Wyoming Department of Health
Medicaid Managed Care
2020 State Quality Strategy

October 1, 2020

WYO MEDICAID
DIVISION OF HEALTHCARE FINANCING

Contents

Section I. Introduction

The Wyoming Department of Health (WDH) is pleased to present the 2020 Wyoming Managed Care State Quality Strategy. WDH administers Wyoming Medicaid, a joint federal and State government program that pays for medical care for some low-income and medically needy individuals and families. Although Wyoming Medicaid operates several programs, there is currently only one Medicaid managed care program in the State – the Wyoming Care Management Entity (CME) program. This quality strategy focuses on the CME program and serves as a blueprint for WDH to assess the quality of services that enrollees receive through the CME program and set forth goals for continuous quality improvement.

A. Background

Wyoming's CME program provides targeted case management services via a high-fidelity wraparound (HFWA) delivery model for Medicaid eligible youth aged 4 – 20 years old with serious emotional disturbance (SED) or serious and persistent mental illness (SPMI) who are high utilizers of behavioral health services. Specifically, the CME program serves Medicaid-enrolled youth who have a SED or SPMI and who meet criteria for Psychiatric Residential Treatment Facility (PRTF) or acute psychiatric stabilization hospital levels of care, as well as those who are enrolled in Wyoming's Children's Mental Health (CMHW) 1915(c) Medicaid waiver.

Outside of the CME program, Medicaid youth with complex behavioral health conditions may 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 may struggle because of gaps in required care coordination, family disruption, and distant out-of-home placements. 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 are better served, improving outcomes, while costs may also be reduced.

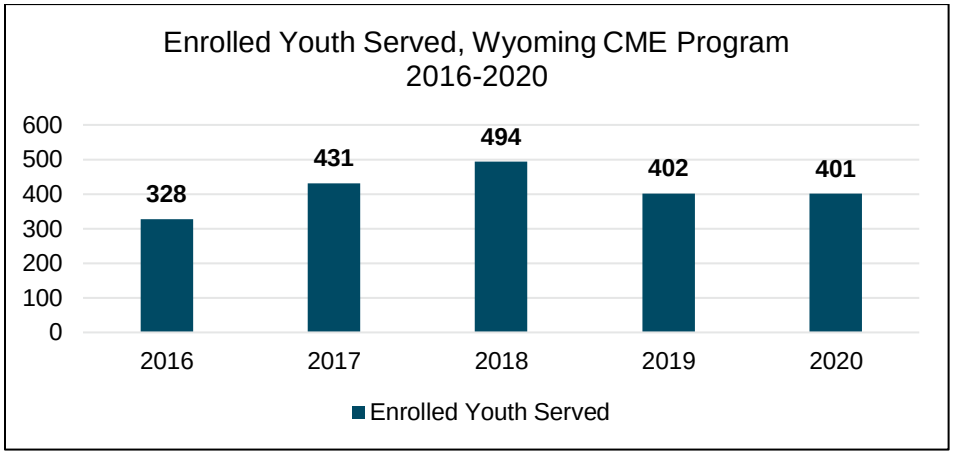
The CME strives to provide youth and their families the services necessary to allow the youth to reside in their community, participate in routine daily activities, and experience long term health and longevity. A key mission of the CME program is to coordinate the full array of care for youth with complex behavioral health needs through a single, centralized care management system. Specifically, the following aspects drive the CME program's mission:

- Offer a statewide model for evolving the system of care in partnership with State agencies through a care coordination approach with HFWA as the vehicle;
- Recognize, embrace, and respond to Wyoming's strengths, unique geographic characteristics, and cultural diversity; and
- Create a HFWA model that is uncomplicated for children and families regardless of their eligibility qualification.

Following a seven-county CME pilot program launched in 2013, the Centers for Medicare and Medicaid Services (CMS) approved WDH's application for a 1915(b) waiver to operate the CME program as a prepaid ambulatory health plan (PAHP) effective September 1, 2015. The PAHP initially served as a risk-based managed care arrangement in which WDH paid the contracted operator for the PAHP a capitated per member per month (PMPM) amount to provide covered services to eligible youth. To alleviate challenges associated with serving a small number of

program enrollees, WDH transitioned the CME program from the capitated risk-based payment model to a non-risk fee-for-service (FFS) model in 2018. Figure 1 below illustrates the number of youth served from 2016 to 2020.

Figure 1. CME Program Enrollment



B. Overview of Quality Management Structure

The WDH Division of Healthcare Financing (DHCF) is the State-appointed entity for administration of Wyoming's Medicaid program. WDH procured and oversees the statewide PAHP which operates the CME program. Table 1 below describes planned mechanisms to assess the CME's performance.

Table 1. Oversight Mechanisms

Frequency	Oversight Activities
Annually	• Review of consumer self-report data • Analysis of disparities by racial or ethnic groups • Utilization review • External Quality Review (EQR), conducted by an external quality review organization (EQRO)
Quarterly	• Data analysis, non-claims • Geographic mapping of provider network • Network adequacy assurance documentation • Performance measures reporting
Other	• Accreditation for non-duplication (one time) • Enrollee hotline operation (available 24/7)

Frequency	Oversight Activities
	• Independent assessment of program impact, access, quality and cost-effectiveness (first two waiver periods)

C. Federal Requirements for the Quality Strategy

Per 42 CFR 438.340, all states with managed care programs must develop and maintain a quality strategy. In 2016, the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) extended federal quality strategy requirements specified at 42 CFR 438.340 to PAHPs, including Wyoming's CME program. Under 42 CFR 438.340, WDH is required to:

- Obtain input from individuals and other stakeholders in the development of the quality strategy
- Make the quality strategy available for public comment prior to finalization
- Submit the quality strategy to CMS
- Annually submit reports on the implementation and progress of the quality strategy
- Update the quality strategy at least once every three years and take into account EQR recommendations

Per 42 CFR 438.340, all quality strategies must include at least the following elements:

- Network adequacy and availability of services standards
- Goals and objectives for continuous quality improvement
- Quality metrics and performance measures
- Performance improvement projects
- External quality review
- Transition of care policy
- Plans to identify, evaluate, and reduce health disparities
- Use of intermediate sanctions (applies to managed care organizations (MCOs) only)
- Assessment of performance and quality outcomes (applies to primary care case management (PCCMs) entity only)
- Identification of persons who need long-term services and supports or persons with special health care needs
- Nonduplication of EQR activities
- Definition of "significant change"

WDH intends to evaluate the state quality strategy's effectiveness on an annual basis and update and re-submit the State's quality strategy as needed but no less than once every three years, in accordance with 42 CFR 438.340.

Section II. Quality Strategy Components

The following sections address federally-required elements described in 42 CFR 438.340.

A. Network Adequacy and Availability of Services Standards

Pursuant to 42 CFR 438.340 (b)(1), WDH is required to describe standards regarding network adequacy and availability of services, as well as examples of evidence-based clinical practice guidelines.

Although the CME program does not offer clinical services, enrollment in the program is based on the prospective enrollee's clinical and functional outcomes as measured by three standardized eligibility assessment tools – Level of Care (LOC) assessment tool, Child and Adolescent Service Intensity Instrument (CASII), and Child and Adolescent Needs and Strengths (CANS).

WDH's key efforts towards network adequacy and availability of services include, but are not limited to, the following:

- Requiring the CME to maintain geographic coverage throughout all regions of the State;
- Allowing the use of State-approved, HIPAA-compliant telehealth platforms to deliver services where and when appropriate;
- Establishing maximum provider-to-enrollee ratios, which vary by provider type;
- Requiring the CME to develop and adhere to documented processes for provider recruitment, retention, certification, re-certification, and non-discrimination practices;
- Requiring network providers to maintain frequent and timely contact with enrollees (e.g., twice monthly contact; contacting new enrollees within three business days);
- Offering accessibility options for enrollees from diverse backgrounds, including interpretation services and making information available in other languages; and
- Offering accessibility options for enrollees with physical or mental disabilities, such as supplying free aids and making information available in other accessible formats.

The CME program has the following **unique provider types**:

- **Family care coordinator (FCC):** Works with a team to implement all activities of the HFWA process and leads coordination of the child and family team.
- **Family support partner (FSP):** Member of the child and family team who helps the youth and family identify peers and other supports.
- **Youth support partner (YSP):** Young adult member of the child and family team with personal experience participating in the system of care. Supports the youth's voice and choice.
- **Respite provider:** Provides relief from the daily burdens of care.

Due to the non-clinical framework of the CME program, not all network adequacy requirements set forth in 42 CRF 438.68 and 42 CFR 438.206 are applicable. Appendix B provides a detailed crosswalk of WDH and CME compliance efforts with federal network adequacy standards where applicable.

B. Program Goals, Objectives, and Outcome Measures

Pursuant to 42 CFR 438.340 (b)(2), WDH is required to define within the state quality strategy goals and objectives for continuous quality improvement of the CME program.

The goal of the CME program is to provide community-based alternatives to institutional care for Medicaid-covered youth (4-20 years of age), who experience SED or SPMI. Based on the authority granted under the Medicaid 1915(b) and 1915(c) waivers and State Plan Targeted Case Management Services, WDH contracts with a single CME who provides an evidence-based intensive care coordination model called "high fidelity wraparound".

The CME program's goals and objectives are based on two main ideologies:

1. National Wraparound Initiative, which promotes a comprehensive, holistic, family and community centric approach to supporting youth.[1]
2. System of care philosophy, which promotes coordinated networks for building meaningful partnerships and addressing members' needs in order to help them function better in all facets of their lives.[2]

Through access to community-based intensive care coordination services, the CME program seeks to:

1. Reduce rate of admissions to inpatient psychiatric treatment facilities[3];
2. Reduce frequency of readmissions to inpatient psychiatric treatment facilities;
3. Reduce length of stay in inpatient psychiatric treatment facilities;
4. Reduce overall Medicaid cost of care for enrolled youth; and
5. Improve child and family integration into home and community life.

WDH established the aforementioned goals and objectives to drive improvements in care delivery and health outcomes for Wyoming youth. In addition, WDH articulates these expectations to the CME and measures progress against these goals via the following outcome measures:

1. Decrease of Out-of-Home (OOH) placements of CME youth;
2. Decrease length of stay (LOS) for inpatient and residential treatment admissions for youth enrolled in the CME program;
3. Decrease recidivism of CME youth moving from a lower level of care to a higher level of care;

[1] National Wraparound Initiative. *The Principles of the Wraparound Process.* https://nwi.pdx.edu/NWI-book/Chapters/Bruns-2.1-(10-principles-of-wrap).pdf

[2] Georgetown University Center for Child and Human Development. *System of Care Definition and Philosophy.* https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

[3] Inpatient psychiatric treatment facilities include psychiatric residential treatment facilities (PRTF) and acute psychiatric hospitals.

4. Decrease recidivism of youth who met their goals, graduated from the CME program, and are moving from a lower level of care to a higher level of care within six months of graduation from the CME program;
5. Increase compliance with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) / increased number of CME youth who have an identified primary care practitioner;
6. Decrease Medicaid costs compared to the target eligible population of non-CME enrolled youth with PRTF stays;
7. Increase fidelity to the HFWA model, as measured by the Wraparound Fidelity Index (WFI-EZ);
8. Increase participation with the WFI-EZ, as measured by the number of WFI-EZ surveys received;
9. Increase family and youth participation at State-level Advisory Committees; and
10. Increase family and youth participation in communities (e.g., community advisory boards, support groups, other stakeholder meetings).

Several goals, objectives, and outcome measures of the CME program align with the goals set forth in national quality initiatives, including the Health and Human Services (HHS) National Quality Strategy[4] and the CMS Quality Strategy.[5] Table 2 below demonstrates alignment between the CME program's goals and objectives and national quality strategies.

Table 2. Alignment with the National Quality Strategies

HHS National Quality Strategy	CMS Quality Strategy	CME Program	
Aims	**Priorities**	**Goals / Objectives**	**Measures**
Better Care: Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.	Strengthen Person and Family Engagement as Partners in Their Care	Improve child and family integration into home and community life.	Increase family and youth participation at State-level Advisory Committees.
			Increase family and youth participation in communities (e.g., community advisory boards, support groups, other

[4] Agency for Healthcare Research and Quality. *National Quality Strategy*. https://www.ahrq.gov/workingforquality/about/index.html

[5] Centers for Medicare and Medicaid Services. *CMS Quality Strategy 2016.* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy.pdf

HHS National Quality Strategy	CMS Quality Strategy	CME Program	
Aims	**Priorities**	**Goals / Objectives**	**Measures**
			stakeholder meetings).
	Promote Effective Communication and Coordination of Care		Increase compliance with EPSDT / increased number of CME youth who have an identified primary care practitioner.
	Work with Communities to Promote Best Practices of Healthy Living		Increase fidelity to the HFWA model, as measured by the WFI-EZ.
			Increase participation with the WFI-EZ, as measured by the number of WFI-EZ surveys received.
	Make Care Safer by Reducing Harm Caused in the Delivery of Care		N / A
Healthy People / Healthy Communities: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care.	Promote Effective Prevention and Treatment of Chronic Disease	Reduce rate of admissions to inpatient psychiatric treatment facilities.	Decrease OOH placements of CME youth.
		Reduce frequency of readmissions to inpatient psychiatric treatment facilities.	Decrease recidivism of CME youth moving from a lower level of care to a higher level of care.
			Decrease recidivism of youth who graduated from the CME program having met their goals and who are moving from

HHS National Quality Strategy	CMS Quality Strategy	CME Program	
Aims	**Priorities**	**Goals / Objectives**	**Measures**
			a lower level of care to a higher level of care within six months of graduation from the CME program.
		Reduce length of stay in inpatient and residential psychiatric treatment facilities.	Decrease LOS for inpatient and residential treatment admissions for youth enrolled in the CME program.
Affordable Care: Reduce the cost of quality health care for individuals, families, employers, and government.	Make Care Affordable	Reduce overall Medicaid cost of care for enrolled youth.	Decrease Medicaid costs compared to the target eligible population of non-CME enrolled youth with PRTF stays.

C. Quality Metrics and Performance Measures

Pursuant to 42 CFR 438.340 (3i), WDH is required to define within the state quality strategy quality metrics and performance measures to assess performance and improvement of the managed care entity.

WDH continually assesses the CME's performance via two main reporting requirements:

1. **Operational Requirements:** The Statement of Work (SOW) between WDH and the CME outlines several operational requirements and associated performance measures. The CME is required to submit data for these measures in a quarterly and annual report to WDH. Operational requirements focus on the following themes:
    a. Provider network caseloads and timeliness
    b. Provider training and certification
    c. Quality and compliance
    d. Clinical process
    e. Member and provider communications
    f. Member / community engagement
2. **Outcome Measures:** The SOW includes 10 outcome measures with specific measurement instructions for each measure. The CME reports on the outcomes annually and may be subject to payment penalties for failing to provide outcome

measure data. As described in Section II. B above, outcome measures focus on the following:

a. Enrollee management
b. Plan of care process / compliance
c. Financial management

WDH and the CME discuss any identified quality or performance concerns on a regular basis during weekly operational meetings. WDH conducts a root cause analysis if concerns are identified and may consider remediation plans or escalation for long-term declines in reported outcome measures.

The CME also maintains its own quality assessment and performance improvement practices, including a quality improvement committee which identifies and monitors opportunities to address program improvements proactively and support outcomes. The CME employs several additional program activities to improve quality and safety of services, including but not limited to:

- Documenting quality initiatives, goals, and effectiveness via annual quality improvement work plans and annual quality program evaluations;
- Tracking and monitoring critical incident reporting to determine if any member safety concerns exist; and
- Evaluating trends and identifying opportunities for improvement in the grievance and appeals process.

WDH is also required to identify which performance measures will be published on the State's website. WDH posts several outcome measures to the website and will post the Managed Care State Quality Strategy once approved.

D. Performance Improvement Projects

Pursuant to 42 CFR 438.340 (3ii), WDH must describe any proposed performance improvement projects and interventions to improve access, quality, or timeliness of care for enrollees.

WDH and the CME work collaboratively to identify areas for improvement, as described in Section II. C. Performance improvement projects (PIPs) often arise from identified concerns in quarterly data reports, retrospective data analysis, and consideration of stakeholder input. WDH requires the CME to report PIP status and results to WDH at least annually, including the following elements:

- Demonstration of significant improvement, sustained over time, in outcomes and enrollee satisfaction;
- Measurement of performance using objective quality indicators;
- Evaluation of the effectiveness of the interventions based on the performance measures; and
- Planning and initiation of activities for increasing or sustaining improvement.

In 2018-2020, PIPs have focused on the following topics:

- **Minimum Contacts:** This initiative tracks providers' compliance with maintaining regular in-person and telephone contact with the enrollee and caregivers. The minimum contacts requirement is an integral part of the HFWA process, as it ensures enrollees and caregivers are consistently engaged and able to obtain full benefit from the program. WDH and the CME prioritized this PIP as an opportunity to improve provider and enrollee engagement in the CME program.
- **Provider Scorecard:** As part of the Provider Scorecard initiative, the CME distributes a scorecard to the provider network once per quarter. The scorecards are intended to help quantify the work of the CME program and tell the story of how HFWA impacts Wyoming's CME youth and families served. The provider scorecard is de-identified and shows providers how they are performing on selected measures compared to their network counterparts. The selected measures focus on quality process, fidelity to wraparound principles, administrative efficiency, and outcomes of wraparound.

WDH continues to identify opportunities for performance improvement projects and will communicate these areas to the CME as needed.

E. External Quality Review

Pursuant to 42 CFR 438.350, states must conduct an external quality review (EQR) of contracted managed care entities, including MCOs, prepaid inpatient health plans (PIHPs), PAHPs, and PCCM entities. The purpose of the EQR is to analyze and evaluate the quality, timeliness, and access to healthcare services provided to Medicaid recipients.

WDH contracts with an external quality review organization (EQRO) to conduct the annual EQR and evaluate the CME program's provision of healthcare services. To conduct the review, the EQRO typically engages in discussions with WDH and CME staff and analyzes documentation made available by WDH and the managed care entity. WDH's State Fiscal Year (SFY)18 and SFY19 efforts included the four mandatory EQR activities as set forth in 42 CFR 438.358, including:

1. Validation of PIPs
2. Validation of Performance Measures Reported by the PAHP
3. Review of Compliance with Medicaid Managed Care Regulations
4. Validation of Network Adequacy

The EQR findings provide a basis for WDH's actions toward managed care compliance remediation or quality improvement. Key findings across the SFY18 and SFY19 EQR efforts included the following, many of which WDH and the managed care entity continue to develop:

- Needed clarification of appeals, grievances, and State fair hearings processes and timeframes within both internal policies and procedures as well as member outreach materials
- Needed clarification of terminology regarding enrollee rights and information standards
- Opportunities to formalize and clearly document policies and procedures related to member disenrollment, provider network enrolment and disenrollment, and measure creation and reporting requirements

- Opportunities to clarify when certain managed care elements are not applicable due to the nature of this program

F. Transition of Care Policy

Pursuant to 42 CFR 438.340(b)(5) and 42 CFR 438.62, the quality strategy must include the State's transition of care policy to ensure continued access to services during a transition from FFS to a managed care entity, or a transition from one managed care entity to another when an enrollee would suffer serious detriment to their health or be at risk of hospitalization or institutionalization in the absence of continued services.

Because the CME is Wyoming's only managed care entity, transitioning from one managed care entity to another is not applicable. However, WDH requires the CME to incorporate transition of care policies related to transitioning out of the CME program when members no longer need HFWA services or reach the program's maximum age limit. WDH requires the CME to describe applicable transition of care policies in the Member Handbook, including the following elements:

- Information to enrollees informing them that they have access to services consistent with the access they previously had under their previous network provider;
- Availability of assistance in finding another network service provider that has access to historical data when appropriate;
- Plan of care (POC) and other documents necessary to implement the transition in a seamless and timely manner with the goal of preventing or reducing the risk of hospitalization or institutionalization; and
- Estimated timeframes in accordance with the HFWA Transition to Discharge Phase.

The CME devotes an entire phase to transitioning members out of the program. The "transition to discharge" phase includes developing a formal plan for ongoing services if necessary, creating a quality crisis plan, storing contact information for community supports, and other tasks.

G. Plans to Identify, Evaluate, and Reduce Health Disparities

Pursuant to 42 CFR 438.340(b)(6), the quality strategy must include the State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. To comply with this requirement, WDH conducts an annual analysis on enrollee demographics to identify, evaluate, and reduce potential disparities between enrollee demographics, statewide demographics, and provider demographics.

Identifying and Evaluating Disparities: Demographic Analysis

The CME is required to report demographic data (including racial/ethnic data), outcomes measures, utilization and special needs population (target population) data to WDH annually. WDH compares enrollee demographic data reported by the CME program to the demographics of the State as a whole and to CME network providers. This disparity analysis is used to monitor the CME, implement performance measures for quality, access, and coordination of care, and improve information made available to CME youth. The findings of the annual demographic data report are included in the CME's performance evaluation.

Reducing Disparities: Corrective Actions

WDH recommends corrective action on both the provider level and system-wide level to reduce health disparities identified in demographic data reports. Corrective action may include, but is not limited to, recommending outreach to target populations, improving recruitment efforts in select regions of the State, and identifying opportunities for partnerships.

H. Use of Intermediate Sanctions

Pursuant to 42 CFR 438.340(b)(7), the quality strategy must include a description of appropriate use of intermediate sanctions in alignment with 42 CFR 438.700. However, this requirement applies to states that contract with an MCO and therefore does not apply to Wyoming's CME program.

I. Assessment of Performance and Quality Outcomes

Pursuant to 42 CFR 438.340(b)(8), the quality strategy must include a description of how the State will assess the performance and quality outcomes achieved by each PCCM entity. This requirement pertains to states contracting with PCCM entities whose contracts provide for shared savings, incentive payments, or other financial reward for improved quality outcomes. Since WDH does not contract with a PCCM or PCCM entity under the CME program, this requirement does not apply to WDH.

J. Identification of Persons Who Need Long-Term Services and Supports or Persons with Special Health Care Needs

Pursuant to 42 CFR 438.340 (b)(9) and 42 CFR 438.208(c)(1), MCOs, PIHPs, and PAHPs are required to identify persons who need long-term services and supports or have special health care needs using mechanisms specified in the State's quality strategy. According to CMS, special health care needs include "chronic physical, developmental, behavioral or emotional conditions" which "are of a type or amount beyond that required by children generally."

Based on the CME program's scope of services and delivery system, the CME does not need to meet the requirements for additional services for enrollees with special health care needs.

WDH's statewide CME program is limited to community-based high fidelity wraparound services (targeted case management provided via a HFWA delivery model) and respite for all enrolled youth, as well as youth and family training and support services provided to youth enrolled through the concurrent 1915(c) Children's Mental Health Waiver. Each enrollee maintains full access to all Medicaid State Plan services, and special health care needs will continue to be identified and treated through primary and specialty care providers in Medicaid FFS.

K. Nonduplication of External Quality Review Activities

Pursuant 42 CFR 438.360, states are permitted to use information from a Medicare or private accreditation review of an MCO, PIHP, or PAHP to provide information for the annual EQR instead of conducting the EQR activities described in 42 CFR 438.358(b)(1)(i) to avoid duplication of activities. To use information from a Medicare or private accreditation review for the annual EQR, states must also meet certain conditions, including compliance with the standards established by a national accrediting organization when the organization's standards are comparable to the federal standards.

Wyoming's CME does not participate in a Medicare or private accreditation review and will not be exercising the option described in this section. However, should WDH determine that a

private accreditation activity is comparable to the State's EQR activities, WDH would work with the EQRO to identify any areas in the private accreditation program that may be duplicative with the EQR and deem these activities accordingly.

L. Definition of "Significant Change"

Pursuant to 42 CFR 438.340(b)(11), WDH is required to define a "significant change" that necessitates revision and resubmission of the state quality strategy to CMS. WDH will also evaluate the state quality strategy's effectiveness on an annual basis and update and resubmit the state quality strategy no less than once every three years.

WDH defines "significant change" as a modification in the Medicaid program or managed care plans' operations that would materially affect service delivery or receipt of benefits, including adjustments in services, benefits, geographic service area, payments, eligible populations, or other circumstances which impact delivery or measurement of the quality of services as determined by the State.

Significant change may include, but is not limited to:

- Addition or removal of service offerings and benefits offered to managed care plan enrollees;
- System-wide changes in the composition, frequency, or amount of payments made to the provider network delivering services to enrollees;
- New or amended federal and/or State regulations which impact programmatic operations.

Section III. Conclusion

As discussed previously, Wyoming's CME program operates as a PAHP program, which requires WDH to develop and maintain a quality strategy as a blueprint to assess the quality of services received by CME youth and set forth goals for continuous quality improvement. The quality strategy is a requirement for all states contracting with managed care entities, pursuant to 42 CFR 438.340.

The quality strategy leverages existing activities and responsibilities outlined in Wyoming's 1915(b) waiver, 1915(c) waiver, and the CME program's SOW to outline the various mechanisms used to assess the CME.

Upon approval from CMS, the quality strategy will be continuously utilized by both WDH and the CME to advance the goals and objectives of the CME program and successfully offer a community-based alternative to inpatient psychiatric treatment for youth in Wyoming. This quality strategy is expected to evolve and receive updates in response to significant program and system changes. As described previously, WDH intends to evaluate the state quality strategy's effectiveness on an annual basis and update and re-submit the State's quality strategy as needed but no less than once every three years, in accordance with 42 CFR 438.340.

Section IV. Appendices

A. Abbreviations and Acronyms

CANS	Child and Adolescent Needs and Strengths
CASII	Child and Adolescent Service Intensity Instrument
CFR	Code of Federal Regulations
CMHW	Wyoming's 1915(c) Children's Mental Health Waiver
CME	Care Management Entity
CMS	Centers for Medicare & Medicaid Services
DHCF	Division of Healthcare Financing
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FFS	Fee-For-Service
HFWA	High Fidelity Wraparound
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
LOC	Level of Care
LOS	Length of Stay
LTSS	Long-term Services and Supports
MCO	Managed Care Organization
OOH	Out-of-Home
PAHP	Prepaid Ambulatory Health Plan
PCCM	Primary Care Case Management
PIHP	Prepaid Inpatient Health Plan

PIP	Performance Improvement Project
PMPM	Per-Member Per-Month
POC	Plan of Care
PRTF	Psychiatric Residential Treatment Facility
SED	Serious Emotional Disturbance
SFY	State Fiscal Year
SOW	Statement of Work
SPMI	Serious and Persistent Mental Illness
WDH	Wyoming Department of Health
WFI-EZ	Wraparound Fidelity Index

B. Network Adequacy Requirements

Table 3 below describes WDH and the CME's requirements relating to network adequacy and availability of services, established in 42 CFR 438.68 and 42 CFR 438.206.

Table 3. Network Adequacy and Availability of Services Requirements

CFR Reference	CFR Requirement	WDH and CME Requirements
42 CFR 438.68 Network Adequacy Standards		
42 CFR 438.68 (a)	General rule. A State that contracts with an MCO, PIHP or PAHP to deliver Medicaid services must develop and enforce network adequacy standards consistent with this section.	See remainder of 42 CFR 438.68 below.
42 CFR 438.68 (b)(1)	Provider-specific network adequacy standards. At a minimum, a State must develop **time and distance standards** for the following provider types, if covered under the contract: (i) Primary care, adult and pediatric. (ii) OB/GYN. (iii) Behavioral health (mental health and substance use disorder), adult and pediatric. (iv) Specialist, adult and pediatric. (v) Hospital. (vi) Pharmacy.	**Not applicable.** This requirement does not apply to the CME program for two reasons: • The community-based nature of the HFWA model involves providers traveling to the enrollees rather than enrollees traveling to a clinic or facility. The enrollee's "child and family team," which is a group of family members and other supports, decides meeting location and all meetings are scheduled at a time and place that works best for each enrollee. Therefore, travel time and distance do not impact enrollee access. • The CME program provides care coordination services only and does not provide any clinical services. Providers must be certified in HFWA, but do not fall into typical clinical provider categories. Therefore, clinical provider categories as specified in the federal regulation (e.g.,

CFR Reference	CFR Requirement	WDH and CME Requirements
	(vii) Pediatric dental. (viii) Additional provider types when it promotes the objectives of the Medicaid program, as determined by CMS, for the provider type to be subject to time and distance access standards	primary care, specialists, hospital, pharmacy, etc.) do not apply to the CME program.
42 CFR 438.68 (b)(2)	**Long-term Services and Supports (LTSS).** States with MCO, PIHP or PAHP contracts which cover LTSS must develop: (i) Time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services; and (ii) Network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services.	**Not applicable.** Requirements regarding LTSS do not apply to the CME program, which delivers care coordination services to children with complex behavioral needs.
42 CFR 438.68 (b)(3)	**Scope** of network adequacy standards. Network standards established in accordance with paragraphs (b)(1) and (2) of this section must include all **geographic areas** covered by the managed care program or, if applicable, the contract between the State and the MCO, PIHP or PAHP. States are permitted to have varying standards for the same provider type based on geographic areas.	WDH requires the CME to demonstrate availability of services in all eight regions of the State. The CME demonstrates compliance by submitting geographic mapping of provider and member locations on a quarterly basis. Additionally, WDH allows providers to leverage State-approved, HIPAA-compliant telehealth platforms to deliver care where and when appropriate and encourages incorporating telehealth into individual Plans of Care (POCs) as appropriate. Wyoming often faces challenges regarding the rural nature of the state (e.g., long distances between communities) or weather challenges (e.g., winter weather events, summer forest fires, rockslides).

CFR Reference	CFR Requirement	WDH and CME Requirements
		Telehealth may also be used to continue service delivery when these types of challenges arise.
42 CFR 438.68 (c)(1)	**Development of network adequacy standards.** States developing network adequacy standards consistent with paragraph (b)(1) of this section must consider, at a minimum, the following elements: (i) The anticipated Medicaid enrollment. (ii) The expected utilization of services. (iii) The characteristics and health care needs of specific Medicaid populations covered in the MCO, PIHP, and PAHP contract. (iv) The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services. (v) The numbers of network providers who are not accepting new Medicaid patients. (vi) The geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees.	WDH takes the following factors in consideration when developing network adequacy standards: • **Anticipated Medicaid enrollment:** WDH maintains a listing of potential enrollees who appear to meet the CME program's eligibility criteria. • **Expected utilization of services:** WDH requires the CME to perform utilization management, including assessment of disenrollment trends as well as patterns in utilization. • **Characteristics and health care needs of specific Medicaid populations covered in the PAHP contract:** Enrollees' plans of care are required to identify enrollees' needs, strengths, and preferences. • **Numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services:** WDH requires the CME to maintain compliance with provider-to-enrollee ratios, which indirectly dictate the number of network providers needed. Additionally, each CME provider must possess certain qualifications and undergo HFWA training, as outlined in the provider handbook. • **Numbers of network providers who are not accepting new Medicaid patients:** The provider directory may indicate whether a provider is accepting new patients. If a requested provider's caseload is full, the enrollee may

CFR Reference	CFR Requirement	WDH and CME Requirements
	(vii) The ability of network providers to communicate with limited English proficient enrollees in their preferred language. (viii) The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities. (ix) The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.	select another provider or wait until the desired provider is available. • **Geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees:** WDH requires the CME to demonstrate availability of services in all eight regions of the State. The CME demonstrates compliance by submitting geographic mapping of provider and member locations on a regular basis. Additionally, telehealth is available for use throughout the State and may be incorporated into individual Plans of Care (POCs) as appropriate. CME providers work with each enrollee to coordinate meeting locations and times that work best for the enrollee. • **Ability of network providers to communicate with limited English proficient enrollees in their preferred language:** WDH requires provision of free interpretation services to enrollees. • **Ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities:** The CME offers free aids and services to enrollees with disabilities, such as sign language and written language in other accessible formats. The CME does not maintain physical offices, so the applicability of physical access accommodations is limited.

CFR Reference	CFR Requirement	WDH and CME Requirements
		• **Availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions:** The CME provides a toll-free phone line and telehealth services.
42 CFR 438.68 (c)(2)	States developing standards consistent with paragraph (b)(2) of this section must consider the following: (i) All elements in paragraphs (c)(1)(i) through (ix) of this section. (ii) Elements that would support an enrollee's choice of provider. (iii) Strategies that would ensure the health and welfare of the enrollee and support community integration of the enrollee. (iv) Other considerations that are in the best interest of the enrollees that need LTSS.	**Not applicable.** These requirements apply to LTSS, which is not provided by the CME program.
42 CFR 438.68 (d)(1)	Exceptions process. To the extent the State permits an exception to any of the provider-specific network standards developed under this section, the standard by which the exception will be evaluated and approved must be:	**Not applicable.** The provider-specific network standards do not apply to this program, and therefore there are not exemptions to the provider-specific network standards.

CFR Reference	CFR Requirement	WDH and CME Requirements
	(i) Specified in the MCO, PIHP or PAHP contract. (ii) Based, at a minimum, on the number of providers in that specialty practicing in the MCO, PIHP, or PAHP service area.	
42 CFR 438.68 (d)(2)	States that grant an exception in accordance with paragraph (d)(1) of this section to an MCO, PIHP or PAHP must monitor enrollee access to that provider type on an ongoing basis and include the findings to CMS in the managed care program assessment report required under §438.66.	**Not applicable.** The provider-specific network standards do not apply to this program, and therefore there are not exemptions to the provider-specific network standards.
42 CFR 438.68 (e)	**Publication of network adequacy standards.** States must publish the standards developed in accordance with paragraphs (b)(1) and (2) of this section on the Web site required by §438.10. Upon request, network adequacy standards must also be made available at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services.	**Not applicable.** The requirement to publish network adequacy standards online applies to states who dictate time and distance standards for specific providers or LTSS providers, neither of which apply to the CME program.
42 CFR 438.206 Availability of Services		
42 CFR 438.206 (a)	Basic rule. Each State must ensure that all services covered under the State plan are available and accessible to enrollees of	See remainder of 42 CFR 438.206 below.

CFR Reference	CFR Requirement	WDH and CME Requirements
	MCOs, PIHPs, and PAHPs in a timely manner. The State must also ensure that MCO, PIHP and PAHP provider networks for services covered under the contract meet the standards developed by the State in accordance with §438.68.	
42 CFR 438.206 (b)(1)	*Delivery network.* The State must ensure, through its contracts, that each MCO, PIHP and PAHP, consistent with the scope of its contracted services, **maintains and monitors a network of appropriate providers** that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities.	WDH requires the CME to maintain a provider network which is "sufficient to provide adequate access to all services covered under the contractual agreement for all enrollees, including those with limited English proficiency or physical or mental disabilities." WDH also requires the CME to develop and adhere to policies and procedures for recruitment, retention, and training of providers to maintain an adequate provider network. The CME closely monitors provider turnover and conducts targeted provider recruitment based on recent turnover. The CME pursues a diverse array of recruitment strategies, including education of community advisory groups, professional organizations, and governmental partners, as well as informative online postings. WDH assesses provider network adequacy via provider-to-enrollee ratios, which vary by provider type. The CME submits quarterly data to affirm compliance with required provider-to-enrollee ratios. Additionally, WDH requires the CME to enter into agreements with each provider. Lastly, the CME maintains a Network Strategy Committee, whose primary purpose is to review network service capacity and identify strategies for network expansion.
42 CFR 438.206 (b)(2)	Provides female enrollees with direct access to a women's health specialist within the	**Not applicable.** The CME does not provide clinical services.

CFR Reference	CFR Requirement	WDH and CME Requirements
	provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.	
42 CFR 438.206 (b)(3)	Provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	**Not applicable.** The CME does not provide clinical services.
42 CFR 438.206 (b)(4)	If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP, or PAHP must adequately and timely cover these services out of network for the enrollee, for as long as the MCO, PIHP, or PAHP's provider network is unable to provide them.	**Not applicable.** The CME does not cover services delivered by out of network providers. The services within the scope of the contract must be delivered by Medicaid providers who meet certain qualifications and undergo HFWA training, as outlined in the provider handbook.
42 CFR 438.206 (b)(5)	Requires out-of-network providers to coordinate with the MCO, PIHP, or PAHP for payment and ensures the cost to the enrollee is no greater than it would be if the services were furnished within the network.	**Not applicable.** The CME does not cover services delivered by out of network providers. The services within the scope of the contract must be delivered by Medicaid providers who meet certain qualifications and undergo HFWA training, as outlined in the provider handbook.
42 CFR 438.206 (b)(6)	Demonstrates that its network providers are credentialed as required by §438.214.	WDH requires the CME to “develop and adhere to a documented process for the recruitment and retention of providers, certification, re-certification and nondiscrimination practices for providers who have signed sub agreements.”

CFR Reference	CFR Requirement	WDH and CME Requirements
		The CME requires providers to meet specific educational and/or experience requirements, as well as basic background qualifications and screenings. The CME also requires providers to complete initial training and certification, depending on provider role. Additional credentialing requirements are outlined in the provider agreement, including not employing providers excluded from participation in Federal health care programs.
42 CFR 438.206 (b)(7)	Demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services.	**Not applicable.** The CME does not provide family planning services.
42 CFR 438.206 (c)(1)	*Furnishing of services.* The State must ensure that each contract with a MCO, PIHP, and PAHP complies with the following requirements. (1) *Timely access.* Each MCO, PIHP, and PAHP must do the following: (i) Meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. (ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees.	WDH requires the CME to submit documentation to the State that demonstrates it offers timely access to services. In particular, WDH and the CME evaluate frequency and timeliness of provider contact with enrollee, both in-person and via telephone. For example, new referrals should be contacted by providers within three business days. Additionally, providers must contact enrollees at least two times per month, based on the family's preferred contact method.

CFR Reference	CFR Requirement	WDH and CME Requirements
	(iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. (iv) Establish mechanisms to ensure compliance by network providers. (v) Monitor network providers regularly to determine compliance. (vi) Take corrective action if there is a failure to comply by a network provider.	
42 CFR 438.206 (c)(2)	*Access and cultural considerations.* Each MCO, PIHP, and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex.	WDH requires that the provider network is "sufficient to provide adequate access to all services covered under the contractual agreement for all enrollees, including those with limited English proficiency or physical or mental disabilities." Additionally, WDH requires that information is made available in other languages and translation services are offered. Finally, WDH requires the CME to maintain an adequate array of culturally and linguistically diverse providers that reflect the overall diversity of CME youth. The CME reports provider network demographics, although this information is voluntarily submitted by network providers. The CME leverages Learning Opportunities, provider one to one calls, newsletters, and all provider calls to educate providers on the importance of self-reporting demographic information to ensure that services are delivered in a culturally competent manner.
42 CFR 438.206 (c)(3)	*Accessibility considerations.* Each MCO, PIHP, and PAHP must ensure that network providers provide physical access, reasonable accommodations, and	The CME offers free aids and services to enrollees with disabilities, such as sign language and written language in other accessible formats. Additionally, many meetings with enrollees occur at a location which works best for the enrollee, and providers honor enrollees' location requests unless the request

CFR Reference	CFR Requirement	WDH and CME Requirements
	accessible equipment for Medicaid enrollees with physical or mental disabilities.	presents a danger; therefore, the applicability of physical access accommodations is limited.