

# Application for a §1915 (c) HCBS Waiver

## HCBS Waiver Application Version 3.5

### Submitted by:

The State of Wyoming, Department of Health, Division of Healthcare Financing

**Submission Date:** April 6, 2015

**CMS Receipt Date (CMS Use)**

*Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment) Include population served and broad description of the waiver program:*

### Brief Description:

The State of Wyoming, Department of Health, Division of Healthcare Financing is requesting an amendment to its existing 1915 (c) Children's Mental Health Waiver. The amended waiver will be administered with a concurrent 1915 (b) authority to align the waiver with the pending statewide expansion of its Care Management Entity (CME) program.

State:	Wyoming
Effective Date	July 1, 2015

# 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.

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# 1. Request Information

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. Waiver Title (optional): **Children's Mental Health Waiver**

C. Type of Request (select only one):

<input type="radio"/>	<b>New Waiver (3 Years)</b>	CMS-Assigned Waiver Number (CMS Use):	
<input type="radio"/>	<b>New Waiver (3 Years) to Replace Waiver #</b>		
	CMS-Assigned Waiver Number (CMS Use):		
	<i>Attachment #1 contains the transition plan to the new waiver.</i>		
<input type="radio"/>	<b>Renewal (5 Years) of Waiver #</b>		
<input checked="" type="radio"/>	<b>Amendment to Waiver #</b>	WY.0451.R02.00	

D. Type of Waiver (select only one):

<input type="radio"/>	<b>Model Waiver.</b> In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
<input checked="" type="radio"/>	<b>Regular Waiver</b> , as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: **July 1, 2015**

E.2 Approved Effective Date (CMS Use):

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):

<input checked="" type="checkbox"/>	<b>Hospital (select applicable level of care)</b>
<input type="radio"/>	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:
<input checked="" type="radio"/>	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
<input type="checkbox"/>	<b>Nursing Facility (select applicable level of care)</b>
<input type="radio"/>	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:
<input type="radio"/>	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
<input type="checkbox"/>	<b>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 facility level of care:</b>

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

<input type="checkbox"/>	Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I		
<input checked="" type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i>		
	1915 (b): Wyoming Medicaid’s Youth Initiative – A High Fidelity Wraparound (HFWA) Community-Based Alternative for Youth with Serious Emotional/Behavioral Challenges will be submitted to CMS concurrent to the submission of this amended 1915 (c) waiver. Both waivers are being submitted with a proposed effective date of July 1, 2015.		
	Specify the §1915(b) authorities under which this program operates ( <i>check each that applies</i> ):		
<input checked="" type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input checked="" type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input checked="" type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	A program operated under §1932(a) of the Act. <i>Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved.</i>		
<input type="checkbox"/>	A program authorized under §1915(i) of the Act		
<input type="checkbox"/>	A program authorized under §1915(j) of the Act		
<input type="checkbox"/>	A program authorized under §1115 of the Act. <i>Specify the program:</i>		
<input type="checkbox"/>	Not applicable		

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## 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 Wyoming Children’s Mental Health Waiver (CMHW) serves youth in coordination with the adult(s) legally responsible for the care of the child as well as the youth’s “family”, as able. “Family” translates loosely to refer to the support system currently in place for the youth, as well as to include the support systems to be further developed for the youth. For the sake of efficiency, this amendment will utilize the phrase “youth/family” to be inclusive of the youth’s legal guardian as well as the youth’s family and natural support system.

The CMHW has been designed to support the development of a natural family support system through education, training and resource identification for at the community level. Appropriate youth for this program will be youth between the ages 4 and 21 who meet the definition of a youth with serious emotional disturbance (SED) or serious and persistent mental illness (SPMI) and who also meet the State’s criteria for requiring an inpatient psychiatric facility level of care pursuant to 42 CFR § 440.160 as confirmed by a qualified licensed mental health practitioner. The purpose of the waiver is to provide a community-based behavioral health alternative for youth with SED/SPMI to receive family-centered individualized services, while identifying and utilizing community resources, natural supports and paid providers. The CMHW allows for more flexibility with the development and implementation of the plan of care and the provision of services allowing for the creation of a strengths-based foundation of natural supports.

Additional CMHW goals are to:

- Prevent parental custody relinquishment of their child in order to access needed mental/behavioral health services;
- Prevent and/or minimize costly institutional services;
- Increase youth and family independence and quality of life through the delivery of outcome-based services;
- Increase the flexibility and individualize service planning and delivery to better meet the needs of the youth and family;
- Encourage relationship-based support network development;
- Offer youth and family assistance with building home and community based supports for transitioning youth home from institutional settings (hospitals, psychiatric residential treatment facilities and centers); and
- Define, measure, trend and monitor clinical and sustainability outcomes for enrolled youth.

### **Organizational Structure:**

The CMHW is administered through the State Medicaid Agency (SMA), within the Wyoming Department of Health, Division of Healthcare Financing. The SMA, under the authority of the CMHW Program Manager, will maintain all processes related to the youth application receipt, processing and eligibility determinations. Once determined eligible for enrollment, the youth will be referred to the prepaid ambulatory health plan (PAHP) contractor. The PAHP contractor will maintain responsibility and authority for provider recruitment, training and credentialing (according to State criteria), and the provider’s Medicaid enrollment. Through contractual relationships with its provider network, the PAHP will review and approve all plans of care, manage provider payments, monitor service quality, utilization and overall clinical improvement for each youth enrolled.

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**Service Delivery:**

Appropriately enrolled Medicaid providers include Family Care Coordinators (FCCs), Family Support Partners (FSPs), Youth Support Partners (YSPs) and Respite providers. These provider types are geographically dispersed in various locations throughout the state to provide non-clinical behavioral health support services to enrolled youth/families. The CMHW Child and Family Team (CFT) may include the youth/family, CMHW high fidelity wraparound (HFWA) providers in addition to other support team members identified by the youth and family for participation in the program (natural supports), local representatives from other child serving agencies (Department of Education, Department of Family Services) and community mental/behavioral health providers. The CFT works collaboratively to ensure that all available community-based services are utilized. CMHW services are not duplicative of other services available to the participant, but rather build on community, agency and home-based individual and/or family therapy provided by local/regional community health centers or privately licensed behavioral health professionals. Waiver services are provided as detailed in the plan of care drafted by the CFT under advisement of the youth/family. Projected service utilization is detailed within the plan, and delivered by qualified and credentialed network providers.

Services provided to enrolled youth by other Wyoming State Agencies (Department of Education, Department of Family Services, or the Juvenile Justice System) will continue to be delivered by those sponsoring agencies. Relevant agency representatives will be included in the CFT as needed.

**Quality Management:**

The SMA, in collaboration with the PAHP contractor, will establish various mechanisms to track the efficiencies and effectiveness of the waiver operations, service delivery, access and provider quality to ensure the program operates in accordance with the stated processes and provisions.

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### 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*):

<input type="radio"/>	The waiver provides for participant direction of services. <i>Appendix E is required.</i>
<input checked="" type="radio"/>	Not applicable. The waiver does not provide for participant direction of services. <i>Appendix E is not completed.</i>

- 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 overall systems improvement 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*):

<input type="radio"/>	Yes
<input type="radio"/>	No
<input checked="" type="radio"/>	Not applicable

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

<input type="radio"/>	<b>Yes</b> ( <i>complete remainder of item</i> )
<input checked="" type="radio"/>	<b>No</b>

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

<input type="checkbox"/>	<b>Geographic Limitation.</b> 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. <i>Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:</i>
<input type="checkbox"/>	<b>Limited Implementation of Participant-Direction.</b> A waiver of statewideness is requested in order to make <i>participant direction of services</i> as specified in <b>Appendix E</b> 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. <i>Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:</i>

## 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**.

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- 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 Improvement Act of 2004 (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) under age 21 when 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 amount, frequency and duration 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

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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 §431.51, 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 throughout the application and in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:

The amended 1915 (c) Children's Mental Health Waiver document was released with a public and Tribal notice announcement on March 6, 2015. Public comments were solicited in writing, in addition to two scheduled conference calls (March 12, 2015 3-4PM and March 20, 2015 4-5PM). All comments provided were reviewed and used to advise the final waiver document as approved by CMS.
- 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

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days before the anticipated submission date as 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:

<b>First Name:</b>	Teri
<b>Last Name</b>	Green
<b>Title:</b>	State Medicaid Agent
<b>Agency:</b>	State Medicaid Agency – Division of Healthcare Financing
<b>Address 1:</b>	6101 Yellowstone Road
<b>Address 2:</b>	Suite 210
<b>City</b>	Cheyenne
<b>State</b>	Wyoming
<b>Zip Code</b>	82002
<b>Telephone:</b>	307-777-7908
<b>E-mail</b>	<a href="mailto:Teri.Green@wyo.gov">Teri.Green@wyo.gov</a>
<b>Fax Number</b>	307-777-6964

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

<b>First Name:</b>	Lisa
<b>Last Name</b>	Brockman
<b>Title:</b>	CMH Waiver Program Manager
<b>Agency:</b>	State Medicaid Agency – Division of Healthcare Financing
<b>Address 1:</b>	6101 Yellowstone Road
<b>Address 2</b>	Suite 210
<b>City</b>	Cheyenne
<b>State</b>	Wyoming
<b>Zip Code</b>	82002
<b>Telephone:</b>	307-777-7326
<b>E-mail</b>	<a href="mailto:Lisa.Brockman@wyo.gov">Lisa.Brockman@wyo.gov</a>
<b>Fax Number</b>	307-777-6964

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## 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:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 State Medicaid Director or Designee

<b>First Name:</b>	Teri
<b>Last Name</b>	Green
<b>Title:</b>	State Medicaid Agent
<b>Agency:</b>	State Medicaid Agency – Division of Healthcare Financing
<b>Address 1:</b>	6101 Yellowstone Road
<b>Address 2:</b>	Suite 210
<b>City</b>	Cheyenne
<b>State</b>	Wyoming
<b>Zip Code</b>	82002
<b>Telephone:</b>	307-777-7908
<b>E-mail</b>	<a href="mailto:Teri.Green@wyo.gov">Teri.Green@wyo.gov</a>
<b>Fax Number</b>	307-777-6964

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## **Attachment #1: Transition Plan**

Specify the transition plan for the waiver:

Summary of Children’s Mental Health Waiver (CMHW) Compliance with the Home and Community Based Services Setting Requirements Adopted by CMS on March 17, 2014:

### **Reason for Compliance Review of HCB Settings**

On March 17, 2014, the Centers for Medicaid and Medicare Services (CMS) promulgated new federal regulations for Home and Community Based (HCB) Waiver Service Settings requirements. The federal regulations are 42 CFR 441.301(c)(4)-(5). CMS posted additional guidance to help states assess compliance and remediate areas that are not fully in compliance. More information on the new rules can be found on the CMS website at [www.medicaid.gov/hcbs](http://www.medicaid.gov/hcbs).

### **Summary of Compliance for CMH Waiver Settings**

- The waiver settings for the Children’s Mental Health Waiver demographics and plans of care were reviewed within the Department of Health.
- All waiver participants live in their family home if they are on the waiver. Provider homes for this waiver are homes where the provider lives with their family.
- This waiver does not have active participants residing in group homes or facilities.
- No services may be offered in congregate facilities.
- Service settings are either based in the provider’s residence, the participant’s residence, or in community locations that are not institutional in nature, such as parks, malls, stores, and other activity centers.
- Therefore, the CMH Waiver settings do not meet the criteria of needing a transition plan.

### **Plan for Monitoring Continued Compliance of HCB Settings**

The Wyoming Department of Health State Medicaid Agency oversees the provider certification processes and ongoing oversight of provider compliance with all state standards. Through annual provider certification visits, ongoing incident and complaint management systems described in Appendix G of the approved waiver, the Department will assess providers for ongoing compliance with the HCB Settings. Certification requirements will be adjusted to ensure service settings for this waiver remain in settings that are not institutional or isolating in nature. Any areas of concern will be addressed through the Department’s corrective action and sanctioning processes pursuant to Chapter 16 of Wyoming Medicaid Rules.

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# 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*):

<input checked="" type="radio"/>	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 ( <i>select one</i> ):	
<input checked="" type="radio"/>	The Medical Assistance Unit ( <i>name of unit</i> ) ( <i>do not complete Item A-2</i> ):	Wyoming Department of Health, Division of Healthcare Financing
<input type="radio"/>	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit ( <i>name of division/unit</i> ). This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency. ( <i>Complete item A-2-a</i> ):	
<input type="radio"/>	The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency. 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. ( <i>Complete item A-2-b</i> ).	

2. **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.

- 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

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requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

**3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency (if applicable) (*select one*):

<input checked="" type="radio"/>	<p><b>Yes.</b> Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. <i>Complete Items A-5 and A-6.</i></p>
<p><b><u>PAHP:</u></b>                  The Wyoming Department of Health (WDH), Division of Healthcare Financing (DHCF), the State appointed entity for administration of Wyoming’s Medicaid program, has procured a statewide PAHP for youth with complex behavioral conditions. The PAHP shall support WDH’s efforts to better serve youth in their homes and communities by providing the necessary services and supports. The PAHP will serve as an entry point for Wyoming’s eligible youth with behavioral health needs so that the youth and their family can achieve the goals of safety, permanency, and well-being in their communities using HFWA.</p> <p>Often times, Medicaid youth with complex behavioral health conditions receive fragmented care due to the involvement of various public and private entities in service delivery, contributing to poor outcomes and unnecessarily high costs. Youth struggle because of gaps in required care coordination, family-disruption, and distant out-of-home placements. National and state spending on youth with complex behavioral health conditions is high. This is partially due to ineffective, uncoordinated, and/or inappropriate service delivery. By focusing on bridging gaps in service delivery and coordinating care, youth with complex behavioral issues will be better served, improving outcomes, while costs may also be reduced. Wyoming is striving to provide youth and their families the services necessary to allow the youth to reside in their community, participate in routine daily activities, and experience long term health and longevity.</p> <p>Medicaid youth with SED/SPMI and youth with a level of care requiring services from an inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160 generally have more frequent emergency room visits, significantly higher utilization of psychotropic drugs at doses that often exceed national parameters, frequent disruption of family and youth resiliency, and higher service costs. With the various parties typically involved with these youth, and the potential of out-of-home placement, the WDH recognizes the need to improve service delivery and increase the coordination of care for youth with SED/SPMI in order to improve health outcomes, decrease</p>	

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recidivism, and contain costs.

Under contract with the DHCF, the PAHP will be responsible for developing and maintaining a provider network appropriate in type and size to support the delivery of HFWA, youth and family training and respite services to all enrolled youth. The PAHP will be responsible for confirming the Medicaid enrollment, monitoring quality and frequency of service delivery and approving all plans of care. The HFWA services will be provided to waiver youth via Medicaid state plan. Respite will be available with some limitations as a 1915 (b)(3) service, and youth and family training will be provided and funded for waiver youth through this amended 1915 (c) waiver.

**MMIS Fiscal Agent:**

The SMA has a contract for the operation and management of the MMIS system to review and pay all claims submitted by the PAHP. This contractor assists the State with provider enrollments (required for all providers contracted in the PAHP provider network) and the execution of provider agreements. The MMIS Fiscal Agent will process the Medicaid provider enrollment applications after the applicable training and credentialing requirements have been met. The MMIS Fiscal Agent will store and retain hard copies of all original provider agreements executed and will be responsible for performing all federally required periodic and ongoing background and database verifications for waiver providers (excludes Central Registry and Federal Bureau of Investigation/Division of Criminal Investigation background checks to be required and monitored by the PAHP contractor).

**Electronic Medicaid Waiver System (EMWS):**

The Behavioral Health Division, in collaboration with the Division of Healthcare Financing, has a contract to manage the EMWS. This system maintains the waiver applicant and eligibility file. This system interfaces with the MMIS system to reconcile program eligibility date spans within the MMIS.

- No.** Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

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**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 (*check each that applies*):

<input type="checkbox"/>	<p><b>Local/Regional non-state public agencies</b> conduct waiver operational and administrative functions at the local or regional level. There is an <b>interagency agreement or memorandum of understanding</b> between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these agencies and complete items A-5 and A-6:</i></p>
<input type="checkbox"/>	<p><b>Local/Regional non-governmental non-state entities</b> conduct waiver operational and administrative functions at the local or regional level. There is a <b>contract</b> 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). <i>Specify the nature of these entities and complete items A-5 and A-6:</i></p>
<input checked="" type="checkbox"/>	<p><b>Not applicable</b> – Local/regional non-state agencies do not perform waiver operational and administrative functions.</p>

**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:

Within the DHCF, under the direction of the CMHW Program Manager, the State will continuously assess the performance of the PAHP, the MMIS contractor and the EMWS contractor via various mechanisms and ongoing communication with other applicable contract managers within the WDH.

**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:

**PAHP:**

The following methodologies have also been detailed in the concurrent 1915 (b) waiver as planned mechanisms for assessing ongoing PAHP and contractor performance:

- Accreditation for non-duplication (Once, upon PAHP procurement and initial contracting);
- Consumer self-report data (Annually);
- Data analysis (non-claims: denials of referral requests, grievance and appeals data) (quarterly);
- Enrollee hotlines (available 24/7);
- Geographic mapping (quarterly);
- Independent assessment (bi-annually for the first two waiver periods);
- Measuring and monitoring disparities by racial or ethnic groups (annually);

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- Network adequacy assurance by plan (quarterly);
- Performance measures (quarterly); and
- Utilization review (annually)

**MMIS:**

The DHCF has a MMIS Contract Manager who assesses the ongoing performance of the MMIS contractor. Performance monitoring metrics detailed in the MMIS contract will be summarized, reported and made available to the CMHW Manager for review.

**EMWS:**

The Behavioral Health Division (BHD), under the authority of the SMA, oversees the contractor responsible for maintaining and supporting the EMWS. The BHD maintains oversight and direction of system enhancements, maintenance, role access, testing, accuracy of data and user training needs. The BHD also oversees the system interfaces between EMWS, the State level provider certification system (IMPROV), and the MMIS.

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**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 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. *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	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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## 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..*

- a.i *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.*

<b>Performance Measure:</b>	Total percentage of policies, procedures, provider manuals, family manuals and handbooks or other PAHP-produced materials that are reviewed and approved by the State prior to distribution (Total # of policies, procedures, provider manuals, family manuals and handbooks reviewed and approved prior to distribution/ Total # of policies, procedures, provider manuals, family manuals and handbooks released).		
<b>Data Source [e.g. – examples cited in IPG]</b>	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
State Agency Program Manager Data Files	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups

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		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

**Add another Data Source for this performance measure**

**Add another Performance measure (button to prompt another performance measure)**

a.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**

b.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 for remediation with contractors:**  
 Include verbal and/or written notification to the contractor detailing any concerns or contract provisions that have not been fulfilled. Communication shall be immediately upon discovery of the issue and additional education may be provided to the contractors as a means of addressing the gap. The initial contract language may also be modified and amended to clarify any State expectations that were not clearly detailed. If the contract performance does not increase, the contract may be terminated or other financial withholds/ penalties assessed.

**Methods for policy remediation – internal:**  
 Feedback may be provided from the Senior Leadership/ State Medicaid Agent regarding the contractor or contract manager performance and/or progress toward meeting the clearly defined performance

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expectations related to the operation of the waiver. If that communication is not successful in resolving the concern, the State Medicaid Agent can present program concerns and issues at the Senior Leadership meetings or in a more casual follow-up with the internal contract managers.

**b.ii Remediation Data Aggregation**

<b>Remediation-related Data Aggregation and Analysis (including trend identification)</b>	<b>Responsible Party (check each that applies)</b>	<b>Frequency of data aggregation and analysis: (check each that applies)</b>
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> 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 Administrative Authority that are currently non-operational.*

<input type="radio"/>	<b>Yes</b> (complete remainder of item)
<input checked="" type="radio"/>	<b>No</b>

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

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# Appendix B: Participant Access and Eligibility

## Appendix 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. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup 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:*

SELECT ONE WAIVER TARGET GROUP	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	NO MAXIMUM AGE LIMIT
<input type="radio"/>	<b>Aged or Disabled, or Both</b> ( <i>select one</i> )			
<input type="radio"/>	<b>Aged or Disabled or Both – General</b> ( <i>check each that applies</i> )			
	<input type="checkbox"/> Aged (age 65 and older)			<input type="checkbox"/>
	<input type="checkbox"/> Disabled (Physical) (under age 65)			
	<input type="checkbox"/> Disabled (Other) (under age 65)			
<input type="radio"/>	<b>Specific Recognized Subgroups</b> ( <i>check each that applies</i> )			
	<input type="checkbox"/> Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/> HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/> Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/> Technology Dependent			<input type="checkbox"/>
<input type="radio"/>	<b>Mental Retardation or Developmental Disability, or Both</b> ( <i>check each that applies</i> )			
	<input type="checkbox"/> Autism			<input type="checkbox"/>
	<input type="checkbox"/> Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/> Mental Retardation			<input type="checkbox"/>
<input checked="" type="radio"/>	<b>Mental Illness</b> ( <i>check each that applies</i> )			
	<input checked="" type="checkbox"/> Mental Illness (age 18 and older)	18	21	<input type="checkbox"/>
	<input checked="" type="checkbox"/> Mental Illness (under age 18)	4	17	

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

**Targeting Criteria - Initial:**

- Medicaid youth ages 4-21 at risk of out-of-home placement (defined and identified as youth with two hundred (200) days or more of behavioral health services within one State fiscal year);or
- Medicaid youth ages 4-21 who currently meet Psychiatric Residential Treatment Facility (PRTF) level of care or are placed in a PRTF; or
- Medicaid youth ages 4-21 who currently meet acute psychiatric stabilization hospital level of care; had an acute hospital stay for mental or behavioral health conditions in the last 365 days; or are currently placed in an acute hospital stay for mental or behavioral health conditions; or
- Medicaid youth ages 4-21 referred to the PAHP (who meet defined eligibility, including clinical eligibility and SED/SPMI criteria).

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**Medical Eligibility Criteria – as a condition for enrollment after initial targeting criteria is met:**

- Youth ages 6 - 21 must have a minimum Child and Adolescent Service Intensity Instrument (CASII) composite score of twenty (20), and youth ages 4 & 5 must have an Early Childhood Service Intensity Instrument (ECSII) score of eighteen (18) to thirty (30) OR the appropriate social and emotional assessment information provided to illustrate level of service need; and
- Must have a DSM Axis 1 or ICD diagnosis that meets the State’s diagnostic criteria.

**Excluded Populations:**

- Youth residing in a Nursing Facility or ICF/MR;
- Youth enrolled in another managed care program;
- Youth enrolled in or a waitlist recipient for another HCBS waiver, specifically those waivers listed below:
  - Children’s Developmental Disability Waiver – WY Waiver 0253
  - Acquired Brain Injury (ABI) – WY Waiver #0370
  - Developmental Disability Supports Waiver – WY Waiver # 1060
  - Developmental Disability Comprehensive Waiver – WY Waiver # 1061
  - Long Term Care Waiver – WY Waiver # 0236
  - Assisted Living Facility Waiver – WY Waiver #0369
- SCHIP Title XXI Children;
- Retroactive Eligibility (Medicaid beneficiaries for the period of retroactive eligibility);
- Any youth, who during enrollment or participation in the waiver, is determined eligible for any other excluded population (i.e. waiver listed above, nursing facility, or ICF/MR); or
- Other: Any other youth, upon application, whose primary need is determined to be for services that are more habilitative in nature vs. the intensive rehabilitative nature of HFWA services. This need will be determined by a level of co-occurrence indicated as “4” or “5” in Dimension III on the CASII or a rating of “4” or “5” on the ECSII assessment, section IV.

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*):

<input type="radio"/>	Not applicable – There is no maximum age limit
<input checked="" type="radio"/>	The following transition planning procedures are employed for participants who will reach the waiver’s maximum age limit ( <i>specify</i> ):  Enrolled youth are no longer eligible for services when they reach the end of the month of their twenty-first (21st) birthday. However, all plans of care must begin the development of a plan objective(s) for the transition goals. Objectives must be measurable and contain specific action steps the team will follow to support the youth and family during their transition off the waiver. The team’s goal will be to identify and secure as many community based resources as available to promote independence and self-reliance for the youth and his/her family. This strategy may include the identification, referral to and inclusion of public and private sector programming options. For older youth, the CFT may include the participation of an adult mental health care manager who can assist with the transition as well. The individual plan of care will specify time frames and milestones for establishing transition links, and appropriately document program referrals.

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## Appendix B-2: Individual Cost Limit

- 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:

<input type="radio"/>	<b>No Cost Limit.</b> The State does not apply an individual cost limit. <i>Do not complete Item B-2-b or Item B-2-c.</i>	
<input type="radio"/>	<b>Cost Limit in Excess of Institutional Costs.</b> 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. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the State is ( <i>select one</i> ):	
<input type="radio"/>		%, a level higher than 100% of the institutional average
<input type="radio"/>	Other ( <i>specify</i> ):	
<input type="radio"/>	<b>Institutional Cost Limit.</b> 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. <i>Complete Items B-2-b and B-2-c.</i>	
<input checked="" type="radio"/>	<b>Cost Limit Lower Than Institutional Costs.</b> 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. <i>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.</i>	
	<p>The current cost limit was established based on an analysis of the historical costs for the waiver services and supports for the CMHW participants enrolled during state fiscal year (SFY) 2013 who live in the family home. The availability of other services and supports (e.g., family caregivers, Medicaid State Plan services, public education) for the CMHW population and information on the utilization of these other services and supports contribute to the basis of this cost limit.</p> <p>The budget limit for a six month period for a participant is \$1,137.84.</p>	
	The cost limit specified by the State is ( <i>select one</i> ):	
<input checked="" type="radio"/>	The following dollar amount: \$	\$1,137.84/6 month plan
	The dollar amount ( <i>select one</i> ):	
<input type="radio"/>	Is adjusted each year that the waiver is in effect by applying the following formula:	

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<input checked="" type="radio"/>	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.
<input type="radio"/>	The following percentage that is less than 100% of the institutional average: <input type="text"/> %
<input type="radio"/>	Other – <i>Specify</i> : <input type="text"/>

- 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:

Prior to waiver entrance, each individual receives a level of care (LOC) assessment and CASII/ECSII. The results reported to the State for the LOC and CASII/ECSII must meet specific qualifying criteria as detailed in this waiver amendment. The youth’s team reviews the preliminary plan of care to ensure that the individual’s health and welfare can be assured within the cost limit for the CMHW. If assessed needs exceed the cost limit for the CMHW, the state will refer the youth to another waiver or Medicaid program with a higher or unlimited cost limit for which they may be eligible. Any individual denied entrance in to the waiver is offered the opportunity to request a fair hearing, as provided in Appendix F-1. Based on careful analysis of service utilization and projected enrollment, \$1,137.84 every six (6) months is sufficient to meet the youth’s needs.

FCCs accept youth participants and acknowledge the CMHW is a short term intensive targeted intervention program. Because there is only one paid waiver service, FCCs are adept in pulling together available community resources to more effectively utilize available funding. This mechanism then begins building long term sustainability for the youth without reliance on CMHW service funding.

- 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*):

<input checked="" type="checkbox"/>	The participant is referred to another waiver that can accommodate the individual’s needs.
<input type="checkbox"/>	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: <input type="text"/>
<input type="checkbox"/>	Other safeguard(s) ( <i>specify</i> ): <input type="text"/>

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## Appendix B-3: Number of Individuals Served

- 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:

<b>Table B-3-a</b>	
Waiver Year	Unduplicated Number of Participants
Year 1	135
Year 2	135
Year 3	135
Year 4 (renewal only)	135
Year 5 (renewal only)	135

- 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*):

<input type="radio"/>	The State does not limit the number of participants that it serves at any point in time during a waiver year.
<input checked="" type="radio"/>	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:

<b>Table B-3-b</b>	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	75
Year 2	75
Year 3	75
Year 4 (renewal only)	75
Year 5 (renewal only)	75

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- 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*):

○	<b>Not applicable.</b> The state does not reserve capacity.	
⊙	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:	
	<b><u>Transition Due to Loss of State Plan Medicaid Eligibility:</u></b> The amended CMHW is one of two eligibility doors for youth enrollment and participation in HFWA services via Medicaid state plan. Through the 1915 (b) state plan population, when a youth loses Medicaid eligibility for any reason (family over income, etc.), the youth is no longer eligible for state plan services. Due to the nature of the service delivery and coordination, the State will reserve five (5) waiver funding opportunities per year for Medicaid state plan youth enrolled in the HFWA program who lose Medicaid eligibility to assist with the transition off or completion of their HFWA plan of care.	
	<b><u>Crisis:</u></b> The State will reserve five (5) CMHW funding opportunities to triage financially and clinically qualified youth with a CASII composite score of 25 or higher or an ECSII composite score of 23 or higher. Immediate service initiation will be used to prevent or divert the youth from being admitted to an inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160.	
	The capacity that the State reserves in each waiver year is specified in the following table:	
	<b>Table B-3-c</b>	
	Purpose:	Purpose:
	Loss of State Plan Medicaid Eligibility: Transition assistance and/or program completion for state plan youth who lose Medicaid eligibility at some point during their plan of care cycle	Crisis: To triage any financially and clinically qualified youth with a CASII composite score of 25 or higher or an ECSII composite score of 23 or higher. Immediate service initiation will be used to prevent or divert the youth from being admitted to an inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160.
Waiver Year	Capacity Reserved	Capacity Reserved
Year 1	5	5
Year 2	5	5
Year 3	5	5
Year 4 (renewal only)	5	5
Year 5 (renewal only)	5	5

- 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*):

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<input checked="" type="radio"/>	The waiver is not subject to a phase-in or a phase-out schedule.
<input type="radio"/>	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 <i>intra-year</i> limitation on the number of participants who are served in the waiver.

e. **Allocation of Waiver Capacity.** *Select one:*

<input checked="" type="radio"/>	Waiver capacity is allocated/managed on a statewide basis.
<input type="radio"/>	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:

The CMHW program requires an application, level of care attestation, and CASII/ECSII assessment in order for the appropriate clinical eligibility determination to be made. A complete application contains all pertinent demographic and identifying information, including the level of care determination as recommended by a qualified licensed mental health professional. The CASII/ECSII assessments are completed by a certified evaluator.

If the application is incomplete, the available information is uploaded and entered in to the EMWS and a letter is drafted and sent via certified mail to the legal guardian with a description of the missing application material. If no response is received within thirty (30) calendar days, the application is closed.

If the applicant is determined ineligible, the documentation is uploaded and entered in to EMWS. The “Application Notice of Action” letter is generated and sent via certified mail to the legal guardian. If the legal guardian does not agree with the determination, they are able to following the instructions provided in requesting an informal dispute resolution and/or an administrative hearing.

If the applicant meets the clinical criteria for the CMHW, the information is uploaded and entered in to the EMWS and a letter is sent via certified mail detailing the process for completing the application for determination of financial eligibility. Once the financial eligibility status has been determined, the information is available to CMHW program staff in two ways. If, because of the youth’s financial resources there is an ineligible determination rendered, a letter is generated and sent via certified mail to the legal guardian by Medicaid LTC Eligibility Unit. However, if the youth is identified to be financially eligible, a letter is generated and sent via certified mail notifying the legal guardian of either the assignment to the wait list or notification of a funding opportunity.

When a waiver opening becomes available, the status of the wait list is updated by the CMH Waiver Program Manager. The applicants will be listed in two wait lists – the first prioritized by combined CASII/ECSII scores from highest to lowest and the second list prioritized by the overall length of time spent on the wait list.

When there is an available funding opportunity, eligible wait list applicants will be funded alternately between:

1. The eligible wait list applicant having the highest score based on the criteria below; then
2. The eligible wait list applicant waiting the longest on the list, based upon the Medicaid financial

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eligibility determination date.

Applicants are scored and ranked on the wait list using the following criteria:

1. The higher level of care criteria score as identified through the following items:

- Eligibility qualification acuity (CASII/ECSII score);
- Threat for custody relinquishment – being denied care because of custody status, CHINS petition is being recommended or considered, or DFS is involved (counts as one point); or
- Threat to home/school situation – expulsion and/or placement from school or homelessness (counts as one point).

Reapplication is an option at any time.

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## Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. a-1. **State Classification.** The State is a (*select one*):

<input checked="" type="radio"/>	§1634 State
<input type="radio"/>	SSI Criteria State
<input type="radio"/>	209(b) State

a-2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State.

<input checked="" type="radio"/>	Yes
<input type="radio"/>	No

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:*

<b><i>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</i></b>	
<input checked="" type="checkbox"/>	Low income families with children as provided in §1931 of the Act
<input checked="" type="checkbox"/>	SSI recipients
<input type="checkbox"/>	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
<input type="checkbox"/>	Optional State supplement recipients
<input type="checkbox"/>	Optional categorically needy aged and/or disabled individuals who have income at: ( <i>select one</i> )
<input type="radio"/>	100% of the Federal poverty level (FPL)
<input type="radio"/>	% of FPL, which is lower than 100% of FPL
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
<input checked="" type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
<input type="checkbox"/>	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)
<input type="checkbox"/>	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)
<input type="checkbox"/>	Medically needy in 209(b) States (42 CFR §435.330)
<input type="checkbox"/>	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
<input checked="" type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> : <ul style="list-style-type: none"> <li>• Poverty Level Children: 42 C.F.R. 435.118</li> <li>• Foster Care Children: 42 CFR, 435.145; 1902(a)(10)(A)(ii)(VIII); Title IV-E of the Social Security Act; and 42 CFR 435.222</li> </ul>

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<b>Special home and community-based waiver group under 42 CFR §435.217</b> Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed	
<input type="radio"/>	<b>No.</b> 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.
<input checked="" type="radio"/>	<b>Yes.</b> The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. <i>Select one and complete Appendix B-5.</i>
<input type="radio"/>	All individuals in the special home and community-based waiver group under 42 CFR §435.217
<input checked="" type="radio"/>	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/>	A special income level equal to (select one):
<input checked="" type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)
<input type="radio"/>	% of FBR, which is lower than 300% (42 CFR §435.236)
<input type="radio"/>	\$ which is lower than 300%
<input type="checkbox"/>	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
<input type="checkbox"/>	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
<input type="checkbox"/>	Medically needy without spend down in 209(b) States (42 CFR §435.330)
<input type="checkbox"/>	Aged and disabled individuals who have income at: ( <i>select one</i> )
<input type="radio"/>	100% of FPL
<input type="radio"/>	% of FPL, which is lower than 100%
<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> :

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## Appendix B-5: Post-Eligibility Treatment of Income

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):

<input checked="" type="radio"/>		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):
	<input type="radio"/>	Use <i>spousal</i> post-eligibility rules under §1924 of the Act. Complete Items B-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) <u>and</u> Item B-5-d.
	<input checked="" type="radio"/>	Use <i>regular</i> post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (Complete Item B-5-b-1) or under §435.735 (209b State) (Complete Item B-5-c-1). Do not complete Item B-5-d.
	<input type="radio"/>	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-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.

**NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.**

**b-1. Regular Post-Eligibility Treatment of Income: SSI State and §1634 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:

<b>i. Allowance for the needs of the waiver participant</b> (select one):		
<input checked="" type="radio"/>		The following standard included under the State plan (select one)
	<input checked="" type="radio"/>	SSI standard
	<input type="radio"/>	Optional State supplement standard
	<input type="radio"/>	Medically needy income standard
	<input type="radio"/>	The special income level for institutionalized persons (select one):
	<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)
	<input type="radio"/>	% of the FBR, which is less than 300%
	<input type="radio"/>	\$ which is less than 300%.
	<input type="radio"/>	% of the Federal poverty level
	<input type="radio"/>	Other standard included under the State Plan (specify):

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<input type="radio"/>	The following dollar amount: \$	If this amount changes, this item will be revised.
<input checked="" type="radio"/>	The following formula is used to determine the needs allowance: 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.	
<input type="radio"/>	Other (specify):	
<b>ii. Allowance for the spouse only (select one):</b>		
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: \$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input checked="" type="radio"/>	Not applicable (see instructions)	
<b>iii. Allowance for the family (select one):</b>		
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following 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.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Other (specify):	
<input checked="" type="radio"/>	Not applicable (see instructions)	
<b>iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:</b>		
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. <i>Select one:</i>		
<input checked="" type="radio"/>	Not applicable (see instructions) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.</i>	
<input type="radio"/>	The State does not establish reasonable limits.	
<input type="radio"/>	The State establishes the following reasonable limits (specify):	

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**c-1. Regular Post-Eligibility: 209(b) State.** The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant’s income:

<b>i. Allowance for the needs of the waiver participant</b> ( <i>select one</i> ):			
<input type="radio"/>	The following standard included under the State plan ( <i>select one</i> )		
<input type="radio"/>	The following standard under 42 CFR §435.121:		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons ( <i>select one</i> )		
<input type="radio"/>	<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	<input type="radio"/>	%	of the FBR, which is less than 300%
<input type="radio"/>	<input type="radio"/>	\$	which is less than 300% of the FBR
<input type="radio"/>	<input type="radio"/>	%	of the Federal poverty level
<input type="radio"/>	Other standard included under the State Plan (specify):		
<input type="radio"/>	The following dollar amount: \$		
			If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:		
<input type="radio"/>	Other (specify)		
<b>ii. Allowance for the spouse only</b> ( <i>select one</i> ):			
<input type="radio"/>	The following standard under 42 CFR §435.121		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount: \$		
			If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Not applicable ( <i>see instructions</i> )		
<b>iii. Allowance for the family</b> ( <i>select one</i> ):			

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<input type="radio"/>	AFDC need standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ <input type="text"/> 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.
<input type="radio"/>	The amount is determined using the following formula: <input type="text"/>
<input type="radio"/>	Other (specify): <input type="text"/>
<input type="radio"/>	Not applicable ( <i>see instructions</i> )
<b>iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:</b>	
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. <i>Select one:</i>	
<input type="radio"/>	Not applicable ( <i>see instructions</i> ) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.</i>
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits ( <i>specify</i> ): <input type="text"/>

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**NOTE: Items B-5-b-2 and B-5-c-2 are for use by states that use spousal impoverishment eligibility rules and elect to apply the spousal post eligibility rules.**

**b-2. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state.** The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. 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:

<b>i. Allowance for the needs of the waiver participant</b> (select one):		
<input type="radio"/>	The following standard included under the State plan (select one)	
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The special income level for institutionalized persons (select one):	
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	%	of the FBR, which is less than 300%
<input type="radio"/>	\$	which is less than 300%.
<input type="radio"/>	%	of the Federal poverty level
<input type="radio"/>	Other standard included under the State Plan (specify):	
<input type="radio"/>		
<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:	
<input type="radio"/>		
<input type="radio"/>	Other (specify):	
<input type="radio"/>		
<b>ii. Allowance for the spouse only</b> (select one):		
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:	
<input type="radio"/>		
<input type="radio"/>	Specify the amount of the allowance:	
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>		

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<input type="radio"/>	Not applicable ( <i>see instructions</i> )
<b>iii. Allowance for the family</b> ( <i>select one</i> ):	
<input type="radio"/>	AFDC need standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ <input type="text"/> 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.
<input type="radio"/>	The amount is determined using the following formula: <input type="text"/>
<input type="radio"/>	Other ( <i>specify</i> ): <input type="text"/>
<input type="radio"/>	Not applicable ( <i>see instructions</i> )
<b>iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:</b>	
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. <i>Select one:</i>	
<input type="radio"/>	Not applicable ( <i>see instructions</i> ) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.</i>
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits ( <i>specify</i> ): <input type="text"/>

**c-2. Regular Post-Eligibility: 209(b) State.** The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

<b>i. Allowance for the needs of the waiver participant</b> ( <i>select one</i> ):	
<input type="radio"/>	The following standard included under the State plan ( <i>select one</i> )
<input type="radio"/>	The following standard under 42 CFR §435.121: <input type="text"/>
<input type="radio"/>	Optional State supplement standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The special income level for institutionalized persons ( <i>select one</i> )
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)

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<input type="radio"/>	%	of the FBR, which is less than 300%
<input type="radio"/>	\$	which is less than 300% of the FBR
<input type="radio"/>	%	of the Federal poverty level
<input type="radio"/>	Other standard included under the State Plan (specify):	
<input type="radio"/>	The following dollar amount: \$ If this amount changes, this item will be revised.	
<input type="radio"/>	The following formula is used to determine the needs allowance:	
<input type="radio"/>	Other (specify):	
<b>ii. Allowance for the spouse only (select one):</b>		
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:	
	Specify the amount of the allowance:	
<input type="radio"/>	The following standard under 42 CFR §435.121:	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Not applicable (see instructions)	
<b>iii. Allowance for the family (select one)</b>		
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following 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.	
<input type="radio"/>	The amount is determined using the following formula:	

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<input type="radio"/>	Other (specify):
<input type="radio"/>	Not applicable ( <i>see instructions</i> )
<b>iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:</b>	
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. <i>Select one:</i>	
<input type="radio"/>	Not applicable ( <i>see instructions</i> ) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.</i>
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits ( <i>specify</i> ):

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**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).

<b>i. Allowance for the personal needs of the waiver participant</b> ( <i>select one</i> ):		
<input type="radio"/>	SSI Standard	
<input type="radio"/>	Optional State Supplement standard	
<input type="radio"/>	Medically Needy Income Standard	
<input type="radio"/>	The special income level for institutionalized persons	
<input type="radio"/>	%	of the Federal Poverty Level
<input type="radio"/>	The following dollar amount: \$	If this amount changes, this item will be revised
<input type="radio"/>	The following formula is used to determine the needs allowance:	
<input type="radio"/>	Other ( <i>specify</i> ):	
<b>ii.</b> If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. <i>Select one</i> :		
<input type="radio"/>	Allowance is the same	
<input type="radio"/>	Allowance is different. Explanation of difference:	
<b>iii.</b> Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:		
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. <i>Select one</i> :		
<input type="radio"/>	Not applicable ( <i>see instructions</i> ) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.</i>	
<input type="radio"/>	The State does not establish reasonable limits.	
<input type="radio"/>	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.	

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## Appendix 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 waiver services:

<b>i.</b>	<b>Minimum number of services.</b>	The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is ( <i>insert number</i> ):
	1	
<b>ii.</b>	<b>Frequency of services.</b>	The State requires ( <i>select one</i> ):
	<input type="radio"/>	The provision of waiver services at least monthly
	<input checked="" type="radio"/>	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:
		Waiver services will be furnished at least once per quarter, but progress notes included in the plan of care must detail progress toward meeting objectives, identified challenges and strengths and changes recorded in the CANS or other evaluation/assessment scores as the youth and family progress.

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

<input type="radio"/>	Directly by the Medicaid agency
<input type="radio"/>	By the operating agency specified in Appendix A
<input type="radio"/>	By an entity under contract with the Medicaid agency. <i>Specify the entity</i> :
<input checked="" type="radio"/>	Other ( <i>specify</i> ):
	Ongoing level of care re-evaluations will be performed by qualified licensed mental health professionals enrolled as Medicaid providers. The outpatient visit resulting in the completed level of care assessment will be billed to Medicaid via the standard claims submission process and will be paid via established fee for service methodology detailed in state plan.

- 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:

A qualified licensed mental health professional is required to evaluate, provide diagnosis and clinical assessment status information along with a signature and date/time. The level of care evaluation is required annually for all waiver enrollees.

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A qualified licensed mental health professional must be a licensed professional practicing in the human services field who is trained and experienced in providing psychiatric, psychological, or lower level mental/behavioral health services to children who have a mental illness. To qualify as a qualified licensed mental health professional in Wyoming, and to perform level of care assessments for the CMHW, the individual must have clinical experience and must either:

- Be a doctor of medicine or osteopathy licensed to practice in Wyoming;
- Have a doctorate or master's degree in psychology from an accredited college or university with at least one year of clinical experience with children or adolescents;
- Have a social work bachelor's or master's degree from an accredited college or university with at least one year of documented clinical experience with children or adolescents;
- Be a registered nurse with at least one year of clinical experience with children and adolescents; or
- Be a licensed mental health professional.

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- 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.

There are two clinical evaluations used collaboratively to determine the applicant's/enrollee's level of care need. Both assessments must be completed in order to determine clinical eligibility for the waiver program.

The first is a Level of Care clinical assessment completed by a qualified licensed mental health professional detailing the following information:

- Primary Diagnosis;
- Assessment of whether or not the applicant/enrollee meets the federal SED/SPMI criterion;
- Assessment as to the ability for the applicant/enrollee to be safely served in the community;
- Assessment of threats related to custody relinquishment, school expulsion or homelessness; and
- Assessment as to whether or not the applicant/enrollee meets at least one Medicaid Criteria for needing or being at risk of needing (within one month) services rendered in an inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160.

The second clinical assessment is completed by a state certified evaluator using either the American Academy of Child and Adolescent Psychiatrists' (AACAP) Early Childhood Service Intensity Instrument (ECSII) or the Child and Adolescent Service Intensity Instrument (CASII) dependent on the applicant's age. Successful completion of this tool by the state certified evaluator will provide the following information on the applicant and the applicant's family, environment and overall risk of institutionalization:

- Risk of Harm;
- Functional Status;
- Co-Occurrence of Conditions: Developmental, Medical, Substance Use and Psychiatric;
- Recovery Environment
  - Environmental Stress
  - Environmental Support
- Resiliency and/or Response to Services
- Involvement in Services
  - Child/Adolescent
  - Parent and/or Primary Caretaker

Annual Re-Evaluation:

Both the LOC and CASII/ECSII must be completed annually for all waiver-enrolled youth.

- 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*):

<input type="radio"/>	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
<input checked="" type="radio"/>	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

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evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The CMHW program relies on the information collected in the LOC assessment and the CASII/ECSII to render initial and ongoing eligibility determinations.

The current State criteria utilized for confirmation of medical necessity for an acute psychiatric or residential placement follow guidance provided in 42CFR441.152 and include the following:

- Ambulatory care resources available in the community do not meet the treatment needs of the recipient;
- Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
- The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

**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:

Initial Evaluation:

As the family prepares the application for CMHW services, a state certified CASII/ECSII evaluator is selected. The CASII/ECSII assists with identifying and detailing the applicant's level of service need. Qualifying criteria for waiver eligibility requires a minimum ECSII score of 18 and a minimum CASII score of 20. The cost of the evaluation is covered by the Medicaid program.

The Level of Care evaluation/assessment details the information required for the State program manager to determine clinical eligibility for participation. Factors reviewed include:

- Primary Diagnosis;
- Assessment of whether or not the applicant/enrollee meets the federal SED/SPMI criterion;
- Assessment as to the ability for the applicant/enrollee to be safely served in the community;
- Assessment of threats related to custody relinquishment, school expulsion or homelessness; and
- Assessment as to whether or not the applicant/enrollee meets at least one Medicaid Criteria for needing or being at risk of needing (within one month) services rendered in an inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160.

For confirmation of eligibility, the LOC evaluations/assessment must confirm the following:

- An Axis 1 primary diagnosis;
- Confirmation that the applicant meets the federal definition of a youth with SED;
- Confirmation that the youth can safely be served in the community;
- Full disclosure of threats related to custody relinquishment, school expulsion or homelessness; and
- Confirmation that the applicant/enrollee meets at least one Medicaid Criteria for needing or being at risk of needing (within one month) services rendered in an inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160.

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Re-Evaluation:

The CASII/ECSII and LOC evaluation/assessments are both to be completed upon initial application and annually thereafter prior to the plan of care development and approval. Ongoing eligibility determinations will be made using the same criteria as that detailed for the initial assessment. The annual re-evaluation schedule continues for the duration of the enrollee’s participation in waiver services.

- 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*):

<input type="radio"/>	Every three months
<input type="radio"/>	Every six months
<input checked="" type="radio"/>	Every twelve months
<input type="radio"/>	Other schedule ( <i>specify</i> ):

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

<input checked="" type="radio"/>	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
<input type="radio"/>	The qualifications are different. The qualifications of individuals who perform reevaluations are ( <i>specify</i> ):

- 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*):

The Family Care Coordinator (FCC), and ultimately the PAHP contractor, is responsible for ensuring the annual re-evaluations occur before the expiration of the previous evaluations/assessments. Details of the State’s expectations for continued annual renewals will be outlined in the contract executed between the State of Wyoming, DHCF and the PAHP.

- 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:

All original evaluations and re-evaluation documents are maintained by the DHCF (initial application documents), youth/family, the FCC, as well as being electronically uploaded and attached to the enrollee/youth’s plan of care. The electronic plans of care are supported by a proprietary software database implemented and utilized by the PAHP contractor. Records are retained for a period of no less than six (6) years after the end of the waiver plan year during which the evaluation was performed. Should the State, at any time, re-procure the PAHP contractor, all existing records will be retained and archived by the State for the period of time described above.

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## 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**

**a.i.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.**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-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.

<b>Performance Measure:</b>	The percent of all CMHW enrollees have a documented level of care satisfying state criterion for participation in the waiver program. (total # of enrollees with a documented level of care satisfying state criterion for participation in the waiver program/ total # of enrollees)		
<b>Data Source [e.g. – examples cited in IPG]]</b>	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
EMWS	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	

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	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

**Add another Data Source for this performance measure**

**Add another Performance measure (button to prompt another performance measure)**

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

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-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.

<b>Performance Measure:</b>	The percent of all annual re-evaluations are conducted on or prior to the expiration of previous evaluations/assessments (total # of re-evaluations conducted on or prior to the expiration of the previous evaluations/assessment/ total # of re-evaluations conducted).		
<b>Data Source [e.g. – examples cited in IPG]</b>	<b>Responsible Party for data collection/generation (check each that applies)</b>	<b>Frequency of data collection/generation: (check each that applies)</b>	<b>Sampling Approach (check each that applies)</b>
PAHP Contractor Provider Data Files	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe

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<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

**Add another Data Source for this performance measure**

**Add another Performance measure (button to prompt another performance measure)**

**a.i.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.**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-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.

<b>Performance Measure:</b>	The percent of CASII/ECSII and LOC evaluations that are completed by a qualified evaluator/ QMHP (total # of CASII/ECSII and LOC evaluations completed by a qualified evaluator/ QMHP/ total # of CASII/ECSII and LOC evaluations completed).		
<b>Data Source [e.g. – examples cited in IPG]</b>	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
Initial Evaluations: EMWS Re-Evaluations: PAHP Contractor Provider Data Files	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

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	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =5%
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

**Add another Data Source for this performance measure**

<b>Performance Measure:</b>	The percent of CASII/ECSII evaluations that are completed in accordance with AACAP guidelines and standards (total # of CASII/ECSII evaluations completed in accordance with AACAP guidelines and standards/ total # of CASII/ECSII evaluations completed).		
<b>Data Source</b> [e.g. – examples cited in IPG]	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
Initial: EMWS Re-Evaluations: PAHP Contractor Provider Data Files	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =5%
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups

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		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<i>Data Aggregation and Analysis</i>	<i>Responsible Party for data aggregation and analysis (check each that applies)</i>	<i>Frequency of data aggregation and analysis: (check each that applies)</i>	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

**Add another Performance measure (button to prompt another performance measure)**

*a.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.*

All initial LOC and CASII/ECSII evaluations received for the purpose of youth application and clinical eligibility determinations for participation in the waiver program will be reviewed (100%) by State program staff.

All recurring LOC and CASII/ECSII evaluations will be reviewed (100%) by the PAHP contractor upon renewal or reauthorization of the existing care plan. Issues or trends identified by the PAHP contract will be immediately reported to the State program staff/ contract manager.

**b. Methods for Remediation/Fixing Individual Problems**

*b.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.*

Any issues or trends identified will result in the development or clarification/revision of existing policy and training materials or may result in waiver provider sanctions (to include certification holds or non-renewals imposed first by the PAHP and then by the State due to continued non-compliance). Referrals will be made to the State Program Integrity Unit for additional research and evaluation. Providers will be handled according to all existing Medicaid Provider Agreement regulations and requirements – up to

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and including payment withholds, recoveries, and enrollment suspensions.

**b.ii Remediation Data Aggregation**

<b>Remediation-related Data Aggregation and Analysis (including trend identification)</b>	<b>Responsible Party (check each that applies)</b>	<b>Frequency of data aggregation and analysis: (check each that applies)</b>
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> 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 Level of Care that are currently non-operational.

<input type="radio"/>	<b>Yes</b> (complete remainder of item)
<input checked="" type="radio"/>	<b>No</b>

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

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## Appendix 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).

To inform individuals of service options under the CHMW a brochure/handbook (developed by the PAHP contractor and approved by the State) outlining the waiver program and available services is part of the waiver application packet.

Following acceptance of the application for waiver services and the completion of the clinical and financial eligibility review, program staff is responsible for informing the youth/family of services available through the waiver program prior to their decision to accept or decline enrollment in the program. It is also explained to the youth/family that they are free to choose whatever available service option they wish (home and community-based waiver services or inpatient hospitalization).

The family is informed of their choice through three written methods of communication:

- 1) The youth/family is informed in the Funding Opportunity letter that is generated and sent certified mail;
- 2) The youth/family receive a current HFWA Family Manual (produced by the PAHP and approved by the State); and
- 3) The third mechanism of notification is the Freedom of Choice statement which is completed and signed by the youth/family indicating their decision to choose HFWA and appropriate providers of their choosing, so long as the providers are in the PAHP network.

- 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.

Freedom of Choice forms are maintained by the FCC and the State Program Manager for a period of no less than six (6) years after the end of the waiver plan year when the Freedom of Choice Forms were executed.

The form is also retained electronically in the EMWS as part of the applicant’s eligibility file. The form is kept for six (6) years, and is only archived electronically when the participant is no longer on the waiver.

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## Appendix B-8: Access to Services by Limited English Proficient 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 provision of access to waiver program information and services for people with limited English proficiency focuses specifically on targeting the program’s general information, the application process and on-going assistance to support full participation in the waiver program.

As detailed in the concurrent 1915 (b) waiver, the State will require the PAHP contractor to develop and print all program informational handbooks in English as well as any additional language spoken by approximately 4.0% or more of the potential enrollee/ enrollee population. For any language services required that are not encompassed in this 4.0% language prevalence metric, the State currently holds a contract with Passport to Languages through whom written translation and oral interpretation services are available to all Medicaid clients (including waiver clients), upon request.

Participants are informed in the waiver handbook that they may request translation services.

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# Appendix C: Participant Services

## Appendix C-1: Summary of Services Covered

- a. **Waiver Services Summary.** Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *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:*

<b>Statutory Services</b> (check each that applies)		
Service	Included	Alternate Service Title (if any)
Case Management	<input type="checkbox"/>	
Homemaker	<input type="checkbox"/>	
Home Health Aide	<input type="checkbox"/>	
Personal Care	<input type="checkbox"/>	
Adult Day Health	<input type="checkbox"/>	
Habilitation	<input type="checkbox"/>	
Residential Habilitation	<input type="checkbox"/>	
Day Habilitation	<input type="checkbox"/>	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	<input type="checkbox"/>	
Supported Employment	<input type="checkbox"/>	
Education	<input type="checkbox"/>	
Respite	<input type="checkbox"/>	
Day Treatment	<input type="checkbox"/>	
Partial Hospitalization	<input type="checkbox"/>	
Psychosocial Rehabilitation	<input type="checkbox"/>	
Clinic Services	<input type="checkbox"/>	
Live-in Caregiver (42 CFR §441.303(f)(8))	<input type="checkbox"/>	
<b>Other Services</b> (select one)		
<input type="radio"/>	Not applicable	
<input checked="" type="radio"/>	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute (list each service by title):	
a.	Youth and Family Training and Support	
<b>Extended State Plan Services</b> (select one)		
<input checked="" type="radio"/>	Not applicable	

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<input type="radio"/>	The following extended State plan services are provided ( <i>list each extended State plan service by service title</i> ):	
a.		
b.		
c.		
<b>Supports for Participant Direction</b> ( <i>check each that applies</i> )		
<input type="checkbox"/>	The waiver provides for participant direction of services as specified in Appendix E. The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services.	
<input type="checkbox"/>	The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E.	
<input checked="" type="radio"/>	Not applicable	
	Support	Included
	Alternate Service Title (if any)	
	Information and Assistance in Support of Participant Direction	<input type="checkbox"/>
	Financial Management Services	<input type="checkbox"/>
Other Supports for Participant Direction ( <i>list each support by service title</i> ):		
a.		
b.		
c.		

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Appendix C: Participant Services  
 HCBS Waiver Application Version 3.5

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*check each that applies*):

<input type="checkbox"/>	As a waiver service defined in Appendix C-3 ( <i>do not complete C-1-c</i> )
<input type="checkbox"/>	As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). <i>Complete item C-1-c.</i>
<input type="checkbox"/>	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). <i>Complete item C-1-c.</i>
<input type="checkbox"/>	As an administrative activity. <i>Complete item C-1-c. NOTE: Pursuant to CMS-2237-IFC this selection is no longer available for 1915(c) waivers.</i>
<input checked="" type="checkbox"/>	Not applicable – Case management is not furnished as a distinct activity to waiver participants. <i>Do not complete Item C-1-c.</i>

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Not applicable.

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## Appendix C-2: General Service Specifications

- 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*):

<input checked="" type="radio"/>	<p><b>Yes.</b> 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):</p> <hr/> <p><b><u>Types of Positions for which investigations must be conducted:</u></b> All waiver service providers.</p> <p><b><u>Scope of Investigation:</u></b> All waiver service providers must successfully complete and pass a central registry check, a Federal Bureau of Investigation (FBI)/Division of Criminal Investigation (DCI) background screening, and an Office of the Inspector General (OIG) background screening. All waiver providers are enrolled with the Medicaid Agency and monitored routinely by all screening and background evaluations conducted for all Medicaid providers.</p> <p><b><u>Process for Ensuring that Mandatory Investigations have been conducted:</u></b> Documentation of successful background screening/evaluations is required (contractually) of the PAHP contractor prior to executing a provider network agreement for services. Documentation of successful background screening/evaluation is also required at the time of Medicaid provider enrollment. Once enrolled with Medicaid (via the State Fiscal Agent), all waiver service providers are subject to monthly/on-going (as required per the Affordable Care Act) background screening and monitoring.</p>
<input type="radio"/>	<p><b>No.</b> Criminal history and/or background investigations are not required.</p>

- 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*):

<input checked="" type="radio"/>	<p><b>Yes.</b> 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):</p> <hr/> <p><b><u>The entity responsible for maintaining the abuse registry:</u></b> The Wyoming Department of Family Services (DFS), in collaboration with DCI maintain the abuse registry for the State of Wyoming.</p> <p><b><u>Types of Positions for which abuse registry screenings must be conducted:</u></b> All waiver service providers.</p> <p><b><u>The Process for Ensuring Mandatory Screenings have been conducted:</u></b> Documentation of successful abuse registry screening is required (contractually) of the PAHP contractor prior to executing a provider network agreement for services. Documentation of successful abuse registry</p>
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	screening is also required at the time of Medicaid provider enrollment. Once enrolled with Medicaid (via the State Fiscal Agent), all waiver service providers are subject to monthly/on-going (as required per the Affordable Care Act) background screening and monitoring.
<input type="radio"/>	<b>No.</b> The State does not conduct abuse registry screening.

**c. Services in Facilities Subject to §1616(e) of the Social Security Act. Select one:**

<input checked="" type="radio"/>	<b>No.</b> Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. <i>Do not complete Items C-2-c.i – c.iii.</i>
<input type="radio"/>	<b>Yes.</b> 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). <i>Complete Items C-2-c.i –c.iii.</i>

**i. Types of Facilities Subject to §1616(e).** Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit

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- ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Not applicable.

- iii. **Scope of Facility Standards.** By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following (*check each that applies*):

Standard	Facility Type	Facility Type	Facility Type	Facility Type
Admission policies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sanitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff : resident ratios	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff training and qualifications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resident rights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of restrictive interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incident reporting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provision of or arrangement for necessary health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Not applicable.

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- 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:*

<input checked="" type="radio"/>	<b>No.</b> The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
<input type="radio"/>	<b>Yes.</b> 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 <i>extraordinary care</i> 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. <i>Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.</i>

- 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:*

<input checked="" type="radio"/>	The State does not make payment to relatives/legal guardians for furnishing waiver services.
<input type="radio"/>	The State makes payment to relatives/legal guardians under <i>specific circumstances</i> 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. <i>Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.</i>
<input type="radio"/>	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-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.</i>
<input type="radio"/>	Other policy. <i>Specify:</i>

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- 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:

Pursuant to the 1915 (b)(4) waiver of authority requested by the State in its 1915 (b) concurrent waiver, through a selective procurement process, the State has selected a single PAHP contractor to administer waiver services. Providers will enroll and contract as waiver service providers through the PAHP. Waiver enrollees will have the option of selecting any qualified and contracted provider within the PAHP network.

## 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**

**a.i.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.***

*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.*

<b>Performance Measure:</b>	Percentage of waiver providers that meet all provider certification and qualification requirements (total # of waiver providers that meet all provider certification and qualification requirements/ total # of waiver providers enrolled).		
<b>Data Source</b> <i>[e.g. – examples cited in IPG]</i>	<b>Responsible Party for data collection/generation</b> <i>(check each that applies)</i>	<b>Frequency of data collection/generation:</b> <i>(check each that applies)</i>	<b>Sampling Approach</b> <i>(check each that applies)</i>
PAHP Contractor Provider Data Files	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

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	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

**Add another Data Source for this performance measure**

Performance Measure:	Percentage of waiver providers that complete all annual recertification processes on or before the expiration of existing certification (total number of waiver providers that complete all annual recertification processes on or before the expiration of existing certification/ total # of enrolled providers).		
Data Source [e.g. – examples cited in IPG]	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)
PAHP Contractor Data Files	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and	<input type="checkbox"/> Stratified:

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		Ongoing	Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
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)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

**Add another Performance measure (button to prompt another performance measure)**

**a.i.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.

<b>Performance Measure:</b>	Wyoming does not allow payment to non-certified/non-licensed waiver providers (total # of non-certified/non-licensed waiver providers/ total # of enrolled waiver providers)		
<b>Data Source [e.g. – examples cited in IPG]</b>	<b>Responsible Party for data collection/generation (check each that applies)</b>	<b>Frequency of data collection/generation: (check each that applies)</b>	<b>Sampling Approach (check each that applies)</b>
PAHP Contractor	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

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	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

*Add another Data Source for this performance measure*

*Add another Performance measure (button to prompt another performance measure)*

**a.i.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.*

<b>Performance Measure:</b>	Percentage of Waiver providers initially certified who completed initial provider training (# of new providers receiving training / # of new providers initially certified)		
<b>Data Source</b>	<b>Responsible Party for data</b>	<b>Frequency of data collection/generation:</b>	<b>Sampling Approach</b> (check each that

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	<b>collection/generation</b> (check each that applies)	(check each that applies)	applies)
PAHP Contractor	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

**Add another Data Source for this performance measure**

**Add another Performance measure (button to prompt another performance measure)**

a.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.

Via a contract between the State and the PAHP Contractor, all providers will be required to meet defined training and credentialing requirements when providing services under contract with the PAHP as part of the provider network. Provider training and credentialing status will be documented and tracked by the PAHP for continued assurance that all network providers meet the defined training and credentialing requirements.

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**b. Methods for Remediation/Fixing Individual Problems**

**b.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.

Individual problems with providers' compliance with rules, regulations and policies can be caught through various mechanisms including:

- Within the initial provider certification process;
- Within the provider recertification process;
- Within the formal grievance process;
- Within the enrollee incident reporting process;
- Within the plan of care approval process;
- Within the team meeting process;
- Through internal referrals; and
- As tracked and monitored through the PAHP contractor provider management system.

When non-compliance is suspected through any of these processes the PAHP contractor completes an investigation or review to determine if non-compliance can be substantiated. If provider non-compliance is confirmed, provider will be immediately suspended from providing services within the PAHP contractor network until all training and credentialing requirements are successfully fulfilled. If a PAHP contractor network provider fails to comply with the training and certification requirements when suspended from service provision, the State will enact all authority under current rule and regulation for provider sanctions and/or payment recovery up to and including enrollment suspension as a Medicaid provider.

**b.ii Remediation Data Aggregation**

<b>Remediation-related Data Aggregation and Analysis (including trend identification)</b>	<b>Responsible Party (check each that applies)</b>	<b>Frequency of data aggregation and analysis: (check each that applies)</b>
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> Other: Specify:

**c. Timelines**

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

<input type="radio"/>	<b>Yes</b> (complete remainder of item)
<input checked="" type="radio"/>	<b>No</b>

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

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## Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
<b>Service Title:</b>	Youth and Family Training and Support
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
<b>Service Definition (Scope):</b>	
<p>Training, services, and activities specifically identified in the POC that support and enhance the youth's/enrollee's overall service goals.</p> <p>These services are provided in a group setting and may include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Skill development and training to support appropriate social interaction;</li> <li>• Skill development and training to support successful family interactions;</li> <li>• Intervention coaching to support the development of coping skills and techniques;</li> <li>• Techniques for strength-based behavior management and/or support;</li> <li>• Specific training on successfully accessing community, cultural and recreational activities;</li> <li>• Training and education directly related to helping the youth and family through objectives and action planning identified in the individualized POC;</li> <li>• Providing instruction regarding health and safety issues;</li> <li>• Training on waiver procedures associated with service provision and waiver responsibilities;</li> <li>• Planning and/or crisis intervention training specific to the POC;</li> <li>• Supporting the youth and family with the development of skills leading to better self- advocacy in the Family Care Team;</li> <li>• Support with skill development related to the identification of services and resources pertinent to youth and family needs;</li> <li>• Explaining and interpreting policies, procedure, and relationships that have an impact on the youth and family's ability to live in the community (such as educational and/or juvenile justice systems); and/or</li> <li>• Providing monthly reporting to the Family Care Coordinator regarding successes and challenges.</li> </ul> <p>This service may require collaboration with a qualified licensed mental health professional in service design and evaluation.</p> <p>The PAHP contractor, under contract specifications with the State, will verify and attest that the Youth and Family Training and Support service is not duplicative under the State Medicaid Plan.</p> <p>Services may be provided in the participant's home, provider agency location or community locations that are non-facility based. The allowable community settings include non-institutional or non-congregate or facility based community locations to include but not limited to stores, playgrounds, activity centers and parks.</p> <p>This service may not be provided in order to train paid caregivers, unless the POC clearly outlines the goal for</p>	

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this services to be for the direct and exclusive benefit of the waiver enrollee/youth.

Training and other related services must be included in the service plan before services are authorized.

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

This service is limited in amount, frequency and duration only to the extent that the services provided do not exceed the plan of care budget as outlined in previous sections (\$1,137.84 per 6-month plan cycle, or the equivalent of \$189.64 in a per member per month payment to the PAHP contractor).

**Provider Specifications**

Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Family Care Coordinators who meet all State Plan requirements for the provision of HFWA services		Agencies who employ or contract with Family Care Coordinators that meet all State Plan requirements for the provision of HFWA services
		Family Support Partners who meet all State Plan requirements for the provision of HFWA services		Agencies who employ or contract with Family Support Partners that meet all State Plan requirements for the provision of HFWA services
		Youth Support Partners who meet all State Plan requirements for the provision of HFWA services		Agencies who employ or contract with Youth Support Partners that meet all State Plan requirements for the provision of HFWA services

Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
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**Provider Qualifications** (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Family Care Coordinator	None	Bachelor's Degree in a human service (or related) field, or two (2) years of work/personnel experience in providing direct services or linking of services for youth experiencing serious emotional disturbance (SED)	<ul style="list-style-type: none"> <li>At least 21 years of age;</li> <li>Completion of all PAHP contractor and State required training components;</li> <li>Posses a valid driver's license, appropriate auto insurance and reliable transportation;</li> <li>CPR and First Aid Certification;</li> <li>Under contract (or other employment agreement) with the PAHP contractor for the provision of waiver services;</li> <li>Completion of all PAHP contractor and State required HFWA credentialing processes;</li> <li>Enrolled as a Wyoming Medicaid</li> </ul>

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			<p>provider through the State's Fiscal Agent; and</p> <ul style="list-style-type: none"> <li>• Successful completion of all Central Registry and FBI/DCI background screenings.</li> </ul>
Family Support Partner	None	High school diploma (or GED equivalent) who is a parent or caregiver of a child with behavioral health needs or someone with two (2) years experience working closely with children with serious emotional/behavioral challenges and their families.	<ul style="list-style-type: none"> <li>• Minimum of two (2) years experience in a behavioral health setting as a parent, client or family advocate;</li> <li>• At least 21 years of age;</li> <li>• Completion of all PAHP contractor and State required training components;</li> <li>• Posses a valid driver's license, appropriate auto insurance and reliable transportation;</li> <li>• CPR and First Aid Certification;</li> <li>• Under contract (or other employment agreement) with the PAHP contractor for the provision of waiver services;</li> <li>• Completion of all PAHP contractor and State required HFWA credentialing processes;</li> <li>• Enrolled as a Wyoming Medicaid provider through the State's Fiscal Agent; and</li> <li>• Successful completion of all Central Registry and FBI/DCI background screenings.</li> </ul>
Youth Support Partner	None	High school diploma (or GED equivalent) with behavioral health needs or someone who has experience overcoming various systems and obstacles related to mental and behavioral health challenges.	<ul style="list-style-type: none"> <li>• Ages 18-26;</li> <li>• Completion of all PAHP contractor and State required training components;</li> <li>• CPR and First Aid Certification;</li> <li>• Under contract (or other employment agreement) with the PAHP contractor for the provision of waiver services;</li> <li>• Completion of all PAHP contractor and State required HFWA credentialing processes;</li> <li>• Enrolled as a Wyoming Medicaid provider through the State's Fiscal Agent; and</li> </ul>

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			<ul style="list-style-type: none"> <li>Successful completion of all Central Registry and FBI/DCI background screenings.</li> </ul>
<b>Verification of Provider Qualifications</b>			
<b>Provider Type:</b>	<b>Entity Responsible for Verification:</b>		<b>Frequency of Verification</b>
Family Care Coordinator	PAHP Contractor, State and MMIS Fiscal Agent		Upon enrollment with Medicaid and annually thereafter
Family Support Partner	PAHP Contractor, State and MMIS Fiscal Agent		Upon enrollment with Medicaid and annually thereafter
Youth Support Partner	PAHP Contractor, State and MMIS Fiscal Agent		Upon enrollment with Medicaid and annually thereafter
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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## Appendix C-4: Additional Limits on Amount of Waiver Services

**Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*check each that applies*).

*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; and, (f) how participants are notified of the amount of the limit.*

<input type="checkbox"/>	<p><b>Limit(s) on Set(s) of Services.</b> 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. <i>Furnish the information specified above.</i></p>
<input checked="" type="checkbox"/>	<p><b>Prospective Individual Budget Amount.</b> There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. <i>Furnish the information specified above.</i></p> <p><b><u>(a) The waiver services to which the limit applies:</u></b>                  The assigned budget for a participant applies to the amount, frequency and duration of Youth and Family Training and Support as included in the plan of care</p> <p><b><u>(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:</u></b>                  A budget of \$1,137.84, which is a hard cap over a six month period, is assigned to each waiver participant based on an analysis of the historical costs for the waiver services and supports for the participants enrolled who live in the family home. The availability of other services and supports (e.g., family caregivers, Medicaid State Plan services, and public education) for the waiver targeted population and information on the utilization of these other services and supports contribute to the basis of the waiver's cost limit. When the budget was established five years ago, the waiver reviewed costs for services on the Wyoming Child Developmental Disability waiver and the costs for services for the mental health population. The budget was designed to provide intensive waiver services upfront enabling youth and family to stabilize and move off of the waiver within 24-36 months.</p> <p>Eligible youth/enrollees ages 21 and under may be eligible to receive services through IDEA and have a portion of their daily support and supervision needs covered by the schools. Waiver services requested during school hours will be reviewed by the PAHP contractor on a case by case basis. Consideration will be made for each youth/enrollee's individual school schedule and educational need. The PAHP contractor, under contractual agreement with the State, will ensure that waiver services are not provided in concert with (or over-lapping) with services provided by any other federal agency.</p> <p><b><u>(c) How the limit will be adjusted over the course of the waiver period:</u></b>                  In collaboration with the PAHP contractor, periodic and ongoing service utilization reviews will be</p>

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conducted. Concurrent with the State's 1915 (b) cost effectiveness demonstration, as additional financial offsets are achieved through the reduction in institutional level and other applicable state plan services, additional funding may become available to support the expansion of waiver services.

**(d) Provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state:**

Through the implementation of a calculated and actuarially sound per member per month payment based on the \$1,700/ 6-month plan budget, the PAHP contractor will have the administrative flexibility to utilize funding as most appropriate for the clinical and emergent needs of each youth in a specified payment period (monthly). The PAHP will, through contractual guidelines and specifications, be allowed the flexibility to distribute the monthly payment for waiver services as detailed in each individual plan of care (i.e. should one youth require more services in one month than the next, the monthly payments issued by the State to the PAHP contractor for each enrolled youth can be aggregated by the PAHP contractor and distributed according to documented and approved need).

**(e) The safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs:**

Based on the payment methodology developed, the State does not consider this to be a potential occurrence for the reasons explained above in (d).

**(f) How participants are notified of the amount of the limit:**

The PAHP contractor, through the provider network of family care coordinators, family support partners and youth support partners will be informed of the waiver service limit during the development, review and approval of the individual plan of care. Any adjustments made to the waiver budget based on legislative action or direction will go through the same notification process. The budget amounts have been proposed as part of the public comment period and will be discussed during program and/or provider forums throughout the life of the waiver. The State will evaluate input periodically to evaluate the sufficiency of the established budget amounts.

<input type="checkbox"/>	<b>Budget Limits by Level of Support.</b> 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. <i>Furnish the information specified above.</i>
<input type="checkbox"/>	<b>Other Type of Limit.</b> The State employs another type of limit. <i>Describe the limit and furnish the information specified above.</i>
<input type="checkbox"/>	<b>Not applicable.</b> The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

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# Appendix D: Participant-Centered Planning and Service Delivery

## Appendix D-1: Service Plan Development

<b>State Participant-Centered Service Plan Title:</b>	Individual Plan of Care
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**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 (*check each that applies*):

<input type="checkbox"/>	Registered nurse, licensed to practice in the State
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under State law
<input type="checkbox"/>	Licensed physician (M.D. or D.O)
<input type="checkbox"/>	Case Manager (qualifications specified in Appendix C-3)
<input type="checkbox"/>	Case Manager (qualifications not specified in Appendix C-3). <i>Specify qualifications:</i>
<input type="checkbox"/>	Social Worker. <i>Specify qualifications:</i>
<input checked="" type="checkbox"/>	Other ( <i>specify the individuals and their qualifications</i> ): Family Care Coordinator <ul style="list-style-type: none"> <li>Bachelor’s Degree in a human service (or related) field, or two (2) years of work/personnel experience in providing direct services or linking of services for youth experiencing serious emotional disturbance (SED);</li> <li>At least 21 years of age;</li> <li>Completion of all PAHP contractor and State required training components;</li> <li>Posses a valid driver’s license, appropriate auto insurance and reliable transportation;</li> <li>CPR and First Aid Certification;</li> <li>Under contract (or other employment agreement) with the PAHP contractor for the provision of waiver services;</li> <li>Completion of all PAHP contractor and State required HFWA credentialing processes;</li> <li>Enrolled as a Wyoming Medicaid provider through the State’s Fiscal Agent; and</li> <li>Successful completion of all Central Registry and FBI/DCI background screenings.</li> </ul>

**b. Service Plan Development Safeguards.** *Select one:*

<input type="radio"/>	Entities and/or individuals that have responsibility for service plan development <i>may not provide</i> other direct waiver services to the participant.
<input checked="" type="radio"/>	Entities and/or individuals that have responsibility for service plan development <i>may provide</i> other direct waiver services to the participant. The State has established the following

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safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

A Family Care Coordinator (the individual responsible for service plan development) MAY NOT provide other direct waiver services to the participant. However, the premise of high fidelity wraparound as a successful service delivery model is the emphasis and acknowledgment of family/youth choice when selecting Family Support and Youth Support Partners to be included in the child and family team. A Family Care Coordinator’s Agency may have credentialed and qualified Family and Youth Support Partners within the same Agency selected by the family for inclusion and participation in the youth’s team and plan of care. All three (3) roles described above are qualified providers for the delivery of the waiver service outlined.

Each plan of care developed by the Family Care Coordinator will be submitted and reviewed by the PAHP contractor. Under contractual guidance from the State, the PAHP contractor will review each plan noting the roles and services being requested by the Family Care Coordinator. The PAHP will evaluate any potential conflict of interest in the service delivery and payment. Any concern or significant issue identified by the PAHP contractor will be referred to the State for review and referral to the Program Integrity unit for the evaluation of necessary provider sanction, payment suspension/recovery up to and including provider enrollment suspension.

- 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.

**(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:**

The State requires and promotes a wrap-around person-centered approach to services. A description of services available and detailed family/youth expectations for the high fidelity wraparound (HFWA) model are detailed in the PAHP contractor’s Participant & Family Handbook. Upon confirmation of clinical and financial eligibility requirements by State program staff, the family is notified of the eligibility decision and the youth demographic and clinical information is transitioned to the PAHP contractor. The PAHP contractor will be the responsible entity for initiating contact with the family and coordinating the selection of the Family Care Coordinator.

Prior to identifying all Family Care Team members and initiating the development of the plan of care, the Family Care Coordinator assists the youth and family with completing a Strengths, Needs, and Cultural Discovery (SNCD) document that will provide all chosen team members a snapshot of family dynamics, youth/family strengths, environmental supports and stressors. The SNCD identifies individual and family strengths and needs, as well as aids in the identification of the family’s vision as well as short and long term goals.

In preparation for service plan development, the Family Care Coordinator educates the family on available waiver and state plan services to include a list of local and statewide provider information. The Family Care Coordinator may also assist in setting up and attending

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interviews, etc. to support the youth and family’s selection of waiver providers they wish to work with.

**(b) the participant's authority to determine who is included in the process:**

The Family Care Coordinator works with the youth/family to identify Team Members/Service Providers and all other individuals the youth/family wish to include on the Family Care Team (i.e. educational representatives, therapists, Department of Family Service case workers, etc.). This may include individuals to assist the youth/family to fully participate in the planning process and exercise their decision-making authority. All individuals identified by the youth/family are invited to the service planning meetings.

Meeting dates are set with input from the youth/family to assure their attendance and participation. The Family Care Coordinator reviews the initial and subsequent meeting processes with the youth/family so they are aware of the format for the meetings and what information the team will want to know to assist the family to develop the individual service plan.

The youth/family also work with the Family Care Coordinator to prepare portions of the draft planning document to include:

- Demographics information;
- Current medications and medical conditions;
- Information regarding other Medicaid State Plan Services the youth may be receiving;
- Development of goals focusing on support-building based on the SNCD document;

The Family Care Coordinator facilitates the planning meeting and assists the family in sharing their input and voicing their choices to the extent they feel comfortable. The Family Care Coordinator advocates for the family’s involvement in all aspects of the planning process and ensures that the youth/family needs and preferences are met.

The youth/family also works with the Family Care Coordinator to finalize the draft planning document to ensure accurate information is covered in the service plan. The HFWA delivery model is youth driven and family guided.

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- 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):

**(a) who develops the plan, who participates in the process, and the timing of the plan:**  
 The Family Care Coordinator, under direction of the youth and youth’s family, is the responsible individual for coordinating the development of the plan. The youth, the youth’s family and/or legal guardian, chosen waiver service providers, family and/or youth support partners, as well as all other natural supports identified by the family are invited to participate in the development of the care plan in the Child and Family Team (CFT) venue.

The Family Care Coordinator identifies a meeting date based on the availability of the youth and family. Written meeting notification is sent by the Family Care Coordinator to members of the Child and Family Team with sufficient advance notice for team members to make arrangements to attend (approximately 2-3 weeks ahead of time). Assessments to be completed for the planning meeting (i.e. SNCD and crisis plan) are submitted to the Family Care Coordinator prior to the meeting.

**(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:**

The initial plan of care is developed utilizing the waiver application, level of care information, eligibility assessments (CASII/ECSII or CANS), the SNCD and other assessments completed by members of the CFT specific to their area of expertise and service provision.

Assessment needs (i.e. CANS, CASII/ECSII) for the bi-annual plan of care reviews are identified by members of the CFT and FCC and are completed following established time lines in preparation for review and consideration during the scheduled CFT meetings.

**(c) how the participant is informed of the services that are available under the waiver:**  
 A description of services available and detailed family/youth expectations for the high fidelity wraparound (HFWA) model are detailed in the PAHP contractor’s Participant & Family Handbook. Upon confirmation of clinical and financial eligibility requirements by State program staff, the family is notified of the eligibility decision and the youth demographic and clinical information is transitioned to the PAHP contractor. The PAHP contractor will be the responsible entity for initiating contact with the family and coordinating the selection of the Family Care Coordinator.

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**(d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences:**

The CFT meeting process ensures that each youth and family drives the process. The assessments and documents used to inform the development of the plan of care are derived and completed based strictly on input, needs, strengths and goals established and/or identified by the youth and their family.

**(e) how waiver and other services are coordinated:**

The Family Care Coordinator, under direction of the youth and youth’s family, is the responsible individual for coordinating the development of the plan and coordination of all services (waiver and Medicaid State Plan). The youth, the youth’s family and/or legal guardian, chosen waiver service providers, family and/or youth support partners, as well as all other natural supports identified by the family are invited to participate in the development of the care plan in the CFT venue.

**(f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan:**

When the team has agreed upon a plan of care that meets the identified needs of the youth and family, the CFT members will assign and take responsibility for specific actions. Action owners will be detailed in the final plan of care and managed by the Family Care Coordinator. After each Child and Family Team meeting, the Family Care Coordinator will update the plan of care to reflect the adjustments and assignments made by the team.

**(g) how and when the plan is updated, including when the participant’s needs change:**

After each CFT meeting, the Family Care Coordinator will update the plan of care to reflect the adjustments and assignments made by the team. In addition, the Family Care Coordinator should be actively following up with the team members about the success of action steps in between meetings.

Through periodic re-evaluations and assessments of the youth’s progress toward meeting specified objectives, any significant changes in the needs of the youth and family will be captured and the plan of care updated.

- 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.

As part of the initial assessment of youth and family need (via the SNCD), a crisis plan and behavioral support plan are also drafted. The behavioral support and crisis component of the plan of care directs the CFT on how to identify and mitigate any behaviors or health issues likely to be dangerous to the youth/family and to develop a plan to prevent or reduce occurrence. This plan may be all or part of a behavior support plan which is developed by the CFT as part of the plan of care. The behavior support plan identifies safety concerns, what individuals in the care team will do the if the behavior causes physical harm to the youth or others, what positive supports are helpful to address these behaviors, and the contingency plan if the behavior support plan is not working. Contingency plans may involve utilizing identified crisis resources including qualified

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licensed mental health professionals, Youth Crisis Centers and Law Enforcement resources. The FCC routinely verifies with the youth and family that sufficient behavioral and crisis plans are in place and working.

The periodic CANS and CASII/ECSII include areas specific to risk of harm and any co-occurring physical health issues that the team may need to monitor and support.

The youth's behavioral and/or health concerns are discussed during each team meeting and the plan of care updated to provide the youth's current status as well as any changes to the Behavior Support Plan and/or Crisis plan. In order to develop an on-call system of both natural and provider supports, the team will evaluate the youth's and family's unique needs and circumstances to determine what situations may arise where the youth may need additional supports. Appropriate contact names and telephone numbers are available in the plan as well as in a visible area in the youth's primary residence for immediate access.

- 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.

A description of services available and detailed family/youth expectations for the high fidelity wraparound (HFWA) model are detailed in the PAHP contractor's Participant & Family Handbook. Upon confirmation of clinical and financial eligibility requirements by State program staff, the family is notified by certified mail of the eligibility decision and the youth's demographic and clinical information is transitioned to the PAHP contractor. The PAHP contractor will be the responsible entity for initiating contact with the family and coordinating the selection of the Family Care Coordinator. The family will have the choice of selecting any Family Care Coordinator in the PAHP's provider network. The PAHP contractor will maintain and have available for distribution a full list of all contracted providers statewide.

Once the Family Care Coordinator is selected and in preparation for service plan development, the Family Care Coordinator educates the family on available waiver and state plan services to include a list of local and statewide provider information. The Family Care Coordinator may also assist in setting up and attending interviews, etc. to support the youth and family's selection of waiver providers they wish to work with.

- 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):

In accordance with the cited CFR reference, the State program staff will have access to the PAHP contractor electronic plan of care management system and will perform ongoing quality assurance reviews.

In addition, under contractual administrative authority of the State Medicaid Agency, all plans of care are submitted to the PAHP contractor for review and approval to ensure that established waiver procedures for plan development have been followed and the plan identifies and addresses the health and welfare of the youth being served.

Plans of care are reviewed by PAHP contractor staff as soon as possible after receipt.

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The completed review of the plan of care and any comments or corrections needed are documented within the PAHP contractor’s electronic plan of care management system and the plan is rolled-back to the Family Care Coordinator for appropriate revision.

The Family Care Coordinator, under advisement of the youth and the youth’s family, is required to respond to the identified issues and resubmit the plan of care to the PAHP contractor. The plan of care effective date is the date the plan is approved and signed by the PAHP contractor clinical staff or a date beyond the plan approval date.

Every subsequent plan is reviewed utilizing the same criteria as the initial service plan and approved by PAHP contractor clinical staff.

**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:*

<input type="radio"/>	Every three months or more frequently when necessary
<input checked="" type="radio"/>	Every six months or more frequently when necessary
<input type="radio"/>	Every twelve months or more frequently when necessary
<input type="radio"/>	Other schedule ( <i>specify</i> ):

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- 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*):

<input type="checkbox"/>	Medicaid agency
<input type="checkbox"/>	Operating agency
<input type="checkbox"/>	Case manager
<input checked="" type="checkbox"/>	Other ( <i>specify</i> ): PAHP Contractor and Family Care Coordinator

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## Appendix 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 plan of care is monitored by CFT members specific to their service responsibilities and action items, the PAHP contractor clinical staff and more globally by the Family Care Coordinator at least twice during the plan period and more frequently as needs dictate. Service objectives and behavior support plans are monitored by the responsible CFT member(s) a minimum of twice per bi-annual plan period or more frequently if problems or increased needs are identified.

Child and Family Team members responsible for implementation of specific service objectives or behavior support plans will provide services according to the duration and frequency outlined in the plan of care. This will require their minimum direct, in-person contact with the youth/family to follow that same schedule. Family Care Coordinators are required to make direct, in-person contact with the youth/family monthly at minimum.

The basis for service monitoring by the members of the CFT and the Family Care Coordinator focuses on service provision as agreed upon and outlined in the plan of care. Service objective start dates, duration and frequency of services, and service interventions are documented and monitoring is done according to those identified requirements.

Waiver provider recruitment and certification shall be a priority for the PAHP contractor to ensure that youth and families served have access to waiver services and choice of waiver providers. Service regionalization will help to facilitate access to both waiver services and providers. However, if this is identified as a problem, the Family Care Coordinator will report the issues to the PAHP contractor so that problems can be addressed in a timely manner on a case-by-case basis and proactive tracking and monitoring of the access issues can be done to ensure it does not become a larger problem.

Needs and preferences of the youth/family are identified in provider assessments and throughout all aspects of the plan of care. Services identified will focus on meeting the needs and preferences of the youth and family. Input from the youth/family on service provision is requested and documented by the CFT. If any of the initial services do not meet the needs of the youth/family as anticipated, the family, a team member or a Family Care Coordinator can request a CFT meeting to discuss the issues and propose changes to the plan of care to address the problems identified. This can be done at any time and should be done as soon as a problem is recognized and evaluated so better interventions can be implemented.

Development of a behavior support plan and crisis plan are part of the service planning process. Review of the plan is done at least every 6 months and changes are made as needed to ensure that the plan is effective and meets the needs and preferences of the youth/family. Input from the youth/family regarding effectiveness is solicited as a part of the team's review.

Overall health and welfare as well as specific health and behavioral health care needs are identified through the assessment process (CASII/ECSII, CANS, SNCD, level of care) as part of the service plan development and implementation. These issues are formally reported by the CFT. More frequent monitoring may be established to address acute issues or problems.

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Youth and family served by the waiver have the right to choose providers they wish to work with. If the relationship with the provider is negatively impacting service delivery and/or progress by the youth, this problem will be identified in the service plan monitoring process and will be addressed through the Family Care Coordinator, who will provide assistance to the family in obtaining current information on certified providers from which the youth/family may choose. The Family Care Coordinator will facilitate the plan of care modification process to formally make the change in service providers.

The plan of care is developed by the youth/family and the CFT, which may include representatives from all child-serving agencies involved with the youth/family. Need for and access to services, regardless of their "type" is part of the planning process. The Family Care Coordinator is responsible for helping to locate, arrange, and refer the youth/family to identified non-waiver services to address their needs and preferences. These services, including health services, are noted in the plan of care document and ongoing utilization is monitored.

The minimum required direct, in-person contact with the youth/family guidelines in combination with the plan and service monitoring schedules allow for the identification and follow-up of problems and concerns. Input from youth and family is solicited as part of the monitoring process and used to monitor follow-up of issues identified.

The Family Care Coordinator is responsible for ensuring that follow-up to identified problems is done as part of their scheduled contact with the youth/family at least monthly (depending on the type and severity of the problem and the time needed to effect a change) to ensure resolution and continuing opportunities for progress.

**b. Monitoring Safeguards. *Select one:***

<input type="radio"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may not provide</i> other direct waiver services to the participant.
<input checked="" type="radio"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may provide</i> 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. <i>Specify:</i>
	<p>A Family Care Coordinator (one of many individuals responsible for monitoring the service plan implementation and participant health and welfare) MAY NOT provide other direct waiver services to the participant. However, the premise of high fidelity wraparound as a successful service delivery model is the emphasis and acknowledgment of family/youth choice when selecting Family Support and Youth Support Partners to be included in the child and family team. A Family Care Coordinator's Agency may employ credentialed and qualified Family and Youth Support Partners within the same Agency selected by the family for inclusion and participation in the youth's team and plan of care. All three (3) roles described above are qualified providers for the delivery and monitoring of the waiver service outlined.</p> <p>Each plan of care developed by the Family Care Coordinator will be submitted and reviewed by the PAHP contractor. Under contract with the State, the PAHP contractor will review each plan noting the roles and services being requested by the Family Care Coordinator. The PAHP will evaluate any potential issues with service plan implementation and/or health and welfare concerns of the participant. Any concern or significant issue identified by the PAHP contractor will be referred to the State for review and referral to the Program Integrity unit for the</p>

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evaluation of necessary provider sanction, payment suspension/recovery up to and including provider enrollment suspension.

The Family Care Coordinator documents plan monitoring via the interim plan of care review/ plan of care modification request process. These reviews are submitted to the PAHP contractor clinical staff. Changes identified through this monitoring process are reflected and documented in the plan of care modification document itself. These changes may be specific to new service objectives, new providers or behavior support plans/crisis plans being added or a change/ addition of waiver service providers and/or service unit allocation. These are submitted to the PAHP contractor clinical staff for review and approval.

The PAHP contractor, under contractual authority of the State Medicaid Agency, as well as the State Medicaid Agency itself are responsible for monitoring the implementation of the plan of care, through the following processes:

- Use of Continuous Quality Improvement: The PAHP contractor’s quality management plan promotes continuous quality improvement and uses an enhanced Plan Do Study Act (PDSA) methodology with an added task “Re-measure”;
- Active Children, Youth and Family Involvement: The PAHP contractor will include active participation from children, youth, families, and their advocates. The PAHP contractor will ensure that the local Quality Improvement Advisory Committees will be comprised of at least 51 percent families, children, and youth.
- Close Collaboration with the Community: The PAHP contractor will include feedback and representation from the key State agencies working with children, youth and families, such as the Department of Family Services (DFS), Department of Corrections (DOC), Department of Workforces Services (DWS), Department of Education (WDE), and the State. The PAHP contractor will use learning communities, town hall meetings at regional sites, advisory committees, the current HFWA providers, and community forums as some of the means for outreach and involvement in community programs.
- Fidelity to HFWA Principles: The PAHP contractor will ensure that all of its operations are in line and reflective of the ten HFWA principles. The PAHP contractor will utilize a system of care (SOC) approach, initial and ongoing provider and facilitator training, active participation by children, youth and families in the service delivery process, and the use of tools such as WIFI-EZ to define and implement a program that is fully responsive to the diverse needs of the children, youth, and families who access services.
- Integrated Information Technology Infrastructure: The PAHP contractor will use its Quality Management Integrated Data Platform, a centralized system to collect, integrate, and manage data from various sources. This Integrated Data Platform allows the PAHP contractor to aggregate all data metrics and create a singular, comprehensive quality management process across all components of its operation and SOC.
- Well-Defined Outcomes and Utilization Measures: As part of its monitoring plan, the PAHP contractor will develop and use a variety of outcomes and utilization measures to ensure the quality of the services managed.
- Formal Grievance Process: The PAHP contractor will maintain a formal grievance process.
- Ongoing contract monitoring performed by the State level program manager.

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The State Medicaid Agency, through its robust contract monitoring tools, will ensure PAHP contract adherence to all defined performance metrics including but not limited to specific metrics and data related to the youth's health and welfare.

## 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**

**a.i.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.**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-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.*

<b>Performance Measure:</b>	Percent of waiver plans of care in which services approved reflect the participant's assessed needs, risks, and personal goals as detailed in the CASII/ECSII, CANS, SNCD, level of care assessment or any other applicable evaluation provided to the Youth and Family Team (# of plans in which the participant's needs, risks, and goals are detailed in the plan of care/ total # of plans reviewed)		
<b>Data Source [e.g. – examples cited in IPG]</b>	<b>Responsible Party for data collection/generation (check each that applies)</b>	<b>Frequency of data collection/generation: (check each that applies)</b>	<b>Sampling Approach (check each that applies)</b>
PAHP Electronic Plan of Care Management System	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	

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		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

<b>Performance Measure:</b>	Percent of waiver participants who report (via a satisfaction survey or other feedback collection tool) that their plan of care addresses their personal goals, health and safety concerns (# of participants who report via a satisfaction survey or through other feedback collection tools, that the plan of care addresses goals, health and safety concerns / total # of satisfaction surveys received)		
<b>Data Source</b> [e.g. – examples cited in IPG]	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
PAHP - via participant survey/feedback mechanisms as detailed in the concurrent 1915 (b) waiver	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups

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		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

**Add another Data Source for this performance measure**

**Add another Performance measure (button to prompt another performance measure)**

**a.i.b Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-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.

<b>Performance Measure:</b>	Percentage of waiver plans of care that include participant and/or guardian signature verifying they participated in the development of the plan (# of plans with signature affixed / total # of plans reviewed)		
<b>Data Source [e.g. – examples cited in IPG]</b>	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
PAHP Electronic Plan of Care Management System	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

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	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

**Add another Data Source for this performance measure**

**Add another Performance measure (button to prompt another performance measure)**

**a.i.c Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant’s needs..**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-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.*

<b>Performance Measure:</b>	Percentage of waiver plans of care (or modifications to existing plans of care) that are completed at least annually or when CASII/ECSII, CANS, level of care or other assessment/evaluation demonstrate a change in the youth’s/enrollee’s needs (total # of waiver plans that are completed at least annually or when CASII/ECSII, CANS, level of care or other
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	assessment/evaluation demonstrate a change in the youth's/enrollee's needs/ total # of plans)		
<b>Data Source</b> <i>[e.g. – examples cited in IPG]</i>	<b>Responsible Party for data collection/generation</b> <i>(check each that applies)</i>	<b>Frequency of data collection/generation:</b> <i>(check each that applies)</i>	<b>Sampling Approach</b> <i>(check each that applies)</i>
PAHP Electronic Plan of Care Management System	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other: Specify: PAHP contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies)</i>	<b>Frequency of data aggregation and analysis:</b> <i>(check each that applies)</i>	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PAHP contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

**Add another Data Source for this performance measure**

**Add another Performance measure (button to prompt another performance measure)**

**a.i.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.**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-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).*

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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.

<b>Performance Measure:</b>	Percentage of plans of care in which services and supports are provided in the type, scope, amount, duration, and frequency specified in the plan (# of plans in which services and supports are provided in the type, scope, amount, duration, and frequency specified in the plan / by total # of plans reviewed).		
<b>Data Source [e.g. – examples cited in IPG]</b>	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
PAHP Electronic Plan of Care Management System	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

**Add another Data Source for this performance measure**

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**Add another Performance measure (button to prompt another performance measure)**

**a.i.e Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-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.

<b>Performance Measure:</b>	Percentage of waiver applications with a fully executed freedom of choice statement (document) prior to approval (total # of waiver applications with a fully executed freedom of choice statement/document prior to approval/ total # of waiver applications approved).		
<b>Data Source [e.g. – examples cited in IPG]</b>	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
State program manager/ EMWS	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	

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		<input type="checkbox"/> Other: Specify:	

<b>Performance Measure:</b>	Percentage of approved plans of care that confirm via signature or another method that the youth and/or guardian had choice of HCBS services and choice of provider offered (total # of plans of care with verification of choice included / total # of plans approved)		
<b>Data Source [e.g. – examples cited in IPG]</b>	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
PAHP Contractor/ PAHP Electronic Plan of Care Management System	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

**Add another Data Source for this performance measure**

**Add another Performance measure (button to prompt another performance measure)**

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*a.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.*

Via a contract between the State and the PAHP Contractor, all providers will be required to submit plans of care that meet State defined requirements for the provision of waiver services under contract with the PAHP as part of the provider network. All plans of care are reviewed by the PAHP contractor clinical staff, and components evaluated for adequacy, applicability, assurance that the plan meets the youth and family needs as identified by the various evaluations/assessments performed and that appropriate safeguards are identified to protect the health and welfare of the waiver youth.

**b. Methods for Remediation/Fixing Individual Problems**

*b.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.*

Individual problems with the development, implementation or monitoring of plans of care can be identified through various mechanisms including:

- Within the formal grievance process;
- Within the enrollee incident reporting process;
- Within the plan of care approval process;
- Within the team meeting process;
- Through internal referrals; and
- As tracked and monitored through the PAHP contractor electronic plan of care management system.

When non-compliance is suspected through any of these processes the PAHP contractor completes an investigation or review to determine if non-compliance can be substantiated. If provider non-compliance is confirmed, providers will be coached and assisted by the PAHP contractor to address any deficiencies identified. If the issues persist, the State’s contract manager will work with the PAHP contractor to develop a corrective action plan. If the provider fails to demonstrate progress toward meeting the program expectations, the State will enact all authority under current rule and regulation for provider sanctions and/or payment recovery up to and including enrollment suspension as a Medicaid provider. The State may also impose financial or other penalties upon the PAHP contractor as detailed in the contract document itself.

**b.ii Remediation Data Aggregation**

<b><i>Remediation-related Data Aggregation and Analysis</i></b>	<b><i>Responsible Party (check each that applies)</i></b>	<b><i>Frequency of data aggregation and analysis:</i></b>
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<i>(including trend identification)</i>		<i>(check each that applies)</i>
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
	<input checked="" type="checkbox"/> <i>Other: Specify: PAHP Contractor</i>	<input checked="" type="checkbox"/> <i>Annually</i>
		<input type="checkbox"/> <i>Continuously and Ongoing</i>
		<input type="checkbox"/> <i>Other: Specify:</i>

**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 Service Plans that are currently non-operational.*

<input type="radio"/>	<b>Yes</b> <i>(complete remainder of item)</i>
<input checked="" type="radio"/>	<b>No</b>

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

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# Appendix E: Participant Direction of Services

[NOTE: Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.]

**Applicability** (select one):

<input type="radio"/>	<b>Yes.</b> This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
<input checked="" type="radio"/>	<b>No.</b> 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):*

<input type="radio"/>	<b>Yes.</b> The State requests that this waiver be considered for Independence Plus designation.
<input type="radio"/>	<b>No.</b> Independence Plus designation is not requested.

## Appendix E-1: Overview

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (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 waiver’s approach to participant direction.

- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*

<input type="radio"/>	<b>Participant – Employer Authority.</b> As specified in <i>Appendix E-2, Item a</i> , the participant (or the participant’s representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
<input type="radio"/>	<b>Participant – Budget Authority.</b> As specified in <i>Appendix E-2, Item b</i> , the participant (or the participant’s representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
<input type="radio"/>	<b>Both Authorities.</b> The waiver provides for both participant direction opportunities as specified in <i>Appendix E-2</i> . Supports and protections are available for participants who exercise these authorities.

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**c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

<input type="checkbox"/>	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
<input type="checkbox"/>	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
<input type="checkbox"/>	The participant direction opportunities are available to persons in the following other living arrangements ( <i>specify</i> ):

**d. Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

<input type="radio"/>	Waiver is designed to support only individuals who want to direct their services.
<input type="radio"/>	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. <i>Specify the criteria:</i>

**e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

--

**f. Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

<input type="radio"/>	The State does not provide for the direction of waiver services by a representative.
<input type="radio"/>	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: ( <i>check each that applies</i> ):
<input type="checkbox"/>	Waiver services may be directed by a legal representative of the participant.
<input type="checkbox"/>	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

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- g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the opportunity or opportunities available for each service):*

Participant-Directed Waiver Service	Employer Authority	Budget Authority
	<input type="checkbox"/>	<input type="checkbox"/>

- h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

<input type="radio"/>	<b>Yes.</b> Financial Management Services are furnished through a third party entity. <i>(Complete item E-1-i).</i> Specify whether governmental and/or private entities furnish these services. <i>Check each that applies:</i>
<input type="checkbox"/>	Governmental entities
<input type="checkbox"/>	Private entities
<input type="radio"/>	<b>No.</b> Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i.</i>

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

<input type="radio"/>	FMS are covered as the waiver service entitled _____ as specified in Appendix C-3. <i>Provide the following information:</i>
<input type="radio"/>	FMS are provided as an administrative activity. <i>Provide the following information:</i>
<b>i.</b>	<b>Types of Entities:</b> Specify the types of entities that furnish FMS and the method of procuring these services: _____
<b>ii.</b>	<b>Payment for FMS.</b> Specify how FMS entities are compensated for the administrative activities that they perform: _____
<b>iii.</b>	<b>Scope of FMS.</b> Specify the scope of the supports that FMS entities provide <i>(check each that applies):</i>
	<i>Supports furnished when the participant is the employer of direct support workers:</i>
<input type="checkbox"/>	Assist participant in verifying support worker citizenship status
<input type="checkbox"/>	Collect and process timesheets of support workers
<input type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

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	<input type="checkbox"/>	Other ( <i>specify</i> ):
		<i>Supports furnished when the participant exercises budget authority:</i>
	<input type="checkbox"/>	Maintain a separate account for each participant's participant-directed budget
	<input type="checkbox"/>	Track and report participant funds, disbursements and the balance-of participant funds
	<input type="checkbox"/>	Process and pay invoices for goods and services approved in the service plan
	<input type="checkbox"/>	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
	<input type="checkbox"/>	Other services and supports ( <i>specify</i> ):
		<i>Additional functions/activities:</i>
	<input type="checkbox"/>	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
	<input type="checkbox"/>	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
	<input type="checkbox"/>	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
	<input type="checkbox"/>	Other ( <i>specify</i> ):
<b>iv.</b>		<b>Oversight of FMS Entities.</b> Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

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**j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

<input type="checkbox"/>	<b>Case Management Activity.</b> Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:</i>
<input type="checkbox"/>	<b>Waiver Service Coverage.</b> Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled: <span style="border: 1px solid black; display: inline-block; width: 150px; height: 15px; vertical-align: middle;"></span>
<input type="checkbox"/>	<b>Administrative Activity.</b> Information and assistance in support of participant direction are furnished as an administrative activity. <i>Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:</i>

**k. Independent Advocacy** (*select one*).

<input type="radio"/>	<b>Yes.</b> Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i>
<input type="radio"/>	<b>No.</b> Arrangements have not been made for independent advocacy.

**l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

**m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

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- n. Goals for Participant Direction.** In the following table, provide the State’s goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

<b>Table E-1-n</b>		
	<b>Employer Authority Only</b>	<b>Budget Authority Only or Budget Authority in Combination with Employer Authority</b>
<b>Waiver Year</b>	<b>Number of Participants</b>	<b>Number of Participants</b>
<b>Year 1</b>		
<b>Year 2</b>		
<b>Year 3</b>		
<b>Year 4 (renewal only)</b>		
<b>Year 5 (renewal only)</b>		

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## Appendix E-2: Opportunities for Participant-Direction

a. **Participant – Employer Authority** (Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)

i. **Participant Employer Status.** Specify the participant’s employer status under the waiver. Check each that applies:

<input type="checkbox"/>	<b>Participant/Co-Employer.</b> 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. <i>Specify the types of agencies (a.k.a., “agencies with choice”) that serve as co-employers of participant-selected staff; the standards and qualifications the State requires of such entities and the safeguards in place to ensure that individuals maintain control and oversight of the employee:</i>
<input type="checkbox"/>	<b>Participant/Common Law Employer.</b> 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.

ii. **Participant Decision Making Authority.** The participant (or the participant’s representative) has decision making authority over workers who provide waiver services. Check the decision making authorities that participants exercise:

<input type="checkbox"/>	Recruit staff
<input type="checkbox"/>	Refer staff to agency for hiring (co-employer)
<input type="checkbox"/>	Select staff from worker registry
<input type="checkbox"/>	Hire staff (common law employer)
<input type="checkbox"/>	Verify staff qualifications
<input type="checkbox"/>	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
<input type="checkbox"/>	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
<input type="checkbox"/>	Determine staff duties consistent with the service specifications in Appendix C-3.
<input type="checkbox"/>	Determine staff wages and benefits subject to applicable State limits
<input type="checkbox"/>	Schedule staff
<input type="checkbox"/>	Orient and instruct-staff in duties
<input type="checkbox"/>	Supervise staff
<input type="checkbox"/>	Evaluate staff performance
<input type="checkbox"/>	Verify time worked by staff and approve time sheets
<input type="checkbox"/>	Discharge staff (common law employer)
<input type="checkbox"/>	Discharge staff from providing services (co-employer)

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<input type="checkbox"/>	Other ( <i>specify</i> ):

**b. Participant – Budget Authority** (*Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b*)

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply:*

<input type="checkbox"/>	Reallocate funds among services included in the budget
<input type="checkbox"/>	Determine the amount paid for services within the State’s established limits
<input type="checkbox"/>	Substitute service providers
<input type="checkbox"/>	Schedule the provision of services
<input type="checkbox"/>	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
<input type="checkbox"/>	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
<input type="checkbox"/>	Identify service providers and refer for provider enrollment
<input type="checkbox"/>	Authorize payment for waiver goods and services
<input type="checkbox"/>	Review and approve provider invoices for services rendered
<input type="checkbox"/>	Other ( <i>specify</i> ):

**ii. Participant-Directed Budget.** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

**iii. Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

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**iv. Participant Exercise of Budget Flexibility.** *Select one:*

<input type="radio"/>	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
<input type="radio"/>	Modifications to the participant-directed budget must be preceded by a change in the service plan.

**v. 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:

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## 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; or
- A participant's services are denied, suspended, reduced or terminated.

If the initial eligibility determination results in a denial, the youth and/or family are notified in writing (via certified mail) and detailed information is included on the process for requesting a Fair Hearing, in accordance with Wyoming Medicaid Rule. 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 applicant has a specified time frame to request a fair hearing in writing to the State program manager within the State Medicaid Agency.

If the request for Fair Hearing is related to the denial of services, provider choice or services being denied, suspended, reduced or terminated, the youth and/or guardian will follow the grievance process established by the PAHP contractor, initially, and can be referred to the State for additional remediation if the resolution proposed by the PAHP contractor is unsatisfactory. If the youth filing a grievance is a current waiver participant and actively receiving waiver services, he/she is notified that services are not terminated or reduced pending the results of the PAHP grievance process or Fair Hearing, unless otherwise authorized as specified in 42 CFR §431.230. All relevant information is included in the letter sent to the youth and/or guardian.

Notices of adverse actions and requests for a formal grievance investigation or fair hearing are retained by the State for 6 years.

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## 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:*

<input checked="" type="radio"/>	<b>Yes.</b> The State operates an additional dispute resolution process ( <i>complete Item b</i> )
<input type="radio"/>	<b>No.</b> This Appendix does not apply ( <i>do not complete Item b</i> )

- 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.

**(a) PAHP Contractor Complaints and Grievance Process OR State Program Request for Reconsideration:**

All quality of care and client safety concerns identified by providers, children, youth, and families, the State or the PAHP contractor will be investigated promptly based on the level of urgency. The investigation results and trending of quality of care and client safety incidents is a core performance indicator used in the PAHP contractor’s quality management plan to manage the effectiveness and safety of the program.

All quality of care and client safety incidents are captured in a database to assist in identifying trends on an individual provider level. If a particular provider has an increased number of incidents or recurrence of a particular type of quality of care or safety incident, the PAHP contractor’s quality management department investigates and makes recommendations for appropriate actions.

At the State level, in cases where a decision is made that result in adverse action against a person who applied for the waiver, the State offers the youth and/or guardian an opportunity to request reconsideration. This informal dispute process does not prohibit a participant or guardian from requesting a Fair Hearing. After the dispute resolution process, participants will be provided another opportunity for a Fair Hearing in any case.

A request for reconsideration for a specific decision may be submitted to the State’s Division Administrator if one of the following conditions is documented and supported in the request:

- Information presented in the application, initial clinical assessments or documentation support financial eligibility was misrepresented;
- Information was not represented to the fullest extent needed;
- There was a misapplication of State’s program eligibility standards and/or policies; or
- The criterion for the case was misunderstood.

If the person wants to waive the informal reconsideration process and move to a Fair Hearing, he/she may do so. Wyoming Medicaid Rule outlines the timeline from the date of the adverse action to request a hearing if the youth/participant disagrees with the State’s decision. The youth and or guardian must submit a written request for an administrative hearing to the Division Administrator. The person may have an attorney, a relative, a friend, or other spokesperson, including him or herself, represented at this hearing.

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The following information shall be included in the hearing request:

- A statement of request for an administrative hearing regarding the denial;
- The reasons why the denied request should be approved or allowed;
- The issues to be raised at the hearing;
- The request must be signed; and
- The request must be typed or legibly printed.

If a request for an administrative hearing concerning this action is submitted timely and appropriately, the State program manager will initiate contact with the Office of Administrative Hearings who will notify the youth and/or guardian of the date, time and place of the hearing.

**(b) The nature of the process, including the types of disputes addressed through the process:**

Complaints and/or grievances filed with the PAHP contractor will include but not be limited to the following:

- Youth/enrollee health and welfare concerns;
- Changes in the amount, duration, scope or frequency of waiver services include in the plan of care;
- Loss of program/waiver eligibility; or
- Denial of provider choice or choice of available services.

Excluded from the PAHP contractor's complaint and grievance process will be issues related to the initial clinical or financial program eligibility. The State will handle all complaints, grievances and/or requests for Fair Hearing regarding initial financial and clinical eligibility determinations.

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## Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

<input type="radio"/>	<b>Yes.</b> 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 <i>(complete the remaining items)</i> .
<input checked="" type="radio"/>	<b>No.</b> This Appendix does not apply <i>(do not complete the remaining items)</i>

**b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

**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).

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# 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:*

<input type="radio"/>	<b>Yes.</b> The State operates a Critical Event or Incident Reporting and Management Process <i>(complete Items b through e)</i>
<input checked="" type="radio"/>	<b>No.</b> This Appendix does not apply <i>(do not complete Items b through e)</i> . <i>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.</i>
	<p>The Critical Event and/or Incident Reporting and Management Processes are operated by the PAHP contractor, according to specific guidelines and requirements as set forth in the operational contract.</p> <p>All quality of care and client safety concerns identified by providers, children, youth, and families, the State or the PAHP contractor will be investigated promptly based on the level of urgency. The investigation results and trending of quality of care and client safety incidents is a core performance indicator used in the PAHP contractor’s quality management plan to manage the effectiveness and safety of the program.</p> <p>All quality of care and client safety incidents reported are captured in a database to assist in identifying trends on an individual provider level. If a particular provider has an increased number of incidents or recurrence of a particular type of quality of care or safety incident, the PAHP contractor’s quality management department investigates and makes recommendations for appropriate actions.</p>

- 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).

Abuse with respect to a child means inflicting or causing physical or mental injury, harm or imminent danger to the physical or mental health or welfare of a child other than by accidental means, including abandonment, excessive or unreasonable corporal punishment, malnutrition or substantial risk thereof by reason of intentional or unintentional neglect, and the commission or allowing the commission of a sexual offense against a child as defined by law (W.S. § 14-3-202.) Per 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, sexually
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abused, neglected, exploited, intimidated, abandoned or is committing self-neglect, shall report the information immediately...”

Under contract as a provider in the PAHP network, all waiver service providers and provider staff are required to submit critical incident reports to the PAHP contractor, State level program manager, the Wyoming Department of Family Services - Protective Services Unit, Protection & Advocacy Systems Inc., the Family Care Coordinator, 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 Sexual abuse;
- 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;
- Injury to the participant;
- Crime committed by a participant;
- Death; or
- Elopement.

In addition to the categories above, all waiver providers and provider staff are required to report any incidence restraint utilization within three (3) business days, using the incident reporting processes and mechanisms implemented and maintained by the PAHP contractor. The only exception to this reporting process is if the restraint 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 FCC, 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 PAHP contractor’s system using the incident reporting processes and mechanisms implemented and maintained by the PAHP contractor. Participants, guardians, and families may contact the PAHP contractor 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 PAHP contractor or State level program manager may 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 PAHP contractor will provide a Family & Participant Handbook to each youth and family enrolled in the waiver program. The Family & Participant Handbook outlines information and

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questions focused on abuse and neglect and guidance as to what the child/youth should do if found in those situations. A list of DFS field offices will be available through the PAHP contractor. The Family & Participant Handbook with all applicable information is available in print at the time of enrollment, but accessible online as well.

Each Family Care Coordinator will be responsible for conducting youth and/or family education on the signs and symptoms of neglect and abuse. This training will be part of the standard program orientation that takes place with families and youth in the first ninety (90) days of waiver enrollment.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receive 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.

The PAHP contractor, all waiver providers and provider staff, are required to report incidents to the PAHP contractor, the State level program manager, the Wyoming Department of Family Services - Protective Services Unit, Protection & Advocacy Systems Inc., the Family Care Coordinator, the guardian as required by law, and to law enforcement if a crime may have been committed. Reports must be filed immediately after ensuring the health and welfare of the participant and other individuals involved. If a potential crime has been committed, law enforcement will be engaged and, when appropriate, will work directly with the Wyoming Department of Family Services Protective Services Unit to coordinate a formal investigation.

If criminal charges are filed against a waiver provider, the State Medicaid Agency and PAHP contractor immediately suspend the provider's contract/enrollment pending the outcome of the criminal case. If the provider is convicted, they are immediately de-certified (contracted terminated with the PAHP contractor) as a waiver provider. If criminal charges are filed against provider staff, the provider is required to immediately remove the staff from providing direct care services pending the outcome of the criminal case. DFS investigates suspected abuse, sexual 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 being listed on the Abuse Central Registry and informs the State Medicaid Agency when a substantiation occurs involving a waiver provider or provider staff.

Providers appearing on the Central Registry are suspended from providing services and de-certified (contract with PAHP terminated) within 60 calendar days unless they submit a new Central Registry Screening verifying they are not listed on the registry. The 60 calendar day delay with de-certification (contract termination) is required so providers can appeal the DFS decision before being de-certified (contractually terminated) as a provider.

The PAHP contractor's incident intake process is separate from the Department of Family Service's. Incident reports are submitted by providers and other stakeholders. The State level program manager has access to the incident reports via the contractor's electronic provider management system. The PAHP is required to notify the State level program manger of any incidents submitted within two (2) working days of receipt.

Upon the PAHP contractor's receipt of an incident that identifies suspected abuse, sexual abuse, neglect, exploitation, self neglect or abandonment, PAHP contractor staff contact the State level

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program manager, 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, neither the PAHP nor the State level program manager can complete follow-up on the specific incident until the investigation is complete. The PAHP contractor will immediately 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.

If a PAHP contractor corrective action plan is warranted, the State level program manager must review and approve the corrective action plan and must monitor implementation of the plan.

- 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, sexual 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 a waiver provider delays reporting an incident, they are 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.

Per Wyoming Medicaid Rule, a provider reporting late incidents must submit a corrective action plan addressing the non-compliance. If the youth/participant continues to be at risk the PAHP contractor will require the provider to immediately alleviate the risks, can remove youth/participants if the risks are not alleviated, and can (in collaboration with the State level program manager) sanction the provider.

The PAHP contractor, under the direction of the State level program manager, conducts monitoring activities to ensure providers are reporting incidents as required. Monitoring of incident report submissions is conducted as reports are received, and as often as required to ensure appropriate following for each reported incident. These activities include but are not limited to:

**Provider certification process** – Providers must be re-certifying annually. Part of the re-certification process includes training and evaluation of each provider's knowledge of reportable incidents to ensure each provider is aware of the categories of reportable incidents and how to report them. All providers are required to have an incident reporting policy.

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## Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

**a. Use of Restraints or Seclusion (*select one*):**

<input type="radio"/>	<p>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:</p>
<p>The CMHW program is a “no restraint program” given the targeted population is youth ages 4-21. If a restraint is used, the PAHP contractor’s critical incident reporting policy is enacted and a formal report documenting the application of restraint must be submitted. This will allow the PAHP contractor to ensure immediate follow-up and/or action to address the restraint used. The PAHP contractor will initiate an investigation, corrective action, and/or any other action or sanction deemed necessary.</p> <p>The PAHP contractor monitors compliance with the no restraint policy through the plan of care approval process, provider re-certification process, incident-reporting process, and complaint process. The focus of this monitoring is to ensure restraint utilization is not occurring and if it does happen, is reported immediately to the PAHP contractor.</p> <p><b><u>Plan of Care Approval Process:</u></b>  PAHP contractor staff review and approve each plan bi-annually, or as changes are requested by the Family Care Coordinator in collaboration with the Child and Family Team. This review includes a review of the positive behavior support plan, making note that a restraint is not included and that the plan of care is not approved if a restraint technique has been detailed in the proposed plan of care.</p> <p><b><u>Provider Recertification Process:</u></b>  The recertification process includes monitoring the incidents recorded to ensure there is no use of restraints. This monitoring includes:</p> <ul style="list-style-type: none"> <li>• Interviews with providers and provider staff about restraint usage;</li> <li>• A review of the provider’s incident reports; and</li> <li>• A review of each provider’s policies and procedures on behavioral intervention techniques.</li> </ul> <p><b><u>Incident and Complaint Processes:</u></b>  The unauthorized use of restraints and the use of seclusion can be discovered through any number of processes listed above. If the unauthorized use of restraints is confirmed, the provider is required to immediately put safeguards in place to ensure 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 as a form of behavioral restraint/ punishment is confirmed, the provider is notified to immediately stop the practice. The PAHP contractor will complete an onsite investigation to confirm seclusion is not being unlawfully utilized.</p> <p>If a restraint incident is reported through the PAHP contractor incident reporting process or through a complaint, the PAHP will promptly investigate the provider and associated incidents within 10 business days. As applicable, a corrective action procedure will commence. Corrective action plans are due to the PAHP contractor within 15 business days if the investigation identifies concerns with health, safety or participant rights and will be due</p>	

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	<p>within 30 calendar days for all other concerns. The PAHP contractor must review and approve the corrective action plan and monitor its implementation. The type of monitoring completed upon implementation and immediately thereafter may include an onsite visit, request for documentation, follow-up interviews with participants, provider and/or provider staff, or additional follow-up activities initiated during the next provider recertification. The PAHP will require the Family Care Coordinator to review and develop a stronger behavior support plan/crisis intervention plan if the current one is not sufficient in preventing the use of restraints and seclusions. If a provider is found to be non-compliant with rules, regulations or policies, including the continued utilization of unauthorized restraints, the PAHP will take all action deemed appropriate to suspend and/or terminate the provider agreement.</p>
○	<p>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:</p>

- 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).

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- 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:

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**b. Use of Restrictive Interventions**

○	<p>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:</p>
⊙	<p>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-a-ii:</p>

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- 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 PAHP contractor has specific safeguards in place concerning use of restrictive measures, as detailed in Wyoming Medicaid Rule. Restrictive interventions are defined as any temporary restriction imposed by a provider towards a youth/participant due to a participant's health or behavioral crisis. Restrictions to community outings, communication, privacy, and possessions are the specific restrictions which providers may impose due to the immediate health or safety of a participant, their peers or community members. Aversive techniques are not allowed during the provision of waiver services.

Restrictive interventions include:

- limits on a participant's movement (Participant movement out of the home may be restricted if the provider needs to not allow the participant to leave the home due to concerns with behavior, as outlined in the behavior support plan);
- limits on a youth's/participant's access to other individuals, locations or activities; or
- limits on a person's possessions.

If a "time out" is in the person's plan, it must meet the definition of "a behavior management technique which involves the separation of a resident from his or her peers, in a non-locked setting, for the purpose of calming".

Restrictive interventions must be included in the plan of care and reviewed and approved by the participant, guardian and the PAHP contractor clinical staff. The plan of care must also include a plan to restore rights and periodic reviews of the restrictions. The PAHP contractor has specific safeguards in place concerning the 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. Consent must be obtained from the person authorized to sign the plan of care and can be changed by that person in writing as well. The Family Care Coordinator will formally submit such modifications to the plan of care through the appropriate mechanisms of the PAHP contractor's electronic plan of care management system.

All restrictions of a youth's rights 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;

All restrictions of a youth's rights shall be reviewed at least every six months by the CFT.

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The person-centered plan of care must identify the specific and individualized need related to the use of a restrictive intervention, show how the use of positive interventions and support must be used prior to the use of more restrictive interventions and provider documentation and the behavior plan must demonstrate less intrusive methods that were tried but did not work.

Providers and provider staff are required to receive participant specific training, including training on the restriction of youth rights 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 the utilization of restrictive interventions occurs on the participant level, provider level and at the PAHP contractor level.

- 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 PAHP contractor, under contract with and direction of the State level program manager, monitors and reports to the State any compliance issues with restrictive interventions through the plan of care approval process, provider re-certification process, incident-reporting process, and complaint process. The goal of this monitoring is to ensure restrictive interventions occur only when necessary as a last resort, are authorized as required in state rule, are approved in the plans of care, and ensure provider staffs have appropriate training in approved restrictive interventions for each participant.

**Plan of Care Approval Process:**

The PAHP contractor clinical staff review and approve each plan semi-annually, at minimum. This review includes a review of restrictive interventions written in the plan of care to be sure 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. Any variances from this process are reported to the State level program manager.

**Provider Recertification Process:**

Providers are initially certified for one year and are required to complete a recertification annually. 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 PAHP's provider management system results of the analysis of restrictive intervention use to ensure trends are being identified and areas of concern are addressed at the provider level.

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**Incident and Complaint Processes:**

When use of restrictive interventions is reported through incidents or complaints, the PAHP contractor reviews the participant's plan of care to ensure the use of restrictive interventions is authorized and that a positive behavior support plan and crisis intervention 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 ensure 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, the provider is required to submit a corrective action plan that identifies the area of noncompliance, 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. Corrective Action plans are due to the PAHP contractor 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 PAHP contractor must review and approve the corrective action plan, and monitor implementation of the plan. The type of monitoring completed on the implementation of the corrective action 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 PAHP contractor will collect and report data on restraints and restrictive interventions to the State level program manager on a quarterly basis.

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## Appendix G-3: Medication Management and Administration

*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:

<input type="radio"/>	<b>Yes.</b> This Appendix applies ( <i>complete the remaining items</i> ).
<input checked="" type="radio"/>	<b>No.</b> This Appendix is not applicable ( <i>do not complete the remaining items</i> ).

**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.

**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.

**c. Medication Administration by Waiver Providers**

**i. Provider Administration of Medications.** *Select one:*

<input type="radio"/>	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. ( <i>complete the remaining items</i> )
<input type="radio"/>	Not applicable ( <i>do not complete the remaining items</i> )

**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).

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**iii. Medication Error Reporting.** *Select one of the following:*

<input type="radio"/>	Providers that are responsible for medication administration are required to <i>both</i> record and report medication errors to a State agency (or agencies). <i>Complete the following three items:</i>
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to <i>record</i> :
	(c) Specify the types of medication errors that providers must <i>report</i> to the State:
<input type="radio"/>	Providers responsible for medication administration are required to <i>record</i> 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.

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## 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.***

**a.i** *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.*

<b>Performance Measure:</b>	Percentage of youth and/or guardians who verify during the bi-annual plan of care review that they have received training on their rights, recognition of, and reporting processes for instances of abuse, neglect, and exploitation (# of verified signatures on this question submitted with the bi-annual plan of care / # of plans received)		
<b>Data Source [e.g. – examples cited in IPG]</b>	<b>Responsible Party for data collection/generation (check each that applies)</b>	<b>Frequency of data collection/generation: (check each that applies)</b>	<b>Sampling Approach (check each that applies)</b>
PAHP Contractor’s Electronic Plan of Care Management System	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b>	<b>Frequency of data aggregation and analysis:</b>	

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	<i>(check each that applies)</i>	<i>(check each that applies)</i>	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

<b>Performance Measure:</b>	Percentage of critical incidents that resulted in PAHP contractor follow up, provider corrective action plans, sanctions, or other disciplinary action (# of critical incidents reviewed and followed up according to state requirements / # of incidents received)		
<b>Data Source [e.g. – examples cited in IPG]</b>	<b>Responsible Party for data collection/generation (check each that applies)</b>	<b>Frequency of data collection/generation: (check each that applies)</b>	<b>Sampling Approach (check each that applies)</b>
PAHP Contractor’s Electronic Plan of Care Management System	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis (check each that applies)</b>	<b>Frequency of data aggregation and analysis: (check each that applies)</b>	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	

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	<input type="checkbox"/> <i>Continuously and Ongoing</i>	
	<input type="checkbox"/> <i>Other: Specify:</i>	

<b><i>Performance Measure:</i></b>	The percentage (#) and type of deaths with provider-related concerns determined by the mortality review committee that result in a provider corrective action, sanction, or other disciplinary action and a resolution status (# of deaths resulting in provider corrective action, sanction, or other disciplinary action and the resolution status of action taken /# of deaths found to have possible provider-related concerns)		
<b><i>Data Source [e.g. – examples cited in IPG]</i></b>	<b><i>Responsible Party for data collection/generation (check each that applies)</i></b>	<b><i>Frequency of data collection/generation: (check each that applies)</i></b>	<b><i>Sampling Approach (check each that applies)</i></b>
Mortality Review Committee	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>100% Review</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input type="checkbox"/> <i>Less than 100% Review</i> <input type="checkbox"/> <i>Representative Sample; Confidence Interval =</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input checked="" type="checkbox"/> <i>Quarterly</i>	
	<input checked="" type="checkbox"/> <i>Other: Specify: PAHP Contractor</i>	<input type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Groups</i> <input type="checkbox"/> <i>Other: Describe</i>
		<input type="checkbox"/> <i>Other: Specify:</i>	
<b><i>Data Aggregation and Analysis</i></b>	<b><i>Responsible Party for data aggregation and analysis (check each that applies)</i></b>	<b><i>Frequency of data aggregation and analysis: (check each that applies)</i></b>	
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	
	<input type="checkbox"/> <i>Other: Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	
		<input type="checkbox"/> <i>Other: Specify:</i>	

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<b>Performance Measure:</b>	The percentage of incidents regarding abuse, neglect, exploitation and unexplained death that were addressed according to state statute (# of abuse, neglect, exploitation, and unexplained death incidents addressed according to state statute / # incidents received)		
<b>Data Source [e.g. – examples cited in IPG]</b>	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
PAHP contractor electronic plan of care management system	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

<b>Performance Measure:</b>	The percentage of PAHP contracted providers that receive training on abuse, neglect and exploitation identification and reporting procedures annually as part of the re-certification process (total # of providers that receive training on abuse, neglect and exploitation identification and reporting procedures annually as part of the re-certification process/ total # of contracted providers).
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<b>Data Source</b> <i>[e.g. – examples cited in IPG]</i>	<b>Responsible Party for data collection/generation</b> <i>(check each that applies)</i>	<b>Frequency of data collection/generation:</b> <i>(check each that applies)</i>	<b>Sampling Approach</b> <i>(check each that applies)</i>
PAHP contractor electronic plan of care management system	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies)</i>	<b>Frequency of data aggregation and analysis:</b> <i>(check each that applies)</i>	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

<b>Performance Measure:</b>	The percentage and type of restrictive intervention and restraints reported to the PAHP confirmed to have followed the state rules and procedures (# and type of restrictive intervention and restraints reported to the PAHP confirmed to have followed the state rules and procedures/ total # of restrictions and restraints reported).		
<b>Data Source</b> <i>[e.g. – examples cited in IPG]</i>	<b>Responsible Party for data collection/generation</b> <i>(check each that applies)</i>	<b>Frequency of data collection/generation:</b> <i>(check each that applies)</i>	<b>Sampling Approach</b> <i>(check each that applies)</i>

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PAHP contractor electronic plan of care management system	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

<b>Performance Measure:</b>	The percentage of participants who are receiving preventive medical care in accordance with federal EPSDT requirements (# of participants who are receiving preventive medical care in accordance with federal EPSDT requirements/ # of youth enrolled in the waiver program).		
<b>Data Source</b> [e.g. – examples cited in IPG]	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
Total Health Record, PAHP contractor electronic plan of care management system, Medicaid’s Continuity of Care	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

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Document, Medicaid MMIS			
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

**Add another Data Source for this performance measure**

**Add another Performance measure (button to prompt another performance measure)**

*a.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**

*b.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.*

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Critical incidents are reported to the PAHP contractor. The incident reports are recorded in the PAHP contractor's electronic plan of care management system. All providers are also required to send a copy of the critical incident to the guardian, Family Care Coordinator, DFS, and Protection and Advocacy (as required by law). PAHP contractor staffs are responsible for assigning a category to the incident depending on the severity and what it entails. DFS reviews 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 PAHP contractor any restraint that results in an injury using the same process as used for the initial incident report submission. Injuries that are a result of a restraint must also be reported to DFS, the guardian, and the FCC. If a restraint is used on a participant that does not result in an injury, it still must be reported to the PAHP contractor, but does not need to be reported to DFS. This includes any emergency restraints that are used on a participant. PAHP contractor staff are responsible for reviewing all restraint utilization to ensure provider compliance.

Ongoing and negligent non-compliance of a provider to appropriate report suspected or confirmed instances of abuse, neglect or exploitation may result in the PAHP contractor mandating the development and implementation of a provider corrective action plan. If a provider fails to submit an acceptable corrective action plan after several attempts working with the PAHP contractor, the State and/or PAHP contractor can impose provider sanctions (contract termination) as allowed under Medicaid Rule. Sanctions include suspending admissions, suspending the provider enrollment with Medicaid,

De-certifying 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 PAHP contractor's electronic plan of care management system. The PAHP contractor will track and monitor the status of all corrective action plans.

In each quarterly performance report required of the PAHP contractor by the State level program manager, data related to incident report trends, problem providers, corrective action plans, provider contract suspensions and all other related actions will be summarized and reported.

***b.ii Remediation Data Aggregation***

<b><i>Remediation-related Data Aggregation and Analysis (including trend identification)</i></b>	<b><i>Responsible Party (check each that applies)</i></b>	<b><i>Frequency of data aggregation and analysis: (check each that applies)</i></b>
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and Ongoing

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		<input type="checkbox"/> <i>Other: Specify:</i>

**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 Health and Welfare that are currently non-operational.*

<input type="radio"/>	<b>Yes</b> <i>(complete remainder of item)</i>
<input checked="" type="radio"/>	<b>No</b>

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

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## Appendix H: Systems Improvement

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.

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### 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.

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## H.1 Systems Improvement

H.1.a.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.

Pursuant to Section B of the current 1915 (b) waiver submission and through its contract with the PAHP, Wyoming will require that specific metrics and trends are identified and reported for the following types of monitoring activities:

- Accreditation for Non-Duplication;
- Consumer Self-Report Data;
- Data Analysis (non-claims);
- Enrollee Hotlines;
- Geographic Mapping;
- Independent Assessment (as required by the 1915 (b) waiver);
- Measurement of Disparities by Racial or Ethnic Groups;
- Network Adequacy Assurance by Plan;
- Performance Measures; and
- Utilization Review.

As a result of the analyses of data and remediation information, the State will develop and deploy system improvements through contract and/or waiver amendments to reflect system of care best practices.

These monitoring activities will be developed and implemented in accordance with the following deployment plan:

### **Accreditation for Non-Duplication:**

- Applicable program: PAHP
- Personnel responsible: State
- Detailed description of activity: If the PAHP selected through the competitive procurement meets NCQA, URAC, JCAHO, CARF, or CAO accreditation standards for accreditation, the state will deem that the state-specific standards required in 42 CFR 43 Subpart D are met
- Frequency of use: Once, upon PAHP selection/initial contracting
- How it yields information about the area(s) being monitored: Accreditation information is used to monitor the following: timely access, provider selection, and quality of care.

The accreditation will be utilized to ensure the quality and effectiveness of the services provided. After review of the result accrediting body survey results, the State may require a written plan for addressing low performance. Accreditation results may be reported and reviewed by the State and the results reviewed as part of the EQRO process. A correct action plan may be requested by the State.

### **Consumer Self-Report Data:**

- Applicable program: PAHP
- Personnel responsible: State and PAHP

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- Detailed description of activity: The State will conduct a consumer satisfaction survey for its enrolled population, which may slightly vary from the existing satisfaction tools. The survey will utilize the sampling method and format defined by the National Committee for Quality Assurance (NCQA).
- Frequency of use: The consumer satisfaction/disenrollment survey will be conducted annually. A random sample for each survey is drawn from Medicaid enrollees who received a covered service in the previous year.
- How it yields information about the area(s) being monitored: The survey information is used to monitor the following: disenrollment, timely access, information to beneficiaries, and quality of care.

The survey results must be submitted to the State. Findings from the results will be utilized to measure and evaluate the client’s perception of the quality and effectiveness of services received and to evaluate reasons for disenrollment from the program. Results will assist the State in monitoring the satisfaction of participants, identify gaps in service and evaluate needs in future policy development. The survey will include the following demographic information: 1) provider/agency in which services are being received; participant’s age, gender, race or ethnic group; and modalities of services received during HFWA.

This information will be utilized to identify issues for performance measures regarding quality of care and to improve the consumer information for member use. After reviewing the results from the satisfaction survey, the State may require a written plan for addressing low performance. Survey results are reported and reviewed by the State. The findings are included in the PAHP’s performance evaluation.

**Data Analysis (non-claims) – Denials of Referral Requests and Grievances and Appeals Data:**

- Applicable program: PAHP
- Personnel responsible: State and PAHP
- Detailed description of activity: The PAHP is required to track disenrollment requests by enrollee from the plan, denials or referral requests, and grievance and appeals data. This data is included in a quarterly report from the PAHP to the State.
- Frequency of use: Data is gathered and reported quarterly with quarterly reviews by the State.
- How it yields information about the area(s) being monitored: The data is used to monitor the following: quality of care, enrollment/disenrollment, coordination/continuity, coverage/authorization and grievances

The data is integrated into the performance measures as part of the overall State performance improvement process. The data is analyzed to identify trends, sentinel and adverse events. The findings are reported to the State. The State then discusses the findings to identify opportunities for improvement. In addition, this information is used to assess the effectiveness of quality initiatives or projects. The findings are included in the PAHP’s performance evaluation.

**Enrollee Hotlines operated by PAHP:**

- Applicable program: PAHP
- Personnel responsible: PAHP and State
- Detailed description of activity: The PAHP is required to have staff available by 800 number 24 hours a day/365 days a year to respond to enrollee calls. Interpreter services are available for the hearing impaired and for non-English speakers. Calls range from non-urgent requests for referral to behavioral health crises. The 800 number is printed in the enrollee benefit book and

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associated materials. The 800 number shall include telephone crisis intervention, risk assessment, and consultation to callers which may include family members or other community agencies regarding behavioral health services.

- Frequency of use: The 800 number is available 24 hours a day, every day.
- How it yields information about the area(s) being monitored: The 800 number is used to monitor the following: information to beneficiaries, grievance, timely access, coordination/continuity, and quality of care

The data is used to monitor the above topics by obtaining information from the beneficiaries, resolving issues, and identifying and addressing trends. If deficiencies are noted the Contractor must perform corrective action until compliance is met. Issues are reported to the State quarterly and the State discusses the findings to identify opportunities for improvement. The findings are included in the PAHP's performance evaluation.

#### **Geographic Mapping of Provider Network:**

- Applicable program: PAHP
- Personnel responsible: PAHP
- Detailed description of activity: Through geographic mapping, distribution of provider types across the state is identified. A full listing is included in the Service Report.
- Frequency of use: Geographic mapping is generated and reported on a quarterly basis.
- How it yields information about the area(s) being monitored: Geographic mapping information is used to monitor marketing, information to beneficiaries, PCP/Specialist Capacity, choice, timely access, coordination/continuity, coverage/authorization, quality of care and Provider Selection. Referral and subsequent enrollment patterns can be mapped to ensure appropriate marketing in all geographic areas.

A software program produces a report that is analyzed for compliance with the State access and capacity requirements. The analysis is part of the PAHP's performance evaluation. The State discusses the findings to identify opportunities for improvement and if deficiencies are noted the Contractor must perform corrective action until compliance is met.

#### **Independent Assessment of Program Impact, Access, Quality and Cost-Effectiveness:**

- Applicable program: PAHP
- Personnel responsible: An independent third party will be contracted to perform this activity/audit.
- Detailed description of activity: The State will hire an independent assessor to assess quality of care, access to services, and cost-effectiveness of this new HFWA delivery system as required by the waiver.
- Frequency of use: One time per waiver period for the first two renewal cycles.
- How it yields information about the area(s) being monitored: The independent assessment will be used to monitor timely access and quality of care.

The assessment is used to monitor the above topics. The data collected is used to 1) analyze the effectiveness of the new program; 2) develop a quantitative understanding of access to the new behavioral health care service delivery system; 3) identify needs for further contracting; and/or 4) identify processes and areas of quality of care for detained study through on-going performance measures. The analysis is part of the PAHP's evaluation. The State discusses the findings to identify opportunities for improvement and if deficiencies are noted the Contractor must perform corrective action until compliance is met.

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**Disparities by Racial or Ethnic Groups:**

- Applicable program: PAHP
- Personnel responsible: PAHP
- Detailed description of activity: The PAHP is required to report demographic data (including racial/ethnic data), outcomes measures, utilization and special needs population (target population) data to the State.
- Frequency of use: The data is collected annually.
- How it yields information about the area(s) being monitored: The measurement of any disparities by racial or ethnic groups will be used to monitor timely access and coverage and authorization of care.

The disparity analysis provides information regarding the effectiveness of the program. This information is utilized for performance measures. The primary focus is to obtain information about problems or opportunities for improvement to implement performance measures for quality, access, or coordination of care or to improve information to beneficiaries. The findings are included in the PAHP’s performance evaluation.

**Network Adequacy Assurance Submitted by Plan (PAHP):**

- Applicable program: PAHP
- Personnel responsible: PAHP
- Detailed description of activity: The PAHP submits documentation to the State that it offers an appropriate range of services that is adequate for the anticipated number of enrollees and maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the enrollees.
- Frequency of use: Documentation is submitted quarterly.
- How it yields information about the area(s) being monitored: Network

The data is used to monitor the above topics by obtaining information from the beneficiaries, resolving issues, and identifying and addressing trends. If deficiencies are noted the Contractor must perform corrective action until compliance is met. The findings are included in the PAHP’s performance evaluation.

**Performance Measures:**

- Applicable program: PAHP
- Personnel responsible: PAHP And State
- Detailed description of activity: The State has established a comprehensive list of performance measures, entitled Startup Requirements, Operational Requirements, and Outcome Measurement and Credits.
- Frequency of use: The performance measures are reported on quarterly, or as otherwise stated in the Requirements.
- How it yields information about the area(s) being monitored: The performance measures provide information on all listed categories.

Data on performance measures is reported to the State quarterly or as otherwise listed in the Requirements. The quarterly reports to the State aid in the identification of opportunities for quality improvement and the assessment of initiative effectiveness. The contract also establishes expectation around continuous quality improvement that includes participating in the development of measures of performance and collecting and reporting baseline data on identified performance indicators, and

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development and implementation of improvement plans. The results are reported to the State and the State discusses the findings and identifies opportunities for improvements. In addition, this information aids in the assessment of the effectiveness of the quality improvement process. The data from all sources is analyzed for compliance. The identified aspects are integrated into the implementation of continuous quality improvement processes. The findings are included in the PAHP's performance evaluation.

**Utilization Review:**

- Applicable program: PAHP
- Personnel responsible: PAHP
- Detailed description of activity: The PAHP conducts a statistically valid sample review. The Contractor shall perform ongoing monitoring of UM data, on site review results, and claims data review. The designated IT staff will review the Contractor's utilization review process
- Frequency of use: Utilization reviews occur at intervals, first within the initial treatment period and then regularly thereafter. Data related to the utilization review are reported to the State and reviewed annually at minimum.
- How it yields information about the area(s) being monitored: Utilization management data can be used to monitor program integrity, choice, marketing, enrollment/disenrollment, timely access, coordination/continuity, provider selection, quality of care and coverage/authorization.

Data is utilized to indicate opportunities for improvement and to assess compliance with utilization policies and procedures at the provider and contractor level. This information is primarily used for provider and enrollee monitoring. The analysis is reported to the State. The State discusses the findings to identify opportunities from improvement and, if areas of improvement are noted, the Contract works with the specific provider noted or incorporates the identified aspects into the implementation of performance measures. The findings are included in the PAHP's performance evaluation.

H.1.a.ii

<b>System Improvement Activities</b>	<b>Responsible Party (check each that applies)</b>	<b>Frequency of monitoring and analysis (check each that applies)</b>
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
	<input type="checkbox"/> Quality Improvement Committee	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Other: Specify: PAHP Contractor	<input checked="" type="checkbox"/> Other: Specify: Various – Specific frequencies are noted for each proposed assessment method.

H.1.b.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

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the processes for monitoring & assessing system design changes, and how the results of the changes and the assessment are communicated (and with what frequency) to stakeholders, including participants, families, providers, agencies and other interested parties. If applicable, include the State’s targeted standards for systems improvement.

The same monitoring and assessment methodologies detailed in H.1.a.i will be deployed and utilized for monitoring and assessing any system design changes. The monitoring and assessment methodologies must remain consistent across the program change to appropriately reflect impacts of the change implemented. Results of the program changes will be communicated to program stakeholders through marketing and promotion efforts under direction of the PAHP contractor with approval from the State and through regional/local stakeholder and community meetings required as an activity of the PAHP contractor. The PAHP contractor will maintain compliance with its External Communication Management Matrix and ensure program performance information is made available through the contractual agreements as set forth.

The State’s targeted standards for systems improvement is predicated upon the national model for the development of a comprehensive children’s mental health system of care.

H.1.b.ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

As required by the concurrent 1915 (b) waiver, the State will procure and contract with a third party entity to complete an independent assessment of program impact, access, quality and cost-effectiveness according to the frequency mandated by the 1915 (b) waiver – one time per waiver period for the first two renewal cycles.

**Independent Assessment of Program Impact, Access, Quality and Cost-Effectiveness:**

- Applicable program: PAHP
- Personnel responsible: An independent third party will be contracted to perform this activity/audit.
- Detailed description of activity: The State will hire an independent assessor to assess quality of care, access to services, and cost-effectiveness of this new HFVA delivery system as required by the waiver.
- Frequency of use: One time per waiver period for the first two renewal cycles.
- How it yields information about the area(s) being monitored: The independent assessment will be used to monitor timely access and quality of care.

The assessment is used to monitor the above topics. The data collected is used to 1) analyze the effectiveness of the new program; 2) develop a quantitative understanding of access to the new behavioral health care service delivery system; 3) identify needs for further contracting; and/or 4) identify processes and areas of quality of care for detained study through on-going performance measures. The analysis is part of the PAHP’s evaluation. The State discusses the findings to identify opportunities for improvement and if deficiencies are noted the Contractor must perform corrective action until compliance is met.

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# Appendix I: Financial Accountability

## APPENDIX 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).

**(a) Independent Assessment of Program Impact, Access, Quality and Cost-Effectiveness:**

- Applicable program: PAHP
- Personnel responsible: An independent third party will be contracted to perform this activity/audit.
- Detailed description of activity: The State will hire an independent assessor to assess quality of care, access to services, financial integrity and accountability and cost-effectiveness of this waiver service.
- Frequency of use: One time per waiver period for the first two renewal cycles.
- How it yields information about the area(s) being monitored: The independent assessment will be used to monitor timely access, financial integrity and accountability, and quality of care.

The assessment is used to monitor the above topics. The data collected is used to 1) analyze the effectiveness of the new program; 2) develop a quantitative understanding of access to the new behavioral health care service delivery system; 3) identify needs for further contracting; and/or 4) identify processes and areas of quality of care for detained study through on-going performance measures. The analysis is part of the PAHP's evaluation. The State discusses the findings to identify opportunities for improvement and if deficiencies are noted the Contractor must perform corrective action until compliance is met.

(b & c) The waiver, through the SMA, is part of the annual State Financial Audit which is conducted every year by an external accounting group, McGee, Hearne & Paiz. The audit always includes a sample of waiver claims (to include PAHP contractor claims for payment). The audit includes the entire process of Medicaid from eligibility all the through to final payment including the process with payment from CMS. The sample is determined by Medicaid Program Integrity's contractor for the audit. It is a random statistically valid sample with a 95% confidence interval and a +/-5% margin of error. The state uses Medicaid Integrity Contractors (MICs), which are private companies that conduct audit-related activities under contract to the Medicaid Integrity Group (MIG), the component within CMS that is charged by the U.S. Department of Health & Human Services with carrying out the Medicaid Integrity Program. The Review MICs run MIG-approved algorithms on claims data from the Medicaid Statistical Information System (MSIS). The MIG's Division of Fraud Research & Detection reviews and approves those results before they are provided to the Audit MICs for audit. The MIG vets providers to be audited with State Medicaid agencies prior to the start of the audits. The MIG also shares the list of potential audits with State and Federal law enforcement agencies. If either a State Medicaid agency or a law enforcement agency is conducting an audit or investigation of the same provider for similar Medicaid issues, then the MIG may cancel or postpone the Audit MIC audit of the provider. Medicaid's Program

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Integrity Unit reviews a random statistically valid sample of provider waiver claims. The auditing of claims is done by random selection as well as targeted claims which meet certain criteria. The auditing process is done on a periodic basis for utilization review and quality assurance purposes. The Wyoming policies for Medicaid's Program Integrity Unit are outlined in Wyoming Medicaid Rule. Medicaid also participates in the Payment Error Reporting Measurement (PERM) program to ensure accuracy of the claims reimbursement process. 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 the Division's Program Integrity Unit. The Program Integrity Unit, in collaboration with the PAHP contractor, 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. Waiver claims are included in the Explanation of Medical Benefits (EOMB) sample sent to participants. This random sample of participants requests the participant verify that the services listed on the EOMB were actually received by them. Responses to the EOMB that indicate services were not received are reviewed by the Program Integrity Unit.

The PAHP contractor provider network manager and staff will complete periodic documentation reviews for each provider. Results of the documentation reviewed are recorded in the PAHP contractor's electronic provider management system. If concerns are found, the issues and concerns are recorded in the PAHP contractor's electronic provider management system as needed.

Reviews 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 clients in the program;
- Audit of provider or agency financial records for reimbursement;
- Determination of whether the health care provided is medically necessary; and/or
- Random sampling of invoices submitted by and payments made to providers.

## 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.*

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**a.i** 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.

<b>Performance Measure:</b>	Number and percent of claims that are paid in accordance with the rate Methodology approved in the waiver (# of claims submitted and paid according to the rate methodology in the approved waiver / total # of claims paid)		
<b>Data Source [e.g. – examples cited in IPG]</b>	<b>Responsible Party for data collection/generation (check each that applies)</b>	<b>Frequency of data collection/generation: (check each that applies)</b>	<b>Sampling Approach (check each that applies)</b>
State Medicaid MMIS and COGNOS DSS	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	95% +/- 5%
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis (check each that applies)</b>	<b>Frequency of data aggregation and analysis: (check each that applies)</b>	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

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<b>Performance Measure:</b>	Number and percent of claims that are paid for enrolled waiver youth only (# of claims paid for enrolled waiver youth/ total # of waiver claims paid)		
<b>Data Source</b> [e.g. – examples cited in IPG]	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
State Medicaid MMIS and COGNOS DSS	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	95% +/- 5%
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<b>Data Aggregation and Analysis</b>	<b>Responsible Party for data aggregation and analysis</b> (check each that applies)	<b>Frequency of data aggregation and analysis:</b> (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

<b>Performance Measure:</b>	Number and percent of provider payment rates that are consistent with rate methodology approved in the original waiver application or subsequent amendment (# of payments consistent with approved waiver rate methodology / total # of claims paid)		
<b>Data Source</b> [e.g. – examples cited in IPG]	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)

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State Medicaid MMIS and COGNOS DSS	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input checked="" type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval =</i>
	<input type="checkbox"/> <i>Other: Specify:</i>	<input type="checkbox"/> <i>Annually</i>	<i>95% +/- 5%</i>
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Groups</i>
		<input type="checkbox"/> <i>Other: Specify:</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
<b><i>Data Aggregation and Analysis</i></b>	<b><i>Responsible Party for data aggregation and analysis</i></b> <i>(check each that applies)</i>	<b><i>Frequency of data aggregation and analysis:</i></b> <i>(check each that applies)</i>	
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	
	<input type="checkbox"/> <i>Other: Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	
		<input type="checkbox"/> <i>Other: Specify:</i>	

***Add another Data Source for this performance measure***

***Add another Performance measure (button to prompt another performance measure)***

*a.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.*

Under the concurrent authority of the 1915 (b) waiver, program expenditures by eligibility program code and service will be pulled and reviewed quarterly for reporting to CMS. Any problems/issues within the waiver program related to financial integrity, payment and/or billing will be easily identified during these quarterly reviews throughout the life of the program.

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**b. Methods for Remediation/Fixing Individual Problems**

**b.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.

Any issues/problems identified during the quarterly review and expenditure reporting to CMS are documented by the State level program manager. The issues/problem will be reviewed as part of the routine contract monitoring process between the State level program manager and the PAHP contractor. As necessary, the State level program manager will work directly with the Fiscal Agent to set up or correct any required claims editing functionality in the MMIS to prevent recurrent issues.

**b.ii Remediation Data Aggregation**

<b>Remediation-related Data Aggregation and Analysis (including trend identification)</b>	<b>Responsible Party (check each that applies)</b>	<b>Frequency of data aggregation and analysis: (check each that applies)</b>
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> 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.

<input type="radio"/>	<b>Yes</b> (complete remainder of item)
<input checked="" type="radio"/>	<b>No</b>

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

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## APPENDIX I-2: Rates, Billing and Claims

- 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).

To calculate the per member per month service rate for waiver enrollees, Navigant extracted never and fully adjusted Wyoming Medicaid claims data from Wyoming's Decision Support System (DSS), Cognos, with dates of service in State Fiscal Year (SFY) 2013.1 For this time period, Navigant:

- Extracted claims data for the Children's Mental Health Waiver program codes only (S95, S96, and S65); and
- Extracted detail level claims data, restricting the data to claim line items with procedure codes T1016 (Family Care Coordination), T1027 (Youth and Family Training) and H0023 (Respite).

The capitation rates were developed based on the state fiscal year 2013 data with trend information from 2013 – 2015, industry data, Lewis and Ellis proprietary data, and Lewis and Ellis' actuary judgement. The capitation rates were developed on an actuarially sound basis from historical claims and enrollment data.

**Enrollment Data:** The data used for the rate development includes the amount spent under the CMHW utilization and payments during the SFY 2013. The Medicaid payments were recorded under the following CMHW 1915 (c) Service Arrays: Family Care Coordination, Youth & Family Training, and Respite. Other waiver data was not included in the analysis.

**PMPM Calculation:** Lewis and Ellis included the summation of Medicaid expenditures from all claims for individuals who met the program criteria as defined in this waiver. The PMPM rate was calculated based on service dates during SFY 2013 with services paid through 2014. The PMP rate is based on Medicaid Funded payments only.

The PMPM rates were developed using the total claims paid for services and number of members enrolled that received those services. The PMPM rates that were developed reflect the average amounts that would have been charged to cover the services rendered based on SFY2013 enrollee utilization as averaged across total program participants.

The actuarially sound rate calculated by Lewis and Ellis for Youth and Family Training and Support was calculated to be 50% of the total certified rate development for Youth and Family Training as provided in the SFY 2013 CMHW to account for the service definition being amended to restrict service provision to group settings only. The 50% reduction in reimbursement for services provided in a group setting follows existing reimbursement methodology implemented in various Medicaid fee for service environments to distinguish individual versus group service modalities.

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The rate determined to be payable to the PAHP on a per member per month basis is detailed in the operational contract between the State Medicaid Agency and the PAHP contractor. The PAHP contractor is responsible for establishing, via provider network contract, the most appropriate payment methodology for providers rendering waiver services. The provider payment rate detailed in the contract between the provider and the PAHP contractor will be assessed and monitored for appropriateness based on the various program monitoring activities detailed in section H.1.a.i.

- 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 waiver providers. The PAHP contractor will directly submit claims using an electronic software system or via web online entry, which are both direct input tools to the Wyoming MMIS. Once the PAHP contractor submits a claim, the claim enters the MMIS and is processed through the processing cycle, which includes all edits and audits.

- c. Certifying Public Expenditures (select one):**

<input type="radio"/>	<b>Yes.</b> 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 ( <i>check each that applies</i> ):
<input type="checkbox"/>	<b>Certified Public Expenditures (CPE) of State Public Agencies.</b> 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). ( <i>Indicate source of revenue for CPEs in Item I-4-a.</i> )
<input type="checkbox"/>	<b>Certified Public Expenditures (CPE) of Local Government Agencies.</b> 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). ( <i>Indicate source of revenue for CPEs in Item I-4-b.</i> )
<input checked="" type="radio"/>	<b>No.</b> State or local government agencies do not certify expenditures for waiver services.

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- 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 authorized by the PAHP contractor clinical, who review the services requested, objectives developed and the requested amount, duration and frequency of each service proposed. The PAHP contractor clinical staff specialist verifies the provider is certified for the requested service and that the services requested do not exceed the specified methodology. All services must receive authorization (via the plan of care approval). All billing for waiver services will be done by the PAHP contractor and submitted electronically through MMIS. All payments will be rendered through the same system. There are many edits built into the MMIS that do not allow payment for restricted services and amounts above those included in the contractual agreement between the State and the PAHP contractor. 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 the MMIS utilizes edits to assure that payments never exceed authorized/contracted amounts. An individual must be an active Medicaid recipient enrolled in the CMH 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 Waiver program (in this case, the CMH 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. 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 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

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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.

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## APPENDIX I-3: Payment

**a. Method of payments — MMIS** (*select one*):

<input checked="" type="radio"/>	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
<input type="radio"/>	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) 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.
<input type="radio"/>	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:
<input type="radio"/>	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:

**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*):

<input type="checkbox"/>	The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
<input type="checkbox"/>	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
<input type="checkbox"/>	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:
<input checked="" type="checkbox"/>	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.
	Waiver service providers are under contract with and operate within the provider network established by the PAHP contractor. The state has developed an actuarially sound per member per month rate payable to the PAHP to fund the provision of waiver services. The PAHP, in

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	turn, establishes appropriate payment methodologies and rates with their contracted provider network. There are no payments made to waiver service providers outside of the State's contract with the PAHP.
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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:*

<input checked="" type="radio"/>	<b>No.</b> The State does not make supplemental or enhanced payments for waiver services.
<input type="radio"/>	<b>Yes.</b> 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.

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

<input type="radio"/>	<b>Yes.</b> State or local government providers receive payment for waiver services. 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. <i>Complete item I-3-e.</i>
<input checked="" type="radio"/>	<b>No.</b> State or local government providers do not receive payment for waiver services. <i>Do not complete Item I-3-e.</i>

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:*

<input type="radio"/>	The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
<input type="radio"/>	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.
<input type="radio"/>	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

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	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:

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**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:*

<input type="radio"/>	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
<input checked="" type="radio"/>	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.
	Waiver service providers are under contract with and operate within the provider network established by the PAHP contractor. The state has developed an actuarially sound per member per month rate payable to the PAHP to fund the provision of waiver services. The PAHP, in turn, establishes appropriate payment methodologies and rates with their contracted provider network. The monthly capitated payment to the PAHP contractor is not reduced or returned in any part to the State.

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

<input type="radio"/>	<b>Yes.</b> 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.
<input checked="" type="radio"/>	<b>No.</b> The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

**ii. Organized Health Care Delivery System.** *Select one:*

<input type="radio"/>	<b>Yes.</b> 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:
<input checked="" type="radio"/>	<b>No.</b> The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

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**iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:***

<input type="radio"/>	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 <i>voluntarily</i> elect to receive <i>waiver</i> 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.
<input checked="" type="radio"/>	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain <i>waiver</i> 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.
<input type="radio"/>	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

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## APPENDIX I-4: Non-Federal Matching Funds

- 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. *Check each that applies:*

<input checked="" type="checkbox"/>	<b>Appropriation of State Tax Revenues to the State Medicaid agency</b>
<input type="checkbox"/>	<b>Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.</b> 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: <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>
<input type="checkbox"/>	<b>Other State Level Source(s) of Funds.</b> 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: <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>

- 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. *Check each that applies:*

<input type="checkbox"/>	<b>Appropriation of Local Government Revenues.</b> 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: <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>
<input type="checkbox"/>	<b>Other Local Government Level Source(s) of Funds.</b> 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: <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>
<input checked="" type="checkbox"/>	<b>Not Applicable.</b> There are no local government level sources of funds utilized as the non-federal share.

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- 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:*

<input checked="" type="radio"/>	None of the specified sources of funds contribute to the non-federal share of computable waiver costs.
<input type="radio"/>	The following source (s) are used. <i>Check each that applies.</i>
<input type="checkbox"/>	Health care-related taxes or fees
<input type="checkbox"/>	Provider-related donations
<input type="checkbox"/>	Federal funds
	For each source of funds indicated above, describe the source of the funds in detail:

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# APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

<input checked="" type="radio"/>	No services under this waiver are furnished in residential settings other than the private residence of the individual. <i>(Do not complete Item I-5-b).</i>
<input type="radio"/>	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. <i>(Complete Item I-5-b)</i>

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:

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## APPENDIX 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:

<input type="radio"/>	<p><b>Yes.</b> 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. <i>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:</i></p> <div style="border: 1px solid black; height: 50px; width: 100%; background-color: #e0e0e0; margin-top: 5px;"></div>
<input checked="" type="radio"/>	<p><b>No.</b> 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.</p>

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## APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

- 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:*

<input checked="" type="radio"/>	<b>No.</b> The State does not impose a co-payment or similar charge upon participants for waiver services. <i>(Do not complete the remaining items; proceed to Item I-7-b).</i>
<input type="radio"/>	<b>Yes.</b> The State imposes a co-payment or similar charge upon participants for one or more waiver services. <i>(Complete the remaining items)</i>

- i. **Co-Pay Arrangement** Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies):*

<i>Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):</i>	
<input type="checkbox"/>	Nominal deductible
<input type="checkbox"/>	Coinsurance
<input type="checkbox"/>	Co-Payment
<input type="checkbox"/>	Other charge <i>(specify):</i>

- ii **Participants Subject to Co-pay Charges for Waiver Services.** Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

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- iii. **Amount of Co-Pay Charges for Waiver Services.** In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Amount of Charge	Basis of the Charge

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**iv. Cumulative Maximum Charges.** Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant (*select one*):

<input type="radio"/>	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
<input type="radio"/>	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

**v. Assurance.** The State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

**b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one*:

<input checked="" type="radio"/>	<b>No.</b> The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
<input type="radio"/>	<b>Yes.</b> 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:

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# Appendix J: Cost Neutrality Demonstration

## Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.** Complete the following table for each year of the waiver.

Level(s) of Care ( <i>specify</i> ):			Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160				
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 (Column 7 less Column 4)
1	\$2,275.68	\$17,160	\$19,435.68	\$38,903	\$50,074	\$88,977	\$69,541.32
2	\$2,275.68	\$17,160	\$19,435.68	\$38,903	\$50,074	\$88,977	\$69,541.32
3	\$2,275.68	\$17,160	\$19,435.68	\$38,903	\$50,074	\$88,977	\$69,541.32
4	\$2,275.68	\$17,160	\$19,435.68	\$38,903	\$50,074	\$88,977	\$69,541.32
5	\$2,275.68	\$17,160	\$19,435.68	\$38,903	\$50,074	\$88,977	\$69,541.32

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## Appendix J-2 - Derivation of Estimates

- 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:

<b>Table J-2-a: Unduplicated Participants</b>			
Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care: Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160	Level of Care:
Year 1	135	135	
Year 2	135	135	
Year 3	135	135	
Year 4 (renewal only)	135	135	
Year 5 (renewal only)	135	135	

- 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-d.

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 CMH SFY2013 CMS 372, based upon reports generated from the Medicaid Management Information System (MMIS), which is the report used to complete the CMS-372. The SFY-2013 MMIS data will be used for each year of the waiver.

- 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-2013 CMS-372, 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

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waiver years are estimated as follows:

- Estimated number of users:

Step 1: Use the SFY-2013 MMIS report data for CMH waiver.

Step 2: Predict the users of new services under the PAHP contractor. Use data from prior 372s and estimate using ages of participants and past usage.

Step 3: Calculate the final assumption based on maximization of all waiver funding opportunities.

- Estimated units/user:

Use the SFY-2013 CMH MMIS claims data to calculate the average units/user and round up to the next whole number. Utilization per 6-month plan period is divided equally by 6 (months) to determine the per member per month payment to be made to the PAHP contractor.

- Estimated cost/unit:

Use the published rates and expenditures paid in SFY 2013.

- 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-2013 CMS-372 for the CMH waiver is used, based on reports generated from the Medicaid Management Information system (MMIS).

Step 2: Use the SFY-2013 MMIS report data.

Factor D' includes institutional costs when a person leaves the waiver for the institution and returns to the waiver in the same waiver year.

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- 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-2013 CMS-372, based upon reports generated from the MMIS that complete the CMS-372.  
 Step 2: Use the SFY-2013 MMIS actual data  
 Step 3: Use the same estimated costs in each subsequent year.

- 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-2013 CMS-372 for the CMH waiver. The data is based upon reports generated from the MMIS.  
 Step 2: Use the SFY-2013 actual data  
 Step 3: Keep the estimates the same in subsequent years due to flat rates and rate reductions in Medicaid.

The prescribed drugs furnished to Medicare/Medicaid dual eligible participants 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'.

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Waiver Year: Year 2						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Youth & Family Training	<input checked="" type="checkbox"/>	12/ year	135	12	\$189.64	\$307,216.80
	<input type="checkbox"/>					
	<input type="checkbox"/>					
	<input type="checkbox"/>					
	<input type="checkbox"/>					
	<input type="checkbox"/>					
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<b>GRAND TOTAL:</b>						\$307,216.80
Total: Services included in capitation						\$307,216.80
Total: Services not included in capitation						\$0
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						135
FACTOR D (Divide grand total by number of participants)						\$2,275.68
Services included in capitation						\$2,275.68
Services not included in capitation						\$0
AVERAGE LENGTH OF STAY ON THE WAIVER						254.15 days

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Waiver Year: Year 3						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Youth & Family Training	<input checked="" type="checkbox"/>	12/ year	135	12	\$189.64	\$307,216.80
	<input type="checkbox"/>					
	<input type="checkbox"/>					
	<input type="checkbox"/>					
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GRAND TOTAL:						\$307,216.80
Total: Services included in capitation						\$307,216.80
Total: Services not included in capitation						\$0
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						135
FACTOR D (Divide grand total by number of participants)						\$2,275.68
Services included in capitation						\$2,275.68
Services not included in capitation						\$0
AVERAGE LENGTH OF STAY ON THE WAIVER						254.15 days

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<b>Waiver Year: Year 4 (Renewal Only)</b>						
<b>Waiver Service</b>	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	<b>Check if included in capitation</b>	<b>Unit</b>	<b># Users</b>	<b>Avg. Units Per User</b>	<b>Avg. Cost/ Unit</b>	<b>Total Cost</b>
Youth & Family Training	<input checked="" type="checkbox"/>	12/ year	135	12	\$189.64	\$307,216.80
	<input type="checkbox"/>					
	<input type="checkbox"/>					
	<input type="checkbox"/>					
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<b>GRAND TOTAL:</b>						\$307,216.80
Total: Services included in capitation						\$307,216.80
Total: Services not included in capitation						\$0
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						135
FACTOR D (Divide grand total by number of participants)						\$2,275.68
Services included in capitation						\$2,275.68
Services not included in capitation						\$0
AVERAGE LENGTH OF STAY ON THE WAIVER						254.15 days

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<b>Waiver Year: Year 5 (Renewal Only)</b>						
<b>Waiver Service</b>	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	<b>Check if included in capitation</b>	<b>Unit</b>	<b># Users</b>	<b>Avg. Units Per User</b>	<b>Avg. Cost/ Unit</b>	<b>Total Cost</b>
Youth & Family Training	<input checked="" type="checkbox"/>	12/ year	135	12	\$189.64	\$307,216.80
	<input type="checkbox"/>					
	<input type="checkbox"/>					
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<b>GRAND TOTAL:</b>						\$307,216.80
Total: Services included in capitation						\$307,216.80
Total: Services not included in capitation						\$0
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						135
FACTOR D (Divide grand total by number of participants)						\$2,275.68
Services included in capitation						\$2,275.68
Services not included in capitation						\$0
AVERAGE LENGTH OF STAY ON THE WAIVER						254.15 days

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