based settings that were considered by the individual.
 - Reflects the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports.
 - Reflect that the setting in which the individual resides is chosen by the individual.
 - Reflects the individual's strengths and preferences.
 - Reflects clinical and support needs as identified through an assessment of functional need.

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- Includes individually identified goals and desired outcomes.
- Reflects the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports.
- Reflects risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
- Is understandable to the individual receiving services and supports, and the individuals important in supporting him or her.
- Identifies the individual and/or entity responsible for monitoring the plan.
- Is finalized and agreed to, with the informed consent of the individual, in writing by the individual and signed by all individuals and providers responsible for its implementation.
- Is distributed to the individual and other people involved in the plan.
- Includes those services, the purchase or control of which the individual elects to self-direct.
- Prevents the provision of unnecessary or inappropriate services and supports.
- 3. Is reviewed at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. (Specify qualifications):

Family Care Coordinator (FCC)

1. **Degree and/or experience:** Bachelor's degree in a human service area or related field or two years work/personal experience in providing direct services or linking of services for youth with serious emotional disturbance.

2. Skills:

- a. Well developed interpersonal and relationship building skills
- b. Efficient time management and scheduling
- c. Small group meeting management
- d. Public speaking
- e. Familiarity with children's services including child welfare, mental health, substance abuse, juvenile justice, and special education
- f. Ability to build trust while maintaining appropriate boundaries
- g. Knowledge and understanding of income supplements and entitlement, emotional and behavioral health disorders in children
- h. Knowledge and understanding of families' rights and responsibilities in the mental health system, their rights at school, and the IEP process, and knowledge of other child-serving systems
- i. Knowledge of the system of care in the community
- j. Effective written, oral, and interpersonal communication skills.
 - i. Ability to communicate, comprehend, and perform functions from written and oral instructions
 - ii. Must be organized with the ability to take direction and prioritize tasks
 - iii. Must have ability to maintain confidentiality and appropriate boundaries
- k. Exhibits mature judgment and emotional stability

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3. Requirements:

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- a. Must be at least 21 years of age
- b. Satisfactorily complete all State required training components
- c. Valid driver's license, appropriate insurance, and reliable car
- d. Maintain current CPR and First Aid Certification
- e. Must successfully pass all background screens as required by the State or CME
- 4. **Reports To:** Wraparound Supervisor/Coach

Service Intensity Evaluators (CASII, ECSII, CANS)

1. **Degree and/or experience:** Bachelor's degree in a human service area or related field or two years work/personal experience in providing direct services or linking of services for youth with serious emotional disturbance.

2. Skills:

- a. Well developed interpersonal and relationship building skills
- b. Efficient time management and scheduling
- a. Small group meeting management
- b. Public speaking
- c. Familiarity with children's services including child welfare, mental health, substance abuse, juvenile justice, and special education
- d. Ability to build trust while maintaining appropriate boundaries
- e. Knowledge and understanding of emotional and behavioral health disorders in children
- f. Knowledge and understanding of families' rights and responsibilities in the mental health system, their rights at school, and the IEP process, and knowledge of other child-serving systems
- g. Knowledge of the system of care in the community
- h. Effective written, oral, and interpersonal communication skills.
 - iv. Ability to communicate, comprehend, and perform functions from written and oral instructions
 - v. Must be organized with the ability to take direction and prioritize tasks
 - vi. Must have ability to maintain confidentiality and appropriate boundaries
- i. Exhibits mature judgment and emotional stability

3. Requirements:

- a. Must be at least 21 years of age
- b. Under employment or contract with the CME and individually credentialed to administer the specific assessment tools they are administering
- c. Valid driver's license, appropriate insurance, and reliable car
- d. Maintain current CPR and First Aid Certification
- e. Must successfully pass all background screens as required by the State or CME

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4. Responsibility for Development of Person-Centered Service Plan. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. (*Specify qualifications*):

All High Fidelity Wraparound Providers are required to be credentialed to provide HFWA services specific to their role. There is an initial credentialing process with ongoing coaching and technical assistance based on results of the Team Outcome Measures and Wraparound Fidelity Instrument for each HFWA provider.

In addition to the qualifications specified in section 3 above, the Family Care Coordinator (FCC) partners with the family, youth/child, and Child and Family Team at the start of the Wraparound process to facilitate phase one (engagement and team preparation) of the wraparound process. Child and family team members are identified by the family and facilitator that are needed to assist with phase two (initial plan development) of the wraparound process. The FCC facilitates child and family team meetings during Phase Three (Plan Implementation) as the team commits to and acts upon actions steps agreed to in the written plan of care. The family and youth are assisted to assume facilitation responsibilities such as presiding over their own child and family team meetings, and begin to direct more of the activities specified in the plan of care in preparation for Phase Four of the wraparound process (Transition) where completion of the final plan may involve a final meeting of the whole team and a final plan is in place that does not require regular team involvement but may include informal supports provided by team members the family chooses to continue with beyond completion of the wraparound process.

The FCC is trained to approach the behavioral and social needs of children and families, which includes coordination of a broad array of behavioral health services and social supports and coordination with the schools, courts, child welfare workers, juvenile probation, etc. FCC's must be certified in High-Fidelity Wraparound and the FCC role. The FCC must partner/collaborate with these child and family serving agencies that are involved with the child/youth and his or her family which means initial child and family team meetings may include probation officers, special education teachers or other child-serving staff that the child/youth and their family are required to be involved with at that time. This involvement assures a comprehensive individualized plan of care that recognizes all of behavioral and social needs of the child/youth and their family.

The Plan of Care must be developed in accordance to the High Fidelity Wraparound process. The FCC may also interface with Primary Care Physician (PCP), who serves as the medical home for the Medicaid child or youth. As part of the medical home function, PCP's will perform and manage EPSDT requirements for children and youth in their care.

5. Supporting the Participant in Development of Person-Centered Service Plan. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. (Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):

The CME works with existing state-wide Family-run Organizations and/or develops a similar Family Support Organization in areas lacking that capacity to ensure adequate number of Family Support Partners and Youth Peer Support Partners. The Family-run Organization must have an existing infrastructure and presence in Wyoming with a philosophy and mission that adheres to the national children's mental health system of care values and principles and that are reflected in the High Fidelity Wraparound values and philosophies.

The CME must work with the family, children or youth, and Child and Family Team, in accordance to the High Fidelity Wraparound process, to ensure Family and Youth Support Partners are available at the start of the Wraparound process and continuously based on the Plan of Care and the individual family and child's or youth's strengths and preferences.

Family and Youth Peer Support Partners may, among other activities, help the family and/or youth acquire skills and knowledge; provide information regarding specific services and the roles of individuals in the Plan

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of Care; participate in the development and revision of the participant's Plan of Care; coordinate services and community resource linkages; accompany the youth and/or family to meetings or other community resources; and provide assistance for transitioning from HCBS services.

Participants and their families are assisted to identify and invite formal and informal supports, including clinical providers, to the Child and Family Team meetings. The goal is to further identify and develop the informal support system that naturally supports the participant and family throughout and beyond the High Fidelity Wraparound process. As the Child and Family Team meets and matures, the ratio of informal to formal supports is anticipated to increase. Certain participants are required to participate in the initial Child and Family Team meetings. These are individuals who have

The Primary Care Physician and the CME must maintain ongoing communications to ensure appropriate tracking of EPSDT requirements and coordination of care. The Family Care Coordinator will notify the family and Child and Family Team (CFT) of Medicaid requirements established by Wyoming Department of Health including, but not limited to EPSDT and other screenings and assessments as medically necessary.

6. Informed Choice of Providers. (Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):

The CME, when assuming responsibility for administering the behavioral health benefit (PIHP), will provide a full suite of new member documents, including rights/responsibilities, reasons for disenrollment, contact information, complaint and grievance processes and customer service call center information.

The CME will assist participants in finding providers that meet their individual needs as the CME assumes responsibility for administering the PIHP benefit on January 1, 2014 by making each enrolled family aware of available options for Family Care Coordinators (FCC) that serve their region, offering choice among any willing and qualified network providers. Should the participant or their family be dissatisfied with the assigned FCC, the CME will assist them in identifying another option and make a reassignment.

The Chosen FCC, during the initial assessment to determine eligibility, High Fidelity Wraparound process, participant and family engagement, team preparation, and initial Plan of Care development, will identify treatment and support needs. The FCC will then make the participants aware of available options that are appropriate to meet the child/youth's identified needs and assist them in engaging and accessing the most appropriate providers. If the participant and/or their family is dissatisfied with a provider, the FCC will liaise with service and support providers on behalf of the member/family if desired and also work to identify alternate service and support providers who could also meet the participant's needs.

The CME will develop a provider network encompassing a wide range of behavioral health providers in and near the regions served, post this information in a searchable format on it's website, provide alternative formats as requested, and assist participants in identifying and accessing qualified providers via the Wraparound process and through the CME customer service call center. In addition, the CME will develop an agreement with Wyoming advocacy organizations that provide assistance and advocacy to families of children and youth who are experiencing serious emotional disorders to assist with outreach, referral and support to potential participants and their families. The CME will perform outreach and education regarding the CME referral process and benefit plan to other child-serving agencies within the State.

7. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency. (Describe the process by which the person-centered service is made subject to the approval of the Medicaid agency):

The Medicaid Agency will make a quarterly request of electronic care plans from the CME for services provided during the previous quarter. The request will be based on a random sample of 10% of the participants served in the previous quarter. Members of the State's Care Management Entity sub-committee will complete the quarterly service plan reviews.

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In addition, ad hoc focused reviews will be conducted as indicated to further identify any issues found during the quarterly review process that identify potential conflicts with current policies and/or procedures, as well as identification of issues that could compromise the health and welfare of participants. Any identified program integrity concerns will be referred to the Medicaid Program Integrity Unit for resolution and provider education recommendations. Findings from the quarterly review process will be compiled into a formal report and shared with the CME, the State's CME Committee and quality assurance work group as part of the quality improvement process.

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8. Maintenance of Person-Centered 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 §74.53. Service plans are maintained by the following (check each that applies):

Medicaid agency	V	Operating agency	<u>N</u>	Case manager
Other (specify):	·			

Services

b. State plan HCBS. (Complete the following table for each service. Copy table as needed):

Service Specifications	(Specify a service	title for the HCBS	listed in A	Attachment 4.19-B	that the
state plans to cover):					

Service Title: Family Care Coordination

Service Definition (Scope):

Family Care Coordinators are responsible for implementing the phases and related activities of the HFWA process, advocating for and supporting the child/youth and family, and coordinating the team meetings, documents, and process.

The FCC is primarily responsible for the following functions:

- 1. Facilitating the four phases of the wraparound process
- 2. Maintaining open lines of communication between all team members;
- 3. Initiating and overseeing completion of needed assessments and evaluations as identified by the team;
- 4. Facilitate the development and execution of the individualized plan;
- 5. Locate, arrange, and refer child/youth and family to direct services as identified in the individualized plan; and
- 6. Identifying when objectives in the plan are not being met, or there are barriers to achieving the objectives of the plans.

Family Support Partner (FSP)

Description: The FSP is a formal member of the wraparound team whose role is to serve the family, and help them engage and actively participate on the team, and make informed decisions and drive the process. The FSP does not provide clinical services, but rather the unique peer to peer support on their lived experience of raising and/or 2 years of work experience in programs serving populations with a child or youth with emotional, behavioral (including substance use), and mental health challenges.

The FSP should be well versed in the community, continuum of care and the social contexts affecting wellness and can be a mediator, facilitator, or bridge between families and agencies. FSPs ensure each family is heard and that their individual needs are being addressed and met. The FSP should communicate and educate agency staff on wraparound principles and family voice and choice to ensure fidelity to the process.

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The FSP must be provided by a parent/family organization or through direct hire by the Provider agency. The preferred option is that the FSP services be provided by a parent/family organization. However, if the FSPs are to be hired by the CME, the organization structure for the oversight of that service must be pre-approved by Medicaid prior to the contract start-date.

Youth Support Partner (YSP)

State: Wyoming

TN: 13-007

YSPs are young adults with personal experience participating in the system of care (mental health, special education, child welfare, juvenile justice) as a youth with behavioral health needs or have experience overcoming various systems and obstacles related to mental and behavioral health. YSPs have the skills, training, and experience to perform the functions of their role. YSPs have four key functions:

- 1. To make youth equal partners if not leaders in the development and implementation of their service plans
- 2. To represent the needs and perspectives of youth to internal and external stakeholders and decision makers within the system of care
- 3. To ensure that youth have access to a comprehensive array of prevention and support services that meet their individual needs
- 4. To ensure that these services are family-centered, easily accessible, respectful of cultural, ethnic and other community characteristics, and stigma free

Youth and Family Training and Support

Training services and activities designed for the child/youth served as specified in the service plan that supports and enhances overall service goals. Training, services, and activities for family members and informal/natural supports identified by the child/youth and family who provide unpaid care, guidance, companionship, or support to the youth to maintain their ability to care and support the youth in his/her home community

Service Intensity Evaluation (CASII, ECSII, CANS)

Initial and subsequent evaluation of a child/youth and family's service intensity needs to assist in needs-based eligibility for the CME. Annual recertification for CME and identification of needed services and supports to be addressed during the wraparound process an included in the plan of care.

High Fidelity Wraparound (HFWA) Supervisor/Coach

HFWA Supervision and Coaching is defined as hands on instruction and oversight by a Wyoming credentialed expert. Credentialing as a coach involves the coach learning to not only manage the credentialing process, but to also master the skills of wraparound and effective teaching, including shadowing, development plans and other key skills.

The HFWA Supervisor/Coach is responsible for preparing local supervisors and advanced facilitators to coach and credential local FCCs. These coaches should use the training materials to provide hands on teaching to

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individuals or small groups of FCCs, FSPs, and/or YSPs. They then use the basic modes of coaching to support these staff as they gain more experience.

HFWA Supervisor/Coaches may carry *a maximum* of ten coaching clients and FCC families combined from any source (Waivers, CME, agency, etc.) and must meet the following requirements:

- 1. Meet minimum qualifications of a Family Care Coordinator below (qualifications, skills, and requirements).
- 2. Complete the HFWA Coaching specific training and Coaching track within one year.

Respite Care

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

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):

- ☐ Categorically needy (*specify limits*):
- ☐ Medically needy (*specify limits*):

Provider Qualifications (For each type of provider. Copy rows as needed):

	1		
Provider Type	License	Certification	Other Standard
(Specify):	(Specify):	(Specify):	(Specify):
Family Care	N/A	Coaching, Credentialing,	
Coordinator (FCC)		and Recredentialing:	wraparound cases from any source
			(Waivers, CME, agency, etc.) and must
		Coaching must include	meet the following requirements:
		one hour monthly of	1. Meet minimum qualifications of
		individual supervision or	a Family Care Coordinator
		one hour of group	(qualifications, skills, and
		supervision, review of all	requirements).
		wraparound and crisis	1
		plans, and documented	
		monthly review of each	2. Complete Wyoming High
		client record with a focus	Fidelity Wraparound Training
		on safety, progress	(Days 1-4) and other core
		toward goals, self-	training as agreed upon by
		sufficiency, and	Medicaid, the CME, and
		implementation of	,, yourne
		HFWA. Coaching must	Leadership.
		be provided by a	
		Wyoming Wraparound	±
		Credentialed Coach or	credentialing process within one
		Master Coach; or	year or approvar as an ree
		someone working toward	and/or their first case
		credentialing and	assignment. This timeframe can

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complete credentialing as a coach within one year. This timeframe can be extended with approval by Medicaid and the CME. The Coach provides direct support to Facilitators and Family Support Partners specific to the skills and activities the wraparound process and leads to credentialing within designated timelines. Once credentialed. coaching continues and involves ongoing monitoring to prevent drift and assist with annual recertification.

Credentialing HFWA FCC must be completed no longer than one year following the acceptance/assignment of their first **HFWA** This participant. timeframe be can extended with approval by Medicaid and the CME. Complete Wyoming High Fidelity Wraparound Training (Days 1-4) and other core training as agreed upon by Medicaid, the CME, and Wyoming Wraparound Leadership.

Recredentialing

including 10 hours of training each year, approved by Medicaid and the CME; complete a professional development plan; 4 be extended with approval by Medicaid and the CME.

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		hours of HFWA specific	
		training; and provide	
		HFWA facilitation for at	
		least one family per year	
		or work with a Coach on	
		a plan to maintain	
		credentialing as	
		approved by the Coach.	
		If there is a question	
		about the FCC's fidelity	
		to the model, the Coach	
		with observe a meeting	
		or a video of a meeting	
		to score a wraparound	
		activity by the	
		Facilitator, which must	
		meet credentialing	
		guidelines.	
		8	
Family Support	N/A	Coaching,	Qualifications, Skills, and Requirements
Partner (FSP)	14/11	Credentialing, and	
()		=	Degree and/or experience:
		~	a. High school diploma or GED
		Coaching must be e	equivalent
		regularly scheduled to	b. Must be a parent or caregiver of a
		include one hour of c	child with behavioral health needs or have two
		individual or one hour y	years experience working closely with
		of group supervision c	children with serious emotional/behavioral
		monthly. To be c	challenges and their families
		provided by a trained	c. Minimum two years experience in
		individual who has th	he behavioral health field
		experience in raising	d. Completion of credentialing
		and/or 2 years of work	equirements as described above
		experience in	
		1 0	Skills:
		1 1	a. Knowledge and understanding of
			income supplements and entitlement,
			emotional and behavioral health disorders in
		<i>U</i> ,	children
		r	b. Knowledge and understanding of
		• •	families' rights and responsibilities in the
			mental health system, their rights at school,
			and the IEP process, and knowledge of other
		• •	child-serving systems
		Ŭ	c. Knowledge of the system of care in
		-	the community and ability to assist the
			family in accessing the system of care
		severe emotional	d. Effective written, oral, and

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and/or behavioral challenges. The supervisor must also be a HFWA Coach or working towards credentialing.

occur

Credentialing

should

within one year of the date of hire. Training towards credentialing must begin within thirty (30) days of hire. This timeframe can be extended with approval by Medicaid and the CME. Complete Wyoming High Fidelity Wraparound Training (Days 1-4), FSP training, and other core training as agreed upon by Medicaid, the CME, and Wyoming Wraparound Leadership.

Recredentialing

including 10 hours of training each year, approved by Medicaid and the CME; complete professional development plan; 4 hours of **HFWA** specific training; and work with at least one family per year. If there is a question about the FSP's fidelity to the model, Coach with the

interpersonal communication skills.

- i. Ability to communicate, comprehend, and perform functions from written and oral instructions
- ii. Must be organized with the ability to take direction and prioritize tasks
- iii. Must have ability to maintain confidentiality and appropriate boundaries
- e. Exhibits mature judgment and emotional stability

Requirements:

- a. Must be at least 21 years of age
- b. Must successfully pass all background screens as required by the CME or Medicaid
- c. Satisfactorily complete all State required training components
- d. Maintain current CPR and First Aid Certification

Reports to: HFWA coach

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		observe a meeting or a video of a meeting to score a wraparound activity by the FSP, which must meet credentialing guidelines.	
Youth Support Partner (YSP)	N/A	Coaching, Credentialing: Coaching must be regularly scheduled to include one hour of individual or one hour of group supervision monthly. To be provided by a trained individual who has experience with severe emotional or behavioral challenges or who is employed by an agency whose primary purpose is to provide support and training specific to the needs of caregivers and family members of children with severe emotional and/or behavioral challenges. The supervisor must also be a HFWA Coach or working towards credentialing. Credentialing should occur within one year of the date of hire. Training towards credentialing must begin within thirty (30) days of hire. This	1. Degree and/or experience: a. High school diploma or GED equivalent b. Must be a youth with behavioral health needs or have experience overcoming various systems and obstacles related to mental and behavioral health c. Completion of credentialing to be a YSP 2. Skills: a. Interpersonal and relationship building skills b. Familiarity with children's services including child welfare, mental health, substance abuse, juvenile justice, and special education c. Ability to build trust while maintaining boundaries 3. Requirements: a. Must be 18-26 years of age b. Satisfactorily complete all State required training components c. Maintain current CPR and First Aid Certification
		timeframe can be extended with approval by Medicaid and the CME. YSP credentialing shall	d. Must successfully pass all background screens as required by the CME and Medicaid 4. Reports To: Wraparound

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Evaluators

		include the completion of Wyoming High Fidelity Wraparound Training (as approved by Medicaid and the CME), YSP training, and other core training as agreed upon by Medicaid, the CME, and Wyoming Wraparound Leadership. Recredentialing including 10 hours of training each year, approved by Medicaid and the CME; complete a professional development plan; 4 hours of HFWA specific training; and work with at least one family per year. If there is a question about the YSP's fidelity to the model, the Coach with observe a meeting or a video of a meeting to score a wraparound activity by the YSP, which must meet credentialing guidelines.	pervisor/Coach
Verification of Proneeded):	vider Qualific	cations (For each provider type listed	l above. Copy rows as
Provider Type (Specify):	Entity	y Responsible for Verification (Specify):	Frequency of Verification (Specify):
Family Care Coordinator	Care Manager	nent Entity	Annually
Youth and Family Training and Support	Care Manager	nent Entity	Annually
Respite	Care Manager		Annually
Service Intensity	State Medicaio	d Agency and Care Management Entity	Annually

State: Wyoming TN: 13-007

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Service Delivery Method. (Check each that applies):			
	Participant-directed	V	Provider managed



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State: Wyoming

TN: 13-007

3. Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians. (By checking this box the state assures that): There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. (Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; I the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):



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Participant-Direction of Services

Definition: Participant-direction means self-direction of services per $\S1915(i)(1)(G)(iii)$.

b. Election of Lancepant-Direction. (Select One)	b.	Election of Participant-Direction.	(Select one):
--	----	---	---------------

State: Wyoming

•	The state does not offer opportunity for participant-direction of State plan HCBS.
0	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
0	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. (Specify criteria):

2.	Description of Participant-Direction. (Provide an overview of the opportunities for participant-
	direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how
	participants may take advantage of these opportunities; (c) the entities that support individuals who direct
	their services and the supports that they provide; and, (d) other relevant information about the approach
	to participant-direction):

3.	Limited Implementation of Participant-Direction.	(Participant direction	is a mode of service delivery,
	not a Medicaid service, and so is not subject to statew	videness requirements.	Select one):

)	available.
0	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (Specify the areas of the state affected by this option):

4. Participant-Directed Services. (Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):

Participant-Directed Service	Employer Authority	Budget Authority

5	Finan	rial i	Management	t (Soloct	ana)

O Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

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6. Participant–Directed Person-Centered Service Plan. (By checking this box the state assures that): Based on the independent assessment, a person-centered process produces a person-centered service plan for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans, that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.



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Voluntary and Involuntary Termination of Participant-Direction. (Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is *involuntary*):

Opportunities for Participant-Direction

- Participant-Employer Authority (individual can hire and supervise staff). (Select one):
- The state does not offer opportunity for participant-employer authority. Participants may elect participant-employer Authority (Check each that applies):
 - **Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An

agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the

participant in conducting employer-related functions.

Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

- b. Participant–Budget Authority (individual directs a budget). (Select one):
 - The state does not offer opportunity for participants to direct a budget.
 - Participants may elect Participant-Budget Authority.

Participant-Directed Budget. (Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan):

Expenditure Safeguards. (Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):

State: §1915(i) State plan HCBS State plan Attachment 3.1-i: TN: Page 28

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Quality Improvement Strategy

(Describe the state's quality improvement strategy in the tables below):

Discovery Activities				Remediation		
Requirement	Discovery Evidence (Performance Measures)	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities (agency or entity that conducts discovery activities)	Frequency	Remediation Responsibilities (Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	Frequency of Analysis and Aggregation
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	Completed Plan of Care documentation with service array, providers, and comparison against client needs assessment; aggregated data from CME systems	CME Case Management System (Guiding Care System) and Wyoming's Total Health Record. All children and youth served in Years 1 and 2. Sample size TBD for beyond year 2	State Medicaid Agency and CME	Monthly	CME – must correct within 60 days	Within 30 days of remediation
Providers meet required qualifications.	Provider Completed Qualifications and Certifications	IMPROV (Provider Qualification and Certification System). Sample size: all providers for years 1 and 2	State Medicaid Agency and CME	Semi-annually	CME – must correct within 90 days	Within 30 days of remediation
Settings meet	Provider	IMPROV	State Medicaid	Every 2	CME – must correct	Within 30 days of remediation

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the home and community-based setting requirements as specified in this SPA.	qualifications and certifications	(Provider Qualification and Certification System). Sample size: all providers for years 1 and 2	Agency and CME	months	within 60 days	
The SMA retains authority and responsibility for program operations and oversight.	Review and monitor of required reports and aggregated data for CME performance as defined in contract. Hold monthly Steering Committee Meetings with CME	CME Case Management System (Guiding Care System), MMIS, Total Health Record. Aggregated data for all children and youth served by the CME	State Medicaid Agency	Monthly	CME – must correct within 30 days	Within 30 days of remediation
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	Review and monitor required reports and aggregated data for CME in MMIS, CME Claims processing System, and Case Management System	MMIS and interface with QNXT (CME's claim processing system)	State Medicaid Agency	Monthly	CME – must correct within 30 days	Within 30 days of remediation
The state identifies, addresses and	Completed Plan of Care documentation	CME Case Management System	State Medicaid Agency and CME	Monthly	CME – must correct within 30 days	Weekly after remediation

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for beyond year

System Improvement:				
(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)				
Methods for Analyzing Data	Roles and Responsibilities	Frequency	Method for Evaluating	
and Prioritizing Need for			Effectiveness of System	
System Improvement			Changes	
	State CME sub-committee and	Quarterly, post payment	Results are compiled and	
Quarterly random sample of	quality assurance group will		shared with the CME to for	
service plans	review a 10% sample of plans		development of a corrective	
	using the HFWA process		action plan to remediate any	
	checklist		issues found as part of the	
			continuous quality	
			improvement process	
Wraparound Fidelity Index	Administration of the WFI to a	Annually	Results are scored, compiled	
(WFI IV)	10% sample of families served		and shared with the CME sub-	
	to assess fidelity of the process		committee and quality	
			assurance group to guide	
			technical assistance to the	
			HFWA providers and inclusion	
			in future HFWA training and	
			credentialing process	

State:	§1915(i) State plan HCBS	State plan Attachment 4.19-B
TN:		

Effective: Approved: Supersedes:

Methods and Standards for Establishing Payment Rates

1.	Services Provided Under Section 1915(i) of the Social Security Act. For each optional service,
	describe the methods and standards used to set the associated payment rate. (Check each that applies, and
	describe methods and standards to set rates):

	HCBS Case Management					
	HCBS Homemaker					
	НСВ	S Home Health Aide				
	HCB	S Personal Care				
	НСВ	S Adult Day Health				
	HCB	S Habilitation				
$\overline{\square}$	НСВ	S Respite Care				
	same rate as respite care under the Children's Mental Health Waiver [1915 (c)]					
For Ir	For Individuals with Chronic Mental Illness, the following services:					
	☐ HCBS Day Treatment or Other Partial Hospitalization Services					
	☐ HCBS Psychosocial Rehabilitation					
	☐ HCBS Clinic Services (whether or not furnished in a facility for CMI)					
V	Other Services (specify below)					
	Family Care Coordination-same rate as Family Care Coordination under the Children's Mental Health Waiver [1915 (c)]					
	Family Support Partner-same rate as State Plan authorized Certified Peer Specialist					
	Youth Support Partner-same rate as State Plan authorized Certified Peer Specialist					
	Youth and Family Training and Support- same rate as under the Children's Mental Health Waiver [1915 (c)]					
	Service Intensity Evaluation (CASII, ECSII, CANS)- same rate as CASII evaluation under the Children's Mental Health Waiver [1915 (c)]					
	High Fidelity Wraparound (HFWA) Supervisor/Coach- same rate as Targeted Case Management for SPMI and ongoing case management for children under expanded EPSDT					

State: TN: Effective: §1915(i) State plan HCBS State plan Attachment 4.19–B:

Approved: Supersedes:



State:	§1915(i) State plan HCBS	State plan Attachment 2.2-A:
TN:		

Effective: Approved: Supersedes:

Groups Covered Optional Groups other than the Medically needy

☑ In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state is **also** covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate. (select at least one):

 \square The state covers all of the individuals described in item 1(a) and (b) as described below. Complete 1(a) and 1(b):

1(a). ☑ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services.

Income Standard	✓	150% FPL
Methodology used (Select one)		
		SSI
	$\overline{\mathbf{V}}$	OTHER (describe):

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.

State: TN:	§1915(i) State	plan HCBS	State plan Attachment 2.2-A:		
Effective:	Approved:	Supersedes:			
	For states that have elected the SSI less restrictive 1902(r)(2) income decrease resource test for this group. (specif	_			
	1(b). ☑ Individuals who are eligible for home and community-based services under a waiver approved for the state under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate. For individuals eligible for 1915(c), (d) or (e) waiver services, this amount must be the same amount as the income standard specified under your state plan for the special income level group. For individuals eligible for 1915(c) like services under an approved 1115, this amount must be the same as the amount of the income standard used for individuals using institutional rules. (Select one):				
	 ☑ 300% of the SSI/FBR ☐ (Specify)% Less than 300% of the SSI/FBR				
	The state uses the same eligibility criteria that it uses for the special income level group.				
☐ The state covers only the following group individuals described be Complete 1(a) or 1(b): 1(a). ☐ Individuals not otherwise eligible for Medicaid who meet based criteria of the 1915(i) benefit, have income that does not exc the federal poverty level, and will receive 1915(i) services.			luals described below.		
			that does not exceed 150% of		
	Income Standard	□ 150% FI	$^{ m PL}$		
	Methodology used (Select one)	□ SSI □ OTHER	(describe):		

For states that have elected the SSI methodology, the state uses the following less restrictive 1902(r)(2) income disregards for this group. There is no resource test for this group. (specify):

1(b). \square Individuals who are eligible for home and community-based services under a waiver approved for the state under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate. For individuals eligible for 1915(c), (d) or (e) waiver services, this amount must be the same amount as the income standard specified under your state plan for the special income level group. For individuals eligible for 1915(c) like services under an approved 1115, this amount must be the same as the amount of the income standard used for individuals using institutional rules. (Select one):

□ 300% of the SSI/FBR
□ (Specify) _____% Less than 300% of the SSI/FBR

The state uses the same eligibility criteria that it uses for the special income level group.