Attachment A-1

Revised Statement of Work

Wyoming Department of Health, Division of Healthcare Financing

Care Management Entity (CME) Administrative Services for Medicaid Children

Provided by:

Magellan Healthcare, Inc.

January 1, 2021

Table of Contents

1. GENERAL DESCRIPTION

This document is intended as a Statement of Work (SOW) to identify and describe important milestones and deliverables for the Care Management Entity (CME) for Medicaid children. The goal of the program is to implement a provider model using High Fidelity Wraparound (HFWA), as defined by the National Wraparound Initiative (NWI) and the national Wraparound Evaluation and Research Team (WERT), to improve the quality and cost of care for Medicaid children and youth with serious emotional and behavioral health challenges.

1.1. Definitions

Definitions

ITEM	DEFINITION
Contract Effective Date	The date when the Contract becomes fully executed
Significant Change	The Agency 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. The approved quality strategy will affirm Agency's intent 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.

1.2. CME Overview

CME Scope Overview

The Contractor will be responsible for coordinating and delivering HFWA services through a network of providers, including targeted case management, respite care, youth and family training and support services. The Contractor will also provide administrative services for the management of the program, including managing the provider network, conducting outreach, determining eligibility and enrolling youth and providers into the program, managing provider

corrective action plans, PMPM claims submission, conducting provider training, and facilitating provider and enrollee communications. Specific Contractor responsibilities and deliverables are included in subsequent sections.

CME Contract Pricing Summary

Table 1 provides a summary of the Implementation costs provided by the Contractor in its response to RFP #0081-E.

Table 1 – Implementation Deliverables, Dates, and Costs

TASK	DESCRIPTION	HOURS	COST	DATE
1	**System Configuration**	N/A	$20,000.00	January 1, 2021
2	**Environment Build & Training**	N/A	$85,000.00	January 1, 2021
3	**Interface Implementations**	N/A	$95,000.00	January 1, 2021
4	**Data Migrations & Transfers**	N/A	$65,000.00	January 1, 2021
5	**Documentation Deliverables**	N/A	$20,000.00	January 1, 2021
	TOTALS		$285,000.00	

Tables 2 and 3 provide the agreed upon Per Member/Per Month (PMPM) pricing, which shall be paid on a per diem basis for administration of the program, including the administration of direct service, for each base Contract Year. The Agency will prorate the per diem rate and issue payments based on Medicaid member days, rather than months. This accommodates days of the month when an enrollee may not be considered Medicaid eligible for CME services.

Table 2 – CME Operational Costs

	PMPM COST Base Year 1 July 1, 2020	PMPM COST Base Year 2 July 1, 2021	PMPM COST Base Year 3 July 1, 2022	PMPM COST Base Year 4 July 1, 2023	PMPM COST Base Year 5 July 1, 2024
Fixed PMPM Rate Monthly	**$801.13**	**$802.45**	**$803.37**	**$804.82**	**$805.87**
Per Diem Member Rate	**$26.34**	**$26.38**	**$26.41**	**$26.46**	**$26.49**

Table 3 – Operational PMPM Rates by Option Year

	PMPM COST Option Year 1 July 1, 2025	PMPM COST Option Year 2 July 1, 2026
Fixed PMPM Rate Monthly	**$897.18**	**$898.49**
Per Diem Member Day Rate	**$29.50**	**$29.54**

Invoicing

The Contractor must be responsible for tracking all associated costs and expenditures related to this Contract. Any and all subcontractor(s) providing services for the operations and support of the CME services shall invoice the Contractor, who will in turn submit all invoices for payment to the Agency's primary point of contact for payment.

The Contractor will invoice the Agency on a monthly basis for completing approved deliverables during implementation. The Contractor will adhere to the payment process outlined in the Contract.

1.3. CME Scope of Services: Implementation of Ongoing HFWA Services

CME Implementation Scope

The Contractor estimates approximately six months to complete the Implementation activities and related deliverables outlined in this SOW. This timeline includes work to continue the CME operations and infrastructure, continue contracts with a network of CME providers, update CME enrollee and applicant data, and other activities to ensure the Contractor is ready for ongoing CME operations by January 1, 2021. The Contractor will pursue all options to complete this implementation on schedule and not exceed the quoted costs included in Table 1 above.

The Contractor must be responsible for the following Implementation responsibilities and comply with requirements in Table 4:

Table 4 – Implementation Requirements

REQ ID	REQUIREMENT	PERFORMANCE EXPECTATION
PI 4-1	Conduct a project Kick-Off meeting (content to be agreed upon by Agency and Contractor)	Provide a Kick-Off meeting plan within ten (10) business days after the Contract Effective

REQ ID	REQUIREMENT	PERFORMANCE EXPECTATION
		Date.
PI 4-2	Provide a revised Implementation Plan originally submitted as part of the proposal response that details the Contractor's milestones and timelines to ensure a seamless Implementation	Provide a revised Implementation Plan within thirty (30) calendar days before the Contract Effective Date.
PI 4-3	Update the comprehensive Provider Management Plan that includes, at minimum, the Contractor's approach to: A. Maintaining the current provider capacity; B. Expanding and scaling the existing provider network to meet service needs; C. Verifying qualifications of providers; D. Monitoring provider network adequacy and performance; E. Authorizing POCs submitted by providers; and F. Establishing a contract management process for overseeing the CME's provider network.	Provide a Provider Management Plan forty-five (45) calendar days before the Contract Effective Date.
PI 4-4	During the Implementation Phase, conduct weekly status meetings. The Contractor must provide a Status Report/Dashboard as the basis for the status meeting. In the Status Report/Dashboard, the Contractor must address: Near term activities; A. Key milestones and activities with their timelines and status; B. Deliverables (submitted, due, overdue, approval status); C. Project risks and mitigation status; The Agency reserves the right to review and approve each Status Report and request that additional information be added to the report template at any point in the project.	Status Meetings will be held weekly during Implementation. After Implementation, the Contractor and Agency will schedule meetings, as necessary. Distribute the status agendas at least one (1) business day in advance of the meeting. Distribute minutes to the Agency within two (2) business days of the meeting.
PI 4-5	Provide the Agency with a Test Plan for conducting testing on any Contractor IT system that will house State data: A. System requirement testing; B. System integration testing; C. Data migration testing; D. Accessibility testing;	Provide the Test Plan within thirty (30) calendar days after the Contract Effective Date.

REQ ID	REQUIREMENT	PERFORMANCE EXPECTATION
	E. Security testing; F. Regression testing; and G. User acceptance testing, where appropriate.	
PI 4-6	Perform comprehensive testing in accordance with the approved Test Plan.	Provide the Testing Results, including Accessibility Test results within one hundred and twenty (120) days after the Contract Effective Date.
PI 4-7	Conduct design sessions with the Agency to discuss and design the integration points between the Contractors IT solution and Agency enterprise architecture and systems prior to implementation.	The approved IT solution is implemented and available to network providers on the Contract Effective Date.
PI 4-8	Provide a Solution Architecture Document that includes the detailed and technical explanation of all aspects of the Contractor's IT solution, including detailed architectural diagrams, data flows, component specifications, COTS products, and integration with Agency systems.	Provide a Solution Architecture Document within sixty (60) calendar days after the Contract Effective Date.
PI 4-9	Establish and test the appropriate Information Technology and systems infrastructure necessary to manage and operate CME functions in accordance with the approved Solution Architecture Document. The Agency reserves the right to perform independent validation testing on all IT and systems that support the Contract.	Establish IT infrastructure necessary to support scope of work within sixty (60) calendar days after the Contract Effective Date.
PI 4-10	Provide a Hosting Plan that includes a detailed list of all technical specifications related to hosting all system environments, third party agreements, hosting provider certifications, key personnel, disaster recovery processes and business continuity approach.	Provide Hosting Plan within sixty (60) calendar days after the Contract Effective Date.
PI 4-11	Document system workflows to inform system training and system design.	Provide Workflow documentation within ninety (90) calendar days after the Contract Effective Date.
PI 4-12	Provide Data Models and Data Management Plan that demonstrates: A. The data structure of the Contractor's IT solutions; B. The approach for maintaining data integrity; and	Provide a Data Management Plan and Data Models within sixty (60) calendar days after the Contract Effective Date.

REQ ID	REQUIREMENT	PERFORMANCE EXPECTATION
	C. Delineation of the data table structure.	
PI 4-13	Provide Systems Operating Manual detailing the Contractor's policies and procedures for operating internal IT systems.	Provide a Systems Operating Manual within one hundred twenty (120) days of the Contract Effective Date.
PI 4-14	Provide a revised Training Plan with the Contractor's approach to training HFWA certified trainers, coaches, Family Care Coordinators, respite providers, and Family and Youth Peer Support Partners that meets or exceeds the previous training plan implemented by the Contractor. The training plan shall also include: A. Approach for conducting ad hoc training and refresh training; B. How the Contractor will leverage CME coaches and customer service avenues to provide technical assistance to providers throughout the Contract term; and C. Approach to validating training was successful and staff are equipped to support the scope of services under this Contract.	Provide the Training Plan within sixty (60) calendar days of the Contract Effective Date. Revise Training Plans and documents upon identification of recommendations and findings from Annual Report, as directed by the Agency. All approved revisions shall be implemented within sixty (60) calendar days upon delivery of the Annual Report.
PI 4-15	Establish an online HFWA training platform, as outlined in the approved Training Plan that provides for online training and on-demand training modules for flexible use and access to Contractor trainings for networked providers. That includes annual HIPAA and security training.	Provide the Training Platform within ninety (90) calendar days after the Contract Effective Date. This training can be part of the onboarding processes and the documentation will be consolidated and submitted annually to the Agency.
PI 4-16	Continue training and certification of network providers in order to support the CME ongoing operations, in accordance with the approved Training Plan. Provide a Training Report that summarizes the training, number of people training, and training outcomes. Specifically, report on the number of on boarded providers that resulted from training.	Complete ongoing training and certification of networked providers submit the Training Summary Report within one hundred and twenty (120) calendar days after the Contract Effective Date.
PI 4-17	Develop a Customer Service Plan in accordance with CFR Part 438 and internal protocols. This shall include the Contractor's approach for improving customer service options, and its approach to maintaining the toll-free number, public website, and any other public-facing self-service tools.	Provide the Customer Service Plan within ninety (90) calendar days after the Contract Effective Date.

REQ ID	REQUIREMENT	PERFORMANCE EXPECTATION
PI 4-18	Conduct a formal operational readiness walkthrough with the Agency demonstrating that the Contractor is ready to continue operations.	Conduct the operational readiness walkthrough with the Agency to demonstrate that the Contractor's network providers will be able to access and utilize the FEHR by December 18, 2020.

1.4. Quality Monitoring, Improvement, Assessment, and Federal Contract and Reporting Requirements

The Contractor must report all Quality Monitoring, Improvement, and Assurance metrics to the Agency as outlined in the Social Security Act Sec. 1915(b) and Sec. 1915(c) waivers as applicable to the Contract and Scope of Work. The Contractor must abide with the following CMS standards and requirements for prepaid ambulatory health plans (PAHPs) for Medicaid Managed Care programs based on Title XIX of the Social Security Act, 42 CFR §438 and other applicable laws as specified below:

Data Analysis and Health Information Systems

The Contractor is required to maintain a health information system that collects, analyzes, integrates and reports data. The Contractor's health information system shall provide information on areas including, but not limited to: denials of referrals, requests; utilization; claims; enrollee and provider grievances and appeals data; and, disenrollment for reasons other than loss of Medicaid eligibility including disenrollment requests made by an enrollee. This data must be included in a quarterly report from the Contractor to the Agency and will be used by the Agency and Contractor to monitor the following: quality of care, enrollment/disenrollment, and coordination/continuity of care, coverage/authorization and grievances.

The Agency has established a comprehensive list of performance measures. The performance measures provide information on process; health status/outcomes; access/availability of care; use of service/utilization; health plan stability/financial/cost of care; health plan/provider characteristics; and beneficiary characteristics. Data on performance measures is reported to the Agency quarterly or as otherwise listed in the contractual requirements negotiated between the Agency and Contractor. The quarterly reports to the Agency aid in the identification of opportunities for quality improvement and the assessment of Contractor 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 development and implementation of improvement plans. Measures must be designed with the goal of maintaining quality of services, controlling costs and are consist with its responsibilities to enrollees. The results are reported to the Agency and the Agency 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 will be included in the Contractor's performance evaluation. The Agency will require the Contractor to undergo annual, external independent reviews of the quality, timeliness, and access to the services covered under this contractual agreement.

Enrollment and Disenrollment

Disenrollment requested by the enrollee may occur for cause at any time. The enrollee (or his or her representative) must submit an oral or written request to the Contractor requesting disenrollment. Causes for disenrollment may include reasons such as a move out of state, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's care needs. The Contractor may approve a request for disenrollment by or on behalf of the enrollee. The effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee requests disenrollment. Should the Contractor fail to make a disenrollment determination within the specified timeframe, the disenrollment is considered approved for the effective date that would have been established had the Contractor made a determination in the specified timeframe. For enrollees that have filed a grievance or appeal, the Contractor must complete the review of the grievance in time to permit the disenrollment to be effective no later than the first day of the second month, following the month in which the enrollee requests disenrollment.

Disenrollment for enrollees requested by the Contractor will be reviewed and approved by the State. The following are some of the causes for disenrollment:

A. Youth is no longer Medicaid eligible;

B. Youth moves out of state;

C. Youth ages out of the program;

D. Youth is incarcerated;

E. Youth is no longer financially eligible;

F. Youth is no longer clinically eligible;

G. Youth is determined eligible for any excluded program/population as detailed in the Agency's 1915(b) waiver, Section A. Part I E, (Excluded Populations); or

H. Youth is in an out of home placement longer than 180 days

The Contractor may not request disenrollment because of:

A. An adverse change in the enrollee's health status;

B. The enrollee's utilization of medical services;

C. The enrollee's diminished mental capacity;

D. The enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Contractor's ability to furnish services to the enrollee or other enrollees).

The Contractor must track disenrollment requests by enrollee and provide a copy to the Agency of each disenrollment letter sent to enrollees so that the Agency may verify that the Contractor did not request disenrollment for reasons other than those permitted under the contract.

Enrollee Rights and Beneficiary Notification

The Contractor will have mechanisms in place to help enrollees and potential enrollees understand the requirements and benefits of their plan and provide such information in a manner and format that may be easily understood and is readily accessible. The Contractor is required to provide each enrollee notice of any significant change in the information specified in the enrollee handbook at least thirty (30) days before the intended effective date of the change. The Contractor is also required to have policies that highlight enrollee's rights, including their right to participate in decisions regarding his/her healthcare, refuse treatment, be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, and request a copy of medical records and to have these record amended or corrected, when necessary. Each enrollee is free to exercise his or her rights without the Contractor or its network providers treating the enrollee adversely. The Contractor must furnish information about any counseling or referral services it doesn't cover because of an objection on moral or religious grounds to the Agency with its application for this contract.

The Contractor must make its written materials available to enrollees including, at a minimum, provider directories, policies and procedures, enrollee handbooks, enrollee rights and responsibilities, appeal and grievance notices, appeals, denial and termination notices, and fair hearing procedures with timeframes as specified in the Agency's rules on beneficiary fair hearing processes. These materials must be drafted using the State developed enrollee notices and Agency model enrollee handbook format and be made available in Spanish, the prevalent non-English language in Wyoming. The Contractor's enrollee handbook must include regarding the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled and the procedures for obtaining such benefits, including requirements for service authorizations. The Contractor must:

A. Mail a printed copy of the information to the enrollee's mailing address;

B. Provide the information by email after obtaining the enrollee's agreement to receive the information by email;

C. Post the information on its website and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and service upon request at no cost; or,

D. Provide the information by any other method that can reasonably be expected to result in the enrollee receiving that information.

The Contractor is required to utilize the model enrollee handbook and state developed notices to describe any transition of care policies for enrollees and potential enrollees. The transition of care policies must include information to enrollees informing them that they have access to services consistent with the access they previously had under their previous network provider, and that when appropriate, will be assisted to find another network service provider that has access to historical data, plan of care 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.

The Contractor must provide specific information in the enrollee handbook that includes:

A. Information about enrollee's rights and responsibilities (including their right to be treated with respect and in due consideration for his or her dignity and privacy);

B. Enrollee's right to file grievances, appeals, State fair hearing, and receive continuation of benefits;

C. Treatment options;

D. Requirements and timeframes for filing a grievance or appeal;

E. Information on the availability of assistance in the filing process for grievances;

F. Specifications that, when requested by the enrollee, benefits that the Contractor seeks to reduce or terminate will continue if the enrollee files an appeal or a request for state fair hearing within the timeframes specified for filing, and that the enrollee may, consistent with state rule and policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee;

G. Information on the availability of assistance in the filing process for appeals; and,

H. Enrollee's right to request a state fair hearing after the Contractor has made a determination on an enrollee's appeal which is adverse to the enrollee.

The Contractor must ensure that all written materials are provided in an easily understood language and format. Written materials must also be made available in alternative formats upon request of the potential enrollee or enrollee at no cost. Auxiliary aids and services must also be made available upon request of the potential enrollee or enrollee at no cost. Written materials must include taglines in the prevalent non-English language in Wyoming, be available in large print (a font size no smaller than 18 point) and provide an explanation of the availability of written translation, American Sign Language (ASL), or oral interpretation to understand the information provided. Written materials must include the toll-free and TTY/TDY telephone number of the Contractor's member/customer service unit. The Contractor must notify its enrollees that oral interpretation, written translation and auxiliary aids and services are available upon request at no cost for enrollees with disabilities, and provide information on how to access those services.

The Contractor must have staff available using an 800 number twenty-four (24) hours a day/three hundred sixty-five (365) days a year to respond to enrollee calls. Interpreter services are available for the hearing impaired and for non-English speakers. Calls may range from non-urgent requests for referral to behavioral health crises. The 800 number is printed in the enrollee handbook, benefit book and associated materials. The 800 number shall include telephone crisis intervention, risk assessment, and consultation to callers which may include family enrollees or other community agencies regarding behavioral health services. The 800 number is used to monitor the following: information to beneficiaries, grievance, timely access, coordination/continuity, fraud, waste, and abuse, 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 Agency quarterly and the Agency discusses the findings to identify opportunities for improvement.

Marketing and General Information Requirements

The Contractor must submit all marketing, including plans and materials, to the Agency for review before release. The Contractor's marketing materials shall not contain any assertion of statement (whether written or oral) that the recipient must enroll in the Contractor's program to obtain benefits or to not lose benefits, or, that the Contractor is endorsed by CMS, the federal or

State government, or a similar entity. The Contractor must use State developed enrollee notices. When the Contractor chooses to provide the required information electronically to enrollees:

A. It must be in a format that is readily accessible;

B. The information must be placed in a location on the Contractor's website that is prominent and readily accessible;

C. The information provided must be provided in an electronic form which can be electronically retained and printed;

D. The information is consistent with content and language requirements;

E. The Contractor must notify the enrollee that the information is available in paper form without charge upon request; and,

F. The Contractor must provide, upon request, information in paper form within five (5) business days.

Providers and Provider Network

The Contractor must maintain and monitor a network of appropriate providers that is supported by written agreements and policies and procedures that document the process the Contractor requires for provider credentialing and re-credentialing. The Contractor is prohibited from restricting network providers from acting within the lawful scope of practice and/or advising or advocating on behalf of their enrollees regarding health status, treatment options, medical care, risks and benefits of non-treatment, and enrollee's right to participate in present and future healthcare decisions. The Agency does not require the Contractor to contract with more providers than necessary to meet the needs of its enrollees and in consideration of the number of enrollees and expected utilization of services, and the number of providers that have met ratio requirements. The Contractor must provide notification to the Agency when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the HFWA program, including the termination of the provider agreement with the Contractor.

The provider network must be 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. The Contractor will also demonstrate that they have complied with availability and accessibility of service requirements. The Contractor provides supporting documentation demonstrating that it has the capacity to serve the expected statewide enrollment. Through geographic mapping, distribution of provider types across the State is identified. A full listing is included in the Service Report and on the Contractor's website. Geographic mapping is generated and reported on a quarterly basis and is developed by the Contractor and provided to the Agency for use in monitoring marketing, information to beneficiaries, enrollee's free choice of providers, timely access, coordination/continuity of care, coverage/authorization, quality of care, and Provider Selection. The Contractor will map referral and subsequent enrollment patterns 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 Contractor's performance evaluation.

The Contractor must give written notice of the reason for its decision when it declines to include individual or groups of providers in its provider network. Additionally, the Contractor will take no punitive action against a provider who requests an expedited resolution or supports an

enrollee's appeal. The Contractor is required to use practice guidelines developed using the core values and principles of the HFWA practice. Practice guidelines should be adopted in consultation with contracting health care professionals and must be reviewed and updated periodically, as appropriate. The Contractor must disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply will be consistent with the guidelines.

A provider directory must also be made available on the Contractor's website in a machine-readable file and format as specified by the Secretary and in 42 CFR 438.10(h). The Contractor's electronic provider directory must be updated no later than thirty (30) calendar days after the Contractor receives updated provider information. The Contractor must make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) calendar days after receipt of issuance of the termination notice, to each enrollee who received his or her care coordination from, or was seen on a regular basis by, the terminated provider.

An active provider in Wyoming's Care Management Entity is defined as someone who meets the following requirements, initially and ongoing:

- Active status and in good standing with Wyoming Medicaid.
- Has met all of the Care Management Entity training requirements for certification.
- Has met the educational and age requirements for the role he or she is serving.
- A National Provider Identifier number with the appropriate taxonomy.
- A valid address in the Magellan of Wyoming system.
- The same valid address in the Wyoming Medicaid system.
- The same valid address in the NPI system.
- A clear background check that includes the FBI and Central Registry.
- CPR/First Aid certification.
- A minimum of liability auto insurance.
- There are no sanctions or exclusions for provider participation.

The Contractor must send network provider disenrollment requests to the state contract manager who will submit them to the state's provider enrollment contractor for processing.

Measurement of Disparities by Racial or Ethnic Groups

The Contractor must report demographic data (including racial/ethnic data), outcomes measures, utilization, and special needs population (target population) data to the Agency annually. 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 Contractor's performance evaluation.

The Contractor is required to participate in the Agency'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 gender, sexual orientation or gender identity.

Network Adequacy Assurance Submitted by Contractor

The Contractor must submit documentation to the Agency demonstrating that the Contractor 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 in the service area at the time it enters in to a Contract with the Agency and any time there is a significant change (as defined by the Agency) in the Contractor's operations that impacts services. Documentation is submitted quarterly. 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.

Utilization Review/Management and Plan Authorization

The Contractor must perform ongoing monitoring of utilization management (UM) data, on site review results, and claims data. The Agency will monitor the Contractor's utilization review process. 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 Agency and reviewed annually at minimum.

Utilization management data can be used to monitor program integrity, free choice of provider, marketing, enrollee enrollment/disenrollment, timely access, coordination and continuity of care, 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 Agency. The Agency 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 Contractor's performance evaluation.

Grievances and Appeals

The Contractor must establish and maintain a grievance and appeal system, composed of the grievance, one-level appeal, and State fair hearing process, under which enrollees, or providers, acting on their behalf, may file and track grievances and appeal, and adverse action notifications. This information, including timeframes specified in 42 C.F.R. 438.400 and 438.424, must be provided to enrollees and providers when they enter into a contract. Enrollees and providers must be made aware of the enrollee's right to file and receive assistance with filing grievances and appeals, state fair hearing process, and the right for the continuation of benefits at that time. The Contractor's process for handling grievances and appeals require timely acknowledgment, in writing, receipt of each grievance and appeal of adverse action notification, and the date, time, and process by which the grievance or appeal is to be heard and decided. Grievances filed only with the Contractor may be filed orally or in writing at any time. However, the Contractor must resolve grievances and provide notice according to the enrollee's health condition, no more than ninety (90) calendar days from grievance receipt. The Contractor can choose to extend the grievance timeline by up to fourteen (14) calendar days if the enrollee requests an extension or the Contractor justifies a need for additional information and is able to demonstrate how the

extension is in the enrollee's best interest. If delayed, the Contractor must provide reasonable efforts to give oral notification, provide written notice within two (2) calendar days, and inform of the right to file a grievance if in disagreement of the delay. Written notice must also be provided to the enrollee of grievance resolution in a reasonable format.

The Contractor must also ensure that individuals making decisions regarding grievance and appeals are free of conflict, were not involved in any previous level of review or decision-making, have appropriate clinical expertise for treatment, if applicable, and must consider all submitted documents and information, considered at any level of the grievance and appeal process. The Contractor must accurately maintain records of grievances and appeals, in a manner accessible to the Agency and available upon request to CMS. Records of grievances or appeals must include a general description of the reason for the appeal or grievance, date received, date of each review or, if applicable, review meeting, resolution information for each level of the appeal or grievance, if applicable, date of resolution at each level, if applicable, and enrollee name for whom the appeal or grievance was filled.

Appeals can be filed orally or in writing by the enrollee or an authorized representative, including the provider, within sixty (60) calendar days from the date on the adverse action notice. An oral notice of appeal or an oral inquiry seeking to appeal an adverse action must be treated as an appeal, unless the enrollee requests an expedited appeal. The Contractor must also provide the enrollee or the authorized representative the opportunity to present legal and factual evidence and arguments, and review the case file, including medical records or other documentation sufficiently in advance of the resolution timeframe for standard and expedited appeal resolution. The Contractor will resolve each appeal and provide the enrollee notice of the decision, as expeditiously as the enrollee's health condition requires and no more than thirty (30) calendar days. This can be extended for up to fourteen (14) calendar days if the enrollee requests an extension or the Contractor justifies a need for additional information and is able to demonstrate how the extension is in the enrollee's best interest. If delayed, the Contractor must provide reasonable efforts to give oral notification, provide written notice within two (2) calendar days, and inform of the right to file a grievance if in disagreement of the delay.

If the Contractor denies a request for expedited resolution of an appeal, the Contractor must transfer the appeal to the standard timeframe of no longer than thirty (30) calendar days from the day the appeal was received. The written notice must be in a format and language that meets the requirements of 42 C.F.R. 438.10 and include the results and date of the appeal resolution, the right to request a State fair hearing, request and receive benefits, and notice of liability of cost. If the Contractor fails to adhere to the notice and timing requirements for appeals then the enrollee may initiate the process for a State fair hearing.

Adverse Action Notification

In the event the Contractor makes an adverse action notification regarding an enrollee or if the action is a denial of payment, written notice of the adverse action notification must be mailed to the enrollee on the date of determination. All notices of adverse action notifications must, at a minimum, explain the determination, reasons for the determination, right to retrieve applicable and related copies of documents and records of the grievance, how and the right to appeal or request State fair hearing. Notices must also include information regarding the expedition of the right to appeal, and the continuation of benefits.

The Contractor must have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services. The Contractor must have if effect

mechanisms to ensure consistent application of review criteria for authorization decisions. For standard authorization decisions, the Contractor must issue service authorizations and/or adverse action notifications as a result of the concurrent review no later than fourteen (14) calendar days after receipt of the plan, with a possible extension of fourteen (14) calendar days if the provider or enrollee requests an extension or the Contractor justifies the need for additional information and how the extension is in the enrollee's best interest. If the timeframe was extended for standard authorization decisions that deny or limit services, the Contractor must issue and carry out its determination expeditiously and no later than the date the extension expires. If the Contractor extends the fourteen (14) calendar day service authorization notice timeframe, it must give the enrollee written notice of the reason for the extension and inform the enrollee of the right to file a grievance if he or she disagrees with the decision. If the provider indicates or the Contractor determines, that following the standard authorization and/or adverse action decision time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice no later than seventy-two (72) hours after receipt of the request for service. This may be extended up to fourteen (14) calendar days if the enrollee requests an extension or the Contractor justifies a need for additional information and is able to demonstrate how the extension is in the enrollee's best interest. If the Contractor's review results in an adverse action, the Contractor must provide a thirty (30) calendar day advance notification to the enrollee and the enrollee's family care coordinator prior to implementing a change in program eligibility and/or service amount, duration or frequency. The Contractor must give notice to the enrollees when service authorizations are not reached within stated timeframes for standard or expedited authorizations. If delayed, the Contractor must provide reasonable efforts to give oral notification, provide written notice within two (2) calendar days, and inform of the right to file a grievance if in disagreement of the delay. The Contractor must also provide prompt oral notice to the enrollee of the resolution of a standard or expedited appeal.

The Contractor must mail the notice of adverse action notification at least ten (10) days before the date of action, when the action is a termination, suspension, or reduction of previously authorized Medicaid covered services. If the Agency has facts indicating that action should be taken because of probable fraud by the enrollee, and the facts have been verified, if possible, through secondary sources, the Contractor must mail the notice of adverse action notification within five (5) days prior to the date of action. The Contractor must mail the notice of adverse action notification by the date of the action when the enrollee has died, knowingly submitted a signed written statement requesting service termination or service reduction, is admitted to an institution, is accepted for Medicaid services in another location, or enrollee's address is unknown.

Continuation of Benefits

The Contractor must continue the enrollee's benefits if the enrollee files a request for an appeal within sixty (60) calendar days from the adverse action notification, if the appeal involves termination, suspension, or reduction of a previously authorized service, if the enrollee's services were ordered by a provider, and the original authorization has not expired. The request for continuation of benefits must be filed within ten (10) calendar days or the intended effective date of adverse action notification, whichever is later. If, at the enrollee's request, the Contractor continues or reinstates the enrollee's benefits while the appeal or request for State fair hearing is pending, the benefits must continue until the enrollee withdraws the appeal, fails to timely request continuation of benefits, or a State fair hearing decision adverse to the enrollee is issued.

If the final resolution of appeal or State fair hearing upholds the adverse action, the Contractor may recover in accordance with State policies, the costs of the enrollee's continued benefits. If services were not furnished during the appeal, the Contractor must authorize or provide the services as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours from the date that the State fair hearing officer reverses a decision to deny, limit or delay services. The Contractor must pay for disputed services if the decision to deny, limit or delay services was overturned.

Initial and Re-evaluation for Enrolled Enrollees: Level of Care

The Contractor must collect and report data (quarterly) on the compliance rate of initial and annual level of care evaluations. This will include the CASII, ECSII, CANS, and required level of care attestation. The level of care attestation is currently required annually. The CASII, ECSII, and CANS may be required more frequently as agreed upon by the Agency and Contractor. The Contractor must review one hundred percent (100%) of all initial and re-evaluations and report data to the Agency quarterly.

Metric Calculation: Total number of annual re-evaluations conducted on or prior to the expiration date of the previous evaluation/assessment/Total number of re-evaluations conducted. This metric shall be reported as a percentage.

Application of Evaluation Instruments: CASII, ECSII, CANS, and Level of Care

The Contract must ensure all evaluations for initial and ongoing program participation are completed by an appropriately qualified mental health professional (QMHP) or otherwise qualified evaluator according to Agency criteria. The CASII and ECSII evaluations must be performed in accordance with the American Academy of Child and Adolescent Psychiatrists (AACAP) guidelines and standards. The Contractor must review one hundred percent (100%) of all initial and re-evaluations and report data to the Agency quarterly.

Qualified Providers

The Contractor must ensure contracted providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services. The Contractor must review one hundred percent (100%) of provider certification and training qualifications and report this information to the Agency quarterly.

Metric Calculation: Total number of contracted providers that meet all initial provider certification and qualification requirements/total number of providers contracted. This metric shall be reported as a percentage (Ops 8-38 A).

Metric Calculation: Total number of contracted providers that continue to meet all ongoing provider credentialing and qualification requirements/total number of enrolled providers. This metric shall be reported as a percentage (Ops 8-38 B).

Metric Calculation: Total number of contracted providers that receive training on abuse, neglect and exploitation identification and reporting procedures annually as part of the re-certification process/total number of contracted providers (Ops 8-38 E).

Service Coverage and Individual Plan of Care

The Contract must ensure that all plans of care address enrollee's assessed needs (including

health and safety risk factors) and personal goals, either by the provision of services or through other means and that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which services are furnished. The Contractor must review one hundred percent (100%) of all plans of care submitted and report this information to the Agency quarterly. The Contractor must require all contracted providers to submit plans of care that meet Agency defined requirements for the provision of waiver services as part of the provider network. All plans of care components are evaluated for adequacy, applicability, assurance that the plan meets the youth and family needs as identified by the various evaluation/assessments performed and that appropriate safeguards are identified to protect the health and welfare of the waiver youth. The Contractor must submit data to the Agency annually showing remediation for individual problems related to the plan of care. Individual problems with the development, implementation or monitoring of plans of care can be identified through various mechanisms including:

A. Within the formal grievance process;

B. Within the enrollee incident reporting process;

C. Within the plan of care approval process;

D. Within the team meeting process;

E . Through internal referrals; and

F. As tracked and monitored through the Contractor's electronic plan of care management system.

When non-compliance is suspected through any of these processes, the 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 Contractor to address any deficiencies identified. If the issues persist, the Agency's contract manager will work with the Contractor to develop a corrective action plan. If the provider fails to demonstrate progress toward meeting the program expectations, the Contractor and the Agency will enact all authority under current rule and regulation for provider sanctions and/or payment recovery up to and including enrollment suspension as a Contractor and Medicaid provider.

The Contractor formally designates a Family Care Coordinator (FCC) of the enrollee's choosing. The FCC is responsible to coordinate the services the Contractor furnishes to the enrollee with the services the enrollee may receive in FFS Medicaid. The Contractor is required to implement procedures to coordinate the services it furnishes to the enrollee with the services the enrollee receives from community and social support providers. The Contractor is required to ensure that each network provider furnishing services to enrollees maintains and shares an enrollee health record in accordance with Medicaid requirements as specified in the CMS 1500 manual.

Metric Calculation: Total number of plans of care in which services were authorized and reflect the enrollee's assessed needs, risks, and personal goals as detailed in the clinical eligibility assessments or any other applicable evaluation provided to the child and family team/total number of plans of care reviewed. This metric shall be reported as a percentage (Ops 8-38 F).

Metric Calculation: Total number of plans of care that are completed at least annually and when CASII, ESCII, CANS, level of care, or other assessment or evaluation demonstrates a change in the enrollee's needs/total number of plans. This metric shall be reported as a percentage (Ops 8-38 G).

Metric Calculation: Total number of plans of care in which services and supports are provided in each type, scope, amount, duration, and frequency specified in the plan/total number of plans of care reviewed. This metric shall be reported as a percentage.

Health and Welfare

The Contractor must, on an ongoing basis, identify, address, and seek to prevent the occurrence of abuse, neglect, and exploitation. The Contractor must review one hundred percent (100%) of all plans of care submitted and report this information to the Agency quarterly. The Contractor must include documentation of appropriate action demonstrating remediation for individual problems related to health and welfare. Data related to incident report trends, problem providers, corrective action plans, provider contract suspensions and all other related actions must be reported.

Metric Calculation: Total number of youth and/or guardians who received training and education on how to identify and reports abuse, neglect, exploitation and unexplained death/total number of waiver participants. This metric shall be reported as a percentage (Ops 8-38 N).

Metric Calculation: Total number of critical incidents reviewed and followed up according to state requirements/number of incidents received. This metric shall be reported as a percentage (Ops 8-38 O).

Metric Calculation: Number of critical incidents where the root cause was identified/number of critical incidents received.

Metric Calculation: Number and percent of unauthorized restraints and restrictive interventions, including seclusion, addressed according to the process in the approved waiver/Total number of reported restraints, incidents involving seclusion, and unauthorized restrictive interventions.

Metric Calculation: Number of participants who have identified a Primary Care Provider at first POC authorization/Number of youth enrolled in the waiver program.

System Design Changes

The Contractor will employ the methodologies discussed above 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 Contractor with approval from the Agency and through regional/local stakeholder and community meetings required as an activity of the Contractor.

Quality Assurance and Program Integrity

The Contractor is required to establish and implement an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) program for the services it furnishes to its enrollees. The QAPI program must include Performance Improvement Projects (PIP), including any required by the Agency or CMS. The QAPI program must include collection and submission of performance measurement data as specified in the Contract and Statement of Work outcome measures and performance requirements and report to the Agency on its performance. Activities of the QAPI program must include mechanisms to detect both underutilization and

overutilization of service. The Contractor must include mechanisms to assess the quality and appropriateness of care coordination furnished to enrollees with special health care needs.

The Contractor's PIP status and results will be reported to the Agency no less than once a year and include at least the following elements:

A. Demonstration of significant improvement, sustained over time, in health outcomes and enrollee satisfaction;

B. Measurement of performance using objective quality indicators;

C. Implementation of interventions to achieve improvement in the access to and quality of care;

D. Evaluation of the effectiveness of the interventions based on the performance measures; and,

E. Planning and initiation of activities for increasing or sustaining improvement.

1.5. CME Scope of Services: Operational Requirements

The Contractor must provide ongoing operational services to fulfill the requirements included in this SOW, including, but not limited to:

- Contract with a network of providers to support HFWA and service delivery, including Family Care Coordinators (FCCs), Family Support Partners (FSPs), Youth Support Partners (YSP), and respite care providers;
- Conduct initial and ongoing training of all providers in the CME network and facilitate the certification of each provider during the onboarding process;
- Develop and offer effective provider and enrollee customer assistance options;
- Facilitate annual provider recertification and trainings;
- Provide intensive care coordination;
- Increase the use of home and community-based services (HCBS) and natural supports as alternatives to costly residential and hospital care;
- Assist families with access to local crisis and response supports;
- Improve coordination of services for enrollees;
- Develop a transparent reporting structure to measure and monitor program services and outcomes;
- Monitoring approach to ensure supporting documentation is in place to validate FFS claims sent directly to agency by Contractor's certified and active network providers; and
- Leverage innovative health information technology (HIT) to support its providers and provide "real-time" data access for care monitoring and quality improvement for HFWA services to the youth and families.

Detailed operational responsibilities of the Contractor are included in subsequent sections.

CME General Requirements

During the Operations Phase, the Contractor will be responsible for operating the CME in accordance with SOW requirements. By reference, the Contractor will be required to follow and adhere to all processes, guidelines, and standards detailed in the Agency's Social Security Act Sec. 1915 (b) and Sec. 1915 (c) waivers and State Plan as approved by CMS. The Contractor must also abide by all federal statutes and regulations, including timeliness standards established for the payment of submitted and verified claims. The Agency also reserves the right to audit the Contractor to review all waiver functions the Contractor performs on behalf of the Agency. Such review will include examination of functions, including recordkeeping, efficiencies, and general performance.

As part of the execution of the Contract, the Contractor must submit the name, address, date of birth, and Social Security Numbers (SSNs) of any managing employee of the Contractor. The Contractor's CEO shall also be published on the Contractor's public-facing website. The Contractor must also disclose to the Agency any persons or corporations with an ownership or control interest in the MCP that:

- Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the Contractor's equity;
- Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least five percent (5%) of the value of the Contractor's assets;
- Is an officer or director of a Pre-paid Ambulatory Health Plan (PAHP) organized as a corporation; or
- Is a partner in a PAHP organized as a partnership with the Contractor

The Contractor must resubmit any disclosures at the time of a contract amendment, renewal, or within thirty (35) calendar days after any change in ownership at the Contractor's organization.

The Contractor must maintain its operations for serving Wyoming within the continental United States. The Agency requires all Contract services and activities to be conducted within the continental United States. With the exception of security controls, software development and defect resolution to Contractor-supplied software which may leverage global resources.

The Contractor must be responsible for the following General responsibilities and comply with requirements in Table 5:

Table 5 – General Requirements

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATION
GR 5-1	Location	Maintain the Contractor's Wyoming	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATION
		operations within the continental United States.	
GR 5-2	Location	The Contractor must serve all approved regions and target populations within the State. Contractor will have staff physically available throughout the regions of the State as indicated by the growth and needs of the Contract. Additional populations may be added or modified as appropriate and agreed upon by both parties in writing.	
GR 5-3	Location	Maintain dedicated HFWA provider locations to provide service in every region in Wyoming.	
GR 5-4	Location	Key Personnel may be required to be onsite in Wyoming for certain Contractor responsibilities, such as day to day operations, network provider recruitment, retention, and training. Contractor personnel who are not on-site in Wyoming must also be available to come to Wyoming if requested to attend meetings or for other on-site responsibilities.	
GR 5-5	Equipment	Provide all electronic and telecommunications equipment needed to support Key Personnel and necessary administrative staff supporting this Contract, including personal computers, printers, fax machines, modems, routers and related equipment.	
GR 5-6	Equipment	The Contractor must bear the cost of establishing and maintaining leased lines, Internet or Intranet servers, virtual private networks, or any other communication devices or protocols used to support the Contract.	
GR 5-7	Quality Assurance/ Quality Control	Comply with the external quality review (EQR), as required by federal regulations at 42 CFR § 438, subpart E.	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATION
GR 5-8	Quality Assurance/Quality Control	Update an ongoing Comprehensive Quality Assessment and Performance Improvement (QAPI) Plan and program for the services it furnishes to its enrollees. The QAPI must, at minimum, include: A. Performance Improvement Projects (PIP), including any required by the Agency or CMS; B. Collection and submission of performance measurement data as specified in the Contract outcome measures and performance requirements. These also need to be reported to the Agency as part of the Quarterly Report; C. Mechanisms to detect and prevent fraud, waste and abuse; D. Mechanisms to identify and notify the Agency on changes to enrollee or provider status or circumstances; E. Procedures to ensure dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract; F. Provision for prompt reporting and recovery of overpayments, specifying the overpayments due to potential fraud to the Agency and the State Medicaid Fraud Control Unit per the 42 CFR 438.60(d)(3) requirement that states that each MCO, PIHP, or PAHP must report annually to the State on their recoveries of overpayments; G. Policies related to the False Claims Act, including protections for whistleblowers; H. Method for sampling whether services represented have been delivered to the received enrollees;	Submit the updated Quality Assessment and Performance Improvement (QAPI) Plan (Trilogy Documents) within ninety (90) calendar days after the Contract Effective Date. Revise the Plan as needed, at minimum annually, to address areas of non-compliance.

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATION
		I. Approach to soliciting feedback and recommendations from key stakeholders, providers, enrollees and families/caregivers, and use the feedback and recommendations to improve performance; and J. Align with other Program Integrity requirements included in §438.608 The Contractor's QAPI shall align with the Agency's Quality Review Strategy (QRS), as directed by the Agency.	
GR 5-9	Quality Assurance/ Quality Control	Report PIP status and results to the Agency no less than once a year and include at least the following elements: A. Demonstration of significant improvement, sustained over time, in outcomes and enrollee satisfaction; B. Measurement of performance using objective quality indicators; C. Evaluation of the effectiveness of the interventions based on the performance measures; and D. Planning and initiation of activities for increasing or sustaining improvement.	
GR 5-10	Quality Assurance/ Quality Control	The Contractor's QAPI and PIP shall align with the most recent CMS protocols.	
GR 5-11	Quality Assurance/ Quality Control	Conduct routine quality assurance and quality control activities, as described in approved QAPI and Project Work Plan.	
GR 5-12	Quality Assurance/ Quality Control	Report all quality monitoring, assurance and improvement metrics to the Agency as outlined in the Social Security Act Sec. 1915(b) and Sec. 1915(c) waivers, as applicable to the Contract. Metrics shall also be included in the Quarterly Report.	
GR 5-13	Quality	Deploy methodologies for monitoring and assessing any changes to the Contractor's	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATION
	Assurance/ Quality Control	service model. The monitoring and assessment methodologies must remain consistent to appropriately reflect impacts of the change implemented. Results of the changes will be communicated to stakeholders under direction of the Agency. The Agency reserves the right to participate in any change discussions as needed.	
GR 5-14	Quality Assurance/ Quality Control	Escalate areas of non-compliance or issues as part of the QAPI and SLA.	
GR 5-15	Deliverable Management	Adhere to the Agency's Deliverable Review Process. The Deliverable Review Process defines how deliverables are: A. Submitted for review; B. Reviewed; C. Commented on; D. How requests for changes are managed; E. The schedule for review; F. The schedule for updates; and G. Deliverables acceptance.	
GR 5-16	Deliverable Management	Correct any issues identified by the Agency relating to deliverables and engage in any investigation necessary to determine the source of such deficiencies, at no cost to the Agency.	
GR 5-17	Deliverable Management	All deliverables will be in Microsoft Windows Suite; Word, Excel, MS Project, PowerPoint or, if applicable, Visio, or other industry standard tools. Deliverables shall not be submitted in PDF unless otherwise agreed to in advance. Graphics and drawings shall be in industry standard file format.	
GR 5-18	Deliverable Management	Obtain written acceptance approval from the Agency on all final deliverables. Any payment tied to deliverables shall be based on the Agency's written approval of the deliverable.	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATION
GR 5-19	Change Management	Maintain a control change process in accordance with the approved Project Work Plan in instances where there is a request for change to the SOW, any change that impacts enrollees or providers and any State or Federal regulation not addressed on an amendment. The control change process must include: A. The reason for the change; B. A complete description of work to be performed; C. An estimate of time and cost to complete the task; D. A completion date for the change; and E. An impact analysis indicating ramifications or impact to the project.	
GR 5-20	Change Management	If unforeseen circumstances arise where a dispute resolution might be needed, the Contractor will submit (in writing) a description of the problem and proposed resolution to the Agency contact for his/her consideration.	
GR 5-21	Contract Communication	Maintain communications as outlined in the approved Project Work Plan.	
GR 5-22	Contract Communication	Conduct weekly operational calls with the Agency Contract Manager during operations.	Distribute the agendas at least one (1) business day in advance of the meeting. Distribute minutes to the Agency within two (2) business days of the meeting.
GR 5-23	Contract Communication	Maintain regular telephone and email contact with the Agency's designated Contract Manager and designated staff throughout the Contract period. The Contractor must produce and distribute minutes of the meeting unless otherwise directed by the Agency.	Distribute minutes to the Agency within two (2) business days of the meeting.
GR 5-24	Contract	Participate in any other meetings, as directed by the Agency. The Contractor must	Distribute minutes to the Agency within two (2) days of the meeting.

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATION
	Communication	produce and distribute minutes of the meeting unless otherwise directed by the Agency.	
GR 5-25	Contract Communication	Participate in annual Contract reviews. Work with the Agency to identify and propose annual Contract year goals, measures, Service Level Agreements and Performance Expectations, and timelines.	The review shall be conducted within thirty (30) days before the Contract review period.
GR 5-26	Risk Management	Maintain a Risk Register in accordance with the approved Project Work Plan that tracks: A. All CME-related risks; B. Initial risk prioritization (urgency), and potential risk impacts (each risk); C. Risk responses for each risk; D. A risk mitigation strategy for each risk; and E. Assignments and updated ownership, due dates, and status tracking notes to each risk. Report on status of risks as part of routine Status Reports to the Agency. The Agency reserves the right to request access to the Contractor's Risk Register.	Provide the Agency access to the Risk Register within three (3) business days of a request.
GR 5-27	Issue Management	Utilize a Project Control and Issue Tracking tool to collect and track reported Contract issues and resolutions in accordance with the approved Project Work Plan. The tool shall capture, at minimum: A. All applicable information about the issue; B. Initial issue prioritization (urgency), and potential impacts; C. An issue resolution strategy for each issue; and D. Assignments and updated ownership, due dates, and status tracking notes to each issue. E. Report on status of issues as part of routine Status Reports to the Agency.	

Technology and Specifications

The Contractor must provide the necessary tools, systems, and infrastructure to support the CME operations and its providers. The Contractor's deployed IT solution(s) shall reflect user experience (UX) design principles to maximize operational and provider efficiencies, maintain compliance with State and federal rules and regulations, and support Contract reporting and requirements, as outlined in the SOW. The Contractor must integrate its IT solution(s) with Agency systems as necessary to streamline the administrative processes for the Agency, the Contractor, and its providers.

The Contractor must be responsible for the following Technology and Specification responsibilities and comply with requirements in Table 6:

Table 6 – Technology and Specification Requirements

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
IT 6-1	Contractor Deployed IT Solution(s) and Resources	The Contractor's IT solution shall support the services and business needs as outlined in this SOW. The Contractor's IT solution shall maximize operational and provider efficiencies, maintain compliance with State and federal rules and regulations, and support Contract reporting and requirements. Minimum functions include, but are not limited to: A. Correspondence module to support enrollee and provider letters, notifications, and communications; B. Provider documentation and notes application to support Contract documentation needs; C. Reporting function to manage, track, and generate reports on required data sets and waiver performance metrics; D. Support and track outcomes and metrics as detailed in the executed Contract; E. Tracking and managing referrals; F. Manage and report Provider Scorecards; G. Manage and store POCs; H. Manage and store Prior Authorizations (PAs) of POCs; I. Provide for automated program integrity reviews, such as monitoring level of service against the POC and units authorized and cross-checking units	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		against claims, converts to 835, 278, 270, and 271; J. Track and manage compliance with provider contact requirements; K. Track provider compliance and status of training and certification requirements; L. Allow upload of provider training requirements into the system for trainer to review; M. Utilization of services; N. Enrollee grievances and appeals; O. Support the generation of surveys, as detailed in Appendix A, Section 5.1 (A-5.1); P. Allow providers to capture informal and formal supports; Q. Monitor the use and transition from formal to informal supports; R. Provide for critical incident reporting monitoring; and S. Capture of crisis support.	
IT 6-2	Contractor Deployed IT Solution(s)	The Contractor's IT solution shall store and manage POCs electronically. POC data shall be discretely stored to enable the Contractor to trigger alerts and report on discrete areas of the electronic POC.	
IT 6-3	Contractor Deployed IT Solution(s)	The Contractor's IT solution shall provide autofill functionality to streamline the data entry process for its providers.	
IT 6-4	Contractor Deployed IT Solution(s)	The Contractor's IT solution must be compatible with multiple operating systems such as Windows 10, Apple OSX and browsers such as Internet Explorer, Mozilla Firefox, Google Chrome, Apple Safari, etc. in accordance to Wyoming IT Standards.	
IT 6-5	Contractor Deployed IT Solution(s)	The Contractor's IT solution shall support transition periods between networked providers through role-based access.	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
IT 6-6	Contractor Deployed IT Solution(s)	The Contractor's IT solution shall seamlessly integrate with and manage results from the following Assessment requirements: A. CANS B. ACE C. ECSII/CASII	
IT 6-7	Contractor Deployed IT Solution(s)	The Contractor's IT solution shall provide alerts and ticklers to staff and providers to assist in task and workflow management. Alerts include, but are not limited to: A. Monitoring compliance with assessment requirements and proactively alert and prompting providers complete assessments; B. Alerting staff when there is no POC on file or is missing documentation. C. Alerting staff to compliance issues with minimum requirements with provider contact with enrollees; D. Proactively alert the Contractor of upcoming WFI-EZ survey needs.	
IT 6-8	Contractor Deployed IT Solution(s)	Provide an electronic referral tool available on the Contractor's website to support the electronic submission and consumption of referrals to the CME.	
IT 6-9	Contractor Deployed IT Solution(s)	Provide a claim and prior authorization solution and submit electronically to the State. The solution shall: A. Validate Magellan PMPM claims prior to submission; B. Magellan PMPM claims will be submitted to the Agency in standardized Accredited Standards Committee (ASC) X12N 837 format, the ASC X12N 835 format, and EDI 270/271 Eligibility Benefit Inquiry and Response formats, as appropriate. The Contractor must provide sufficient Magellan PMPM claims and prior authorization data to identify the provider who delivers any services to individuals.	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
IT 6-10	Interaction with Agency and External Systems	The Contractor must use the standard X12N 270/271 Eligibility Benefit Inquiry and Response process to confirm eligibility. The Contractor must work with the Agency to develop a real-time interface to the Agency's Data Warehouse and Operational Data Store (ODS) to automatically receive and consume this data in the future.	
IT 6-11	Interaction with Agency and External Systems	The Contractor must work with the Agency's Fiscal Agent to capture and document provider eligibility status. Provider eligibility shall be electronically stored in the Contractor's IT solution. The Contractor must work with the Agency to develop an automated extract from the Agency's Data Warehouse and Operational Data Store (ODS) to automatically receive and consume this data in the future.	
IT 6-12	Interaction with Agency and External Systems	The Contractor's IT solution shall transmit data to WERT through the WFI-EZ survey and consume the fidelity score provided by WERT. The Agency recognizes that the WFI-EZ is changing in the future, so will work with the Contractor to identify the impact of this change on the Contract when necessary.	
IT 6-13	Interaction with Agency and External Systems	Maintain the license and operate the WFI-EZ (or another approved assessment tool for measuring fidelity to the HFWA model) throughout the operational phase.	
IT 6-14	Interaction with Agency and External Systems	Work with the Enterprise Technology Services, and Agency's Fiscal Agents, or other IT contractors to establish appropriate role-based access to the Agency's systems, as directed by the Agency.	
IT 6-15	General IT and System Requirements	Conduct routine System Usability Surveys with providers to identify areas of efficiency or improvement with the Contractor's IT solutions. These surveys may be conducted along with the Quarterly Surveys.	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
IT 6-16	General IT and System Requirements	Provide the Agency with read-only access to any Contractor-deployed EHR solutions upon request.	
IT 6-17	General IT and System Requirements	Acquire and maintain all systems hardware and software necessary to perform operations needed for this Contract, in a format compatible with software utilized by the Agency. The Agency is currently running on XP Professional using Office 2007 Professional Suite.	
IT 6-18	General IT and System Requirements	Maintain software capable of accepting and storing electronic signatures.	
IT 6-19	General IT and System Requirements	Provide an appropriate data storage solution to maintain enrollee and provider information and related data gathered from the Contractor's other data sources.	
IT 6-20	General IT and System Requirements	Conduct all routine maintenance and upgrades required to support all Contractor-deployed hardware and software.	
IT 6-21	General IT and System Requirements	Any Contractor-deployed IT solutions shall support audit controls for hardware, software, and/or procedural mechanisms that record and examine activity in information systems that contain or use Electronic Protected Health Information (ePHI).	
IT 6-22	General IT and System Requirements	Any Contractor-deployed IT solutions shall not permit the alteration of any security log or audit trail, and log repositories shall be encrypted.	
IT 6-23	General IT and System Requirements	Any Contractor-deployed IT solutions shall have the ability to implement stringent logging for all user types, including database administrators, and create an audit trail that cannot be modified.	
IT 6-24	General IT and System	Purchase and maintain, at no additional cost to the Agency, any required software licenses	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
	Requirements	and utilities applications necessary to meet the SOW of the contract.	
IT 6-25	General IT and System Requirements	The Contractor must clearly define the type of software and licensing type. Open source software is preferred however, it must be of enterprise/commercial quality as applicable and must provide clear and detailed documentation. Proprietary, commercial, open source, shareware and freeware may be used. However, the specifics of the restrictions, configuration management and how updated versions will be leveraged must be described. Licensing type shall be documented such as GNU, proprietary, End User Licensing Agreements (EULA), enterprise, concurrent, etc.	
IT 6-26	General IT and System Requirements	The Contractor must agree that any license purchased by the Contractor must be transferred, if applicable, to the Agency at a predetermined time.	
IT 6-27	General IT and System Requirements	Ensure that all technologies implemented and used in compliance with all EULA or other licensing arrangements determined by the Licensor, include the management and maintenance of software upgrades and patches.	
IT 6-28	General IT and System Requirements	If any of the Contractor's staff perform work under this Contract remotely, the Contractor must ensure they access the networks and systems in accordance with the State of Wyoming VPN access guidelines. A secure email connection with the State shall be required using the Agency's mail system for the secure transmission of data to the Agency. The Contractor is required to utilize the State of Wyoming VPN client software and meet the requirements for Contractor remote access.	
IT 6-29	General IT and System Requirements	Host the Contractor IT solution in accordance with State requirements, and performance expectations described in the RFP and ensure security and data retention.	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
IT 6-30	General IT and System Requirements	The Contractor's selected data center shall perform SSAE-16/18 Type 2 audits annually (by an independent auditor). Responses to findings, action plans, and remediation plans shall be submitted to the Agency for approval. The Contractor must coordinate responses to initial findings with the Agency that may impact operations.	
IT 6-31	Privacy and Security	Provide multiple layers of external and internal security that provides administrative, physical, and technical means to protect sensitive or confidential information used in performing the responsibilities and duties set forth in this SOW.	
IT 6-32	Privacy and Security	Transmission security shall use TLS 1.2, SHA 2 with a minimum of a 2048-bit key.	
IT 6-33	Privacy and Security	Access to any of the Contractor deployed IT solution shall be granted through the use of a unique user identifier and user profile, combined with a strong password. Any transaction or change to data shall be traced and audited by the Contractor, down to the User ID level.	
IT 6-34	Privacy and Security	Routinely review an appropriate subset of audit logs of any Contractor systems activity looking for suspicious activity.	Conduct audit reviews for suspicious activity no less than quarterly.
IT 6-35	Privacy and Security	Any Contractor-deployed IT solution shall encrypt ePHI whenever deemed appropriate, including in databases using an agreed upon and appropriate strength cipher.	
IT 6-36	Privacy and Security	Any Contractor-deployed third-party applications shall adhere to any applicable Agency system security practices, configurations, and procedures.	
IT 6-37	Privacy and Security	Apply all security patches for any Windows Operating System and any other software for the System. The Contractor must provide a user administration module that allows authorized users, including authorized	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		providers and system administrators, to assign access to functions in a secure manner in accordance with privacy and security requirements.	
IT 6-38	Privacy and Security	Any Contractor-deployed IT solution shall support either a hierarchical role structure whereby user and password define program or individual menu item access, or logon program/device security based strictly on user and password or PIN.	
IT 6-39	Privacy and Security	Maintain confidentiality of enrollee records.	
IT 6-40	Privacy and Security	Facilitate the signature of consent forms from enrollees to share information between approved providers.	
IT 6-41	Privacy and Security	The Contractor must conduct routine penetration and vulnerability testing of the pertinent Contractor systems containing enrollee ePHI.	An executive summary of the annual findings will be submitted to the Agency in the following quarterly report. The report must contain an overview of the test performed by the third party group and a summary of the findings identified during the test.
IT 6-42	Business Continuity and Disaster Recovery	Maintain current expectations related to business continuity and disaster recovery, as outlined in requirements and included the SLAs.	
IT 6-43	Business Continuity and Disaster Recovery	Provide disaster recovery and business continuance processes, including offsite storage capability.	
IT 6-44	Business Continuity and Disaster Recovery	Provide uninterrupted services in the event that any telephone line(s) stops working in accordance with the approved Business Continuity and Disaster Recovery Plan.	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
IT 6-45	Business Continuity and Disaster Recovery	Demonstrate requirements for backup and archiving using CMS and industry standards. Data archiving requirements shall meet Agency standards which is currently seven (7) years.	

Staffing and Resource Management

The Contractor must provide the key personnel included in Section 4 of this SOW who have previous experience in providing quality work on projects of similar scope. The Contractor must ensure that the Contract is adequately staffed with experienced, knowledgeable personnel who can meet the responsibilities outlined in this SOW throughout the Contract term.

The Contractor must be responsible for the following Staffing and Resource Management responsibilities and comply with requirements in Table 7:

Table 7 – Staffing and Resource Management Requirements

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
Staff 7-1	Staffing and Resource Management	Notify the Agency in advance of any planned key personnel changes or reassignment.	When possible, the Agency shall be notified at least thirty (30) calendar days prior to key personnel changes or departures. In unexpected termination circumstances, the Agency shall be notified at least two (2) business days after receiving notification of departure.
Staff 7-2	Staffing and Resource Management	In the event that a key personnel resigns or is terminated, the Contractor must provide the Agency with immediate notice of the vacancy, the reason(s) for the vacancy, and an action plan for backfilling the position until a replacement is found and approved by the Agency. The Contractor may not fill vacant key personnel positions with other existing key personnel without approval by the Agency. The Agency should also have the authority to approve proposed replacements of key personnel by the Contractor.	In unexpected termination circumstances, the Agency shall be notified at least two (2) business days after receiving notification of departure. When possible, the Agency shall be notified at least thirty (30) calendar days prior to key personnel changes. Key Personnel positions may not be open for more than two (2) weeks without a qualified substitute (temporary replacement). A qualified substitute must be in place no more than two (2) weeks after the separation date of the original resource. The definition of a qualified substitute is having experience in the position, meeting the requirements of the position and understanding of the CME SOW. The Contractor will have sixty (60) calendar days to fill this position with the permanent

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
			replacement.
Staff 7-3	Staffing and Resource Management	Supply an attestation (written documentation) of favorable background checks on Contractor network providers, at no cost to the Agency. The background checks must be performed by recognized law enforcement agencies or qualified third parties only, including the Federal Bureau of Investigations (FBI), on an annual basis. The Agency reserves the right to disqualify any network providers of the Contractor whose background checks suggest conduct, involvement, and/or associations that the Agency determines, in its reasonable discretion, are inconsistent with the performance and/or security requirements set forth in this Contract. The Agency reserves the right to request the Contractor to perform additional background checks on Contractor's network providers. Note: The Agency is in the process of implementing a new Provider Enrollment application. Providers shall enroll and complete background checks through this application in the future, as directed by the Agency.	
Staff 7-4	Staffing and Resource Management	Establish and implement Contractor personnel administration policies that reflect the State and Federal policies, standards, and regulations.	At minimum, the Contractor must provide staff with HIPAA and Security training annually.

CME General Operational Responsibilities and Requirements

The Agency expects the Contractor to implement an operational philosophy that focuses on continuous improvement and efficiency in service delivery to maximize outcomes for

Wyoming's children and youth with serious emotional challenges. The Contractor must maintain a network of providers to sufficiently support enrollees and operational requirements, while meeting or exceeded performance related requirements in subsequent sections of this SOW. This includes requirements specific to CME operations, such as outreach, data and reporting, enrollee grievances and appeals.

The Contractor must be responsible for the following General Operational responsibilities and comply with requirements in Table 8.

Table 8 – General Operational Responsibilities and Requirements

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
Ops 8-1	Ongoing Operations	Comply with all applicable federal and State laws that pertain to enrollee rights and ensure that all Network Providers take those rights in to account when furnishing services to enrollees.	
Ops 8-2	Ongoing Operations	The Contractor must demonstrate a relationship with multiple agencies, organizations, and resources (at the State and local level), including, but not limited to: A. Family-based or family-run organizations; B. State and local agencies serving the population of focus; C. Community-based organizations; D. Schools; E. Informal resources in the community; F. Child Welfare and Juvenile Justice stakeholders and systems; and G. Current resources, such as 211, as directed by the Agency (resource to human services referrals).	Provide number of meetings with stakeholders, agencies, organizations, and resources across the State as part of the Quarterly Report. This includes all Quality Improvement Committee (QIC) and Advisory council meetings.
Ops 8-3	Ongoing Operations	Develop Policies and Procedures that includes, at minimum: A. The Contractor's standard operating procedures; B. Incident response plan and procedures;	Provide the Policies and Procedures Manual within ninety (90) calendar days after the Contract Effective Date.

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		C. Policies and processes for enrollee grievances, appeals, and State fair hearings; D. Grievance tracking, resolution policies and procedures; E. Utilization management policies and procedures and procedures for adjusting POCs in accordance with the authorization policies; F. Provider and enrollee application policies and procedures; G. Transition of care policies and procedures; H. Process for identifying PCP; I. Policies and procedures for recruitment and retention of providers, certification, re-certification and nondiscrimination practices for providers; J. Policies and procedures for oversight, management, and monitoring of the CME's provider network; K. Policy that demonstrates that the Contractor does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment; L. Policies and procedures for the Contractor's Provider Report Card; M. Approach for coordinating services with external stakeholders, including the UM contractor; N. Personnel administration policies that reflect the State and federal policies, standards, and regulations; and O. Other policies and procedures required by the Contractor or Agency to support efficient CME operations.	
Ops 8-4	Ongoing Operations	Provide scalability for CME functions and service delivery to expand and contract based on changing children,	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		youth, and family needs in accordance with the approved Change Management processes.	
Ops 8-5	Ongoing Operations	Share knowledge of new federal regulations impacting the Medicaid children and youth being served.	
Ops 8-6	Ongoing Operations	Conduct research on HFWA trends and provide ability to adjust CME HFWA model based on evolving HFWA trends.	
Ops 8-7	Ongoing Operations	Execute risk management processes as outlined in the approved Project Work Plan in order to identify, mitigate, and report on risks associated with service delivery for population and organization ability to fulfill scope of work.	
Ops 8-8	Ongoing Operations	The Contractor may identify tasks, processes, or other methods where increased or improved outcomes can be realized by Agency users.	
Ops 8-9	Ongoing Operations	Maintain a WFI-EZ score that is at or above the national average.	
Ops 8-10	Ongoing Operations	The Contractor shall facilitate quarterly meetings or when requested by the Agency, to discuss opportunities for value added services, innovations and outcome improvements.	
Ops 8-11	Ongoing Operations	Respond to all provider and enrollee calls and email.	
Ops 8-12	Ongoing Operations	Develop and maintain a public-facing website that includes at minimum: A. Information on the services and eligibility requirements B. Marketing materials and opportunities	The Contractor must maintain website uptime of ninety-nine percent (99.0%), excluding planned downtime.

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		C. Ability to submit electronic referrals online D. Ability to submit general inquiries	
Ops 8-13	Ongoing Operations	Develop and maintain a public-facing website for enrollees that includes, at minimum: A. Information on the Contractor's scope of work information about how to apply B. Contact information and resources for families and providers C. Information on the Contractor's CEO for accountability, as required by CMS D. Directory of the CME provider network with current availability to provide services; E. Other information as directed by the Agency. The Contractor may provide a separate enrollee and provider sites and seamlessly integrate tools or systems into a single website with single sign on for providers to promote a streamlined access to provider tools.	
Ops 8-14	Ongoing Operations	Develop and maintain websites for providers that includes, at minimum: A. Information on the Contractor's scope of work B. Contact information and resources for families and providers C. Training and enrollment information, including links to online training modules D. Ability to submit electronic referrals online E. Ability for providers to edit practice information F. Ability to request and view prior authorizations	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		G. Ability for providers to edit practice information H. Access to Provider Scorecards I. Information on the Contractor's CEO for accountability, as required by CMS J. Other information as directed by the Agency.	
Ops 8-15	Ongoing Operations	The website and any other public-facing system or tool must be fully accessible per required Section 508 Standards and contain a link to translation services if necessary. This includes the option for interpreter services for the hearing impaired and for non-English speakers.	
Ops 8-16	Ongoing Operations	Conduct satisfaction surveys for all enrollees and network providers on a regular basis to inform the performance improvement process. The Contractor must provide draft surveys to the Agency for review prior to sending. Surveys shall, at minimum: A. Allow for the measurement of performance using objective quality measures; B. Ask if the respondent would recommend CME services to others. C. Survey providers on usability of Contractor-provided systems and solicit recommendations for improvements.	Submit the outline of the draft survey to the Agency for review and approval ten (10) business days prior to release. Conduct the survey annually, at minimum, in a timeframe agreed upon by the Agency. The Agency may require more frequent surveys based on findings reported in the Quarterly Report. Report both summary-level and detailed-level results of the surveys to the Agency within ten (10) business days after the survey closure. The reports shall include any planned activities to promote performance and quality improvement as a result of the surveys.
Ops 8-17	Ongoing Operations	The Contractor will only conduct prior authorization (PA)/utilization management (UM) of HFWA, respite and Youth and Family Training (YFT) and Support services provided to enrolled youth. The PA/UM process will require the Contractor to implement a service authorization review process which is conducted by Contractor staff with appropriate	The Contractor must issue service authorizations and/or adverse action notifications as a result of the concurrent review no later than fourteen (14) calendar days after receipt of the completed plan of care and supporting documents, with a possible extension of fourteen (14) calendar days if the provider or enrollee requests an

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		expertise in addressing the enrollee's needs. During the approved period this will include a concurrent review process to monitor clinical intervention tied to eligibility justification, delivery of benefits (HFWA, Respite, and YFT) and adherence to any benefit limitations. The mechanism and documents to be reviewed for the concurrent review will include the plan of care (POC), crisis plan, CASII, CANS and any other information deemed necessary to determine service authorization.	extension or the Contractor justifies the need for additional information and how the extension is in the enrollee's best interest. If the Contractor extends the fourteen (14) calendar day service authorization notice timeframe, it must give the enrollee written notice of the reason for the extension and inform the enrollee of the right to file a grievance if he or she disagrees with the decision. If the provider indicates or the Contractor determines, that following the standard authorization and/or adverse action decision time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an authorization decision and provide notice no later than three (3) business days after receipt of the complete documentation that includes the plan of care and other supporting documents required by the Contractor for the service authorization request. This may be extended up to fourteen (14) calendar days if the enrollee requests an extension or the Contractor justifies a need for additional information and is able to demonstrate how the extension is in the enrollee's best interest. If the Contractor's review results in an adverse action, the Contractor must provide a thirty (30) calendar day advance notification to the enrollee and the enrollee's Family Care Coordinator prior to implementing a change in program eligibility and/or service amount, duration or frequency.
Ops 8-18	Ongoing Operations	**Flex Funding** Flex funds are funds used for expenditures in support of the youth and family's POC for a youth and family receiving services from providers. A	The Contractor must include a description in the annual report describing how flex funds were spent. The report should include the recipient, the amount, reason

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		reasonable cost for flex funding is one that, in its nature and amount, does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. Unallowable costs include, but are not limited to the following: A. Alcoholic Beverages; B. Bad Debts; C. Contributions and Donations; D. Defense and prosecution of criminal and civil proceedings, claims, appeals and patent infringement; E. Entertainment Costs (unless specific written approval has been provided in advance by the Agency); F. Fines and Penalties; G. Interest on Borrowed Capital/Lines of Credit; H. Costs of Organized Fundraising; I. Costs of Investments Counsel/Management; J. Lobbying; and K. Renovation/remodeling and Capital Projects (unless specific written approval has been provided in advance by the Agency).	for the flex fund distribution, the date of distribution, and a brief description of the flex funds use/purpose.
Ops 8-19	Ongoing Operations	**Critical Incidents** The Contractor must notify the Agency immediately and in writing of the following: Critical incidents may include any event that affects the health, safety, and welfare of an enrollee.	The Contractor must notify the Agency within two (2) business days of any critical incident event. Data showing compliance with this requirement shall be included in the quarterly data report.
Ops 8-20	Outreach and Communication	Submit all provider and enrollee notices, outreach materials, and communication templates to the Agency for review and approval prior	Submit notice and communication templates for Agency review and approval prior to sending to

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		to sending to enrollees.	enrollees.
Ops 8-21	Outreach and Communication	Provide all enrollee notices, informational and outreach materials, and communications in an easily understood format and manner. The Contractor must provide written materials for enrollees in 8th grade reading level, unless agreed to by the Agency.	
Ops 8-22	Outreach and Communication	Inform all enrollees and potential enrollees that program information is available in alternative formats and how to access those formats.	
Ops 8-23	Outreach and Communication	Make written information available in the prevalent non-English languages identified by the Agency in its particular service area. "Prevalent" is defined by the Agency as any language spoken by more than four percent (4%) of Wyoming's population. English and Spanish are currently Wyoming's prevalent languages.	
Ops 8-24	Outreach and Communication	Make interpretation services available free of charge to each enrollee and potential enrollee. This shall include American Sign Language (ASL), if needed by the enrollee. The Contractor must notify its enrollees that interpretation services are available for any language and provide direction on how to access those services.	
Ops 8-25	Enrollee Appeals & Grievances (Complaints)	Provide enrollee grievance, appeal, and information about the right to a State fair hearings process to enrollees and designated representatives to voice expressions of dissatisfaction. This process shall be documented in the Policies and Procedures, Member Handbook, and Provider Handbook and communicated to enrollees and providers, as directed by the Agency. Enrollee grievances may be filled orally or in writing at any time. The	An appeal must be filed by an enrollee within sixty (60) calendar days from the date on the adverse benefit determination notice. An enrollee may file a grievance with the CME at any time. The Contractor must present a proposed resolution to the issue reported within ninety (90) calendar days from the date the Contractor receives the enrollee

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		Contractor must also ensure that individuals making decisions regarding enrollee grievances and appeals are free of conflict, were not involved in any previous level of review or decision-making, have appropriate clinical expertise for treatment, if applicable, and must consider all submitted documents and information, considered at any level of the enrollee grievance and appeal process.	grievance or appeal. If the Contractor's proposed resolution is not accepted by the individual or entity acting on their behalf, the Contractor has thirty (30) calendar days to review and respond to the enrollee grievance or appeal. After exhausting the enrollee grievance and appeal process with the Contractor, the enrollee must have no less than ninety (90) calendar days the date of the Contractor's final notice of resolution to request an Agency fair hearing. Contractor must resolve enrollee grievances and provide notice according to the enrollee's health condition, no more than ninety (90) calendar days from grievance receipt.
Ops 8-26	Appeals	Provide a written notice to the enrollee of appeal resolution in a reasonable format. Written notices must be in a format and language that meets the requirements of 42 C.F.R. 438.10 and include the results and date of the appeal resolution, the right to request a State fair hearing, request and receive benefits, and notice of liability of cost.	
Ops 8-27	Appeals & Enrollee Grievances	Maintain records of grievances and appeals, in a manner accessible to the Agency and available upon request to CMS. Records of grievances or appeals must include a general description of the reason for the appeal or grievance, date received, date of each review or, if applicable, review meeting, resolution information for each level of the appeal or grievance, if applicable, date of resolution at each level, if applicable, and enrollee name for whom the appeal or grievance was filled.	
Ops 8-28	Appeals	Provide a process for handling expedited resolutions of appeals, upon request of the enrollee.	Make a decision and send written notification to the requestor of the appeal review (an enrollee of their authorized representative such as the ordering and/or rendering

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
			provider) within seventy-two (72) hours of receipt of the initial verbal or written request for appeal review. This may be extended up to fourteen (14) calendar days if the enrollee requests an extension or the Contractor justifies a need for additional information and is able to demonstrate how the extension is in the enrollee's best interest. If the Contractor denies a request for expedited resolution of an appeal, the Contractor must transfer the appeal to the standard timeframe of no longer than thirty (30) calendar days from the day the appeal was received
Ops 8-29	Grievances & Appeals	In the event the Contractor makes an adverse action notification regarding an enrollee or if the action is a denial of payment, written notice of the adverse action notification must be mailed to the enrollee on the date of determination. All notices of adverse action must, at a minimum, explain the determination, reasons for the determination, right to retrieve applicable and related copies of documents and records of the grievance, the right and process to appeal or request State fair hearing. Notices must also include information regarding the expedition of the right to appeal, and the continuation of benefits. CME network providers do not have the right to file a grievance on behalf of themselves due to any adverse benefit determination regarding an enrollee they serve.	Appeals can be filed orally or in writing by the enrollee or an authorized representative, including the provider, within sixty (60) calendar days from the date on the adverse action notice. If the Contractor's review results in an adverse action, the Contractor must provide a thirty (30) calendar day advance notification to the enrollee and the enrollee's Family Care Coordinator prior to implementing a change in program eligibility and/or service amount, duration or frequency. The Contractor must mail the notice of adverse action notification at least ten (10) business days before the date of action, when the action is a termination, suspension, or reduction of previously authorized Medicaid covered services. If the Agency has facts indicating that action should be taken because of probable fraud by the enrollee, and the facts have been verified, if possible, through secondary sources, the Contractor must mail the notice of adverse action

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
			notification within five (5) business days prior to the date of action.
Ops 8-30	Appeals	Provide continuous enrollee benefits if the enrollee files a request for an appeal within sixty (60) calendar days from the adverse action notification. Benefits shall continue until the enrollee withdraws the appeal, fails to timely request continuation of benefits, or a State fair hearing decision adverse to the enrollee is issued. If the final resolution of appeal or State fair hearing upholds the adverse action, the Contractor may recover in accordance with State policies, the costs of the enrollee's continued benefits. The Contractor must pay for disputed services if the decision to deny, limit or delay services was overturned.	If services were not furnished during the appeal, the Contractor must authorize or provide the services as expeditiously as the enrollee's health condition requires, but no later than seventy-two hours from the date that the State fair hearing officer reverses a decision to deny, limit or delay services.
Ops 8-31	Enrollee Grievances	The Contractor must send enrollee grievances, received about the Contractor, to the Agency. Data showing compliance with this requirement shall be included in the Quarterly Report.	
Ops 8-32	Data Management and Reporting	Develop a Data Management Plan and process for reporting outcomes of enrollees served. The Plan shall address the Contractor's approach to monitoring and reporting on the required elements included in the Quarterly and Annual reports as detailed in subsequent requirements. The Plan shall also address the Contractor's approach to ad hoc reporting requests by the Agency.	Develop a Data Management Plan and process for reporting outcomes of enrollees served within one hundred and twenty (120) calendar days after the Contract Effective Date.
Ops 8-33	Data Management and Reporting	Provide the Agency with report templates for review and approval.	Develop report templates within one hundred and twenty (120) calendar days after the Contract Effective Date.
Ops 8-34	Data Management and Reporting	Provide a Weekly Report or EHR access to the Agency that includes, at	The Contractor must provide Weekly Reports to the Agency or,

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		minimum: A. Roster of admissions and discharges B. Roster of current enrollees. C. Roster of P07 program code reconciliation requests.	access to the same information in the CME's EHR
Ops 8-35	Data Management and Reporting	Provide a Quarterly Report to the Agency that includes, at minimum: A. Clinical and functional outcomes as measured by the clinical eligibility assessment tool, as specified by the Agency and the agreed upon assessment timeframes; B. Statistics on enrolled youth and families served; C. Prior Authorizations; D. Youth and family satisfaction survey results; E. Disenrollment requests from the plan made by enrollees; F. Denials and referral requests, including the number of children and youth referred, and turnaround time for referrals; G. Enrollee grievance and appeals data; H. Trends in coordination and continuity of care to include any enrollee disruption in care, barriers to enrollee care coordination and accessing care, or continued enrollment in the CME program; I. Summary of enrollee grievances received from enrollees and providers; J. Geographic mapping of provider networks by Contractor; K. Demographics of children and youth served, including age, race, ethnicity, gender, school, parental status, and involvement in public child-serving systems; L. Network adequacy assurance	The Contractor must provide quarterly reports to the Agency by the forty-fifth (45th) business day of following quarter end. Example, Q-1 Jan - March report due May 15th, unless an extension of time is approved by the Agency.

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		submitted by Contractor; M. Compliance with provider initial and recertification requirements; N. Compliance with the forty-six (46) calendar day POC development timeframe requirement; O. Trends and resolutions from enrollee and provider calls and emails; P. Number of all QIC and Advisory council meetings; Q. Compliance with waiver metrics, performance indicators and outcomes, as part of the SOW; R. Implementation status of PIPs; S. Utilization and outcomes management, including: I. Disenrollment status of youth and reason for disenrollment, II. Patterns and cost, attention to outliers specific to the CME program, III. Youth graduating the program, IV. Utilization of authorized units vs. authorized to identify utilization trends and issues, V. Number of enrolled children and youth in out-of-home placement during the reporting period and the percentage of children and youth that were disenrolled due to out-of-home placement; T. inclusion of natural supports in service plans; U. Measurement of fidelity to high fidelity wraparound model; V. Enrollee contact summary (minimal contact requirements); and W. Summary of the provider certification process and statistics.	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
Ops 8-36	Data Management and Reporting	Provide as an Attachment to the Quarterly Report, a summary of metrics to support the Wyoming Medicaid 1915(c) Waiver. Specifically, the Contractor must provide the following measures: A. Percentage of providers that meet all initial provider credentialing and qualification requirements (total # of waiver providers that meet all provider credentialing and qualification requirements/ total # of providers enrolled); B. Percentage of providers that meet all ongoing provider credentialing and qualification requirements (total number of providers that continue to meet all ongoing provider credentialing and qualification requirements/total number of enrolled providers); C. Percentage of service providers that meet all initial training requirements (total # of providers that meet all initial training requirements/ total # of providers enrolled); D. Percentage of providers that meet all ongoing training requirements. (total # of providers that meet all ongoing training requirements/ total # of providers enrolled); E. The percentage of providers that receive training on abuse, neglect and exploitation identification and reporting procedures annually as part of the recertification process (total # of providers that receive training on abuse, neglect and exploitation identification and reporting procedures annually as part of the recertification process/ total # of contracted providers); F. Percent of POC that reflect enrollee's assessed needs, risks, and personal goals as detailed in the clinical eligibility assessments, or any other applicable evaluation provided to the CFT (# of POC that reflect enrollee's assessed needs,	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		risks, and personal goals as detailed in the clinical eligibility assessments, or any other applicable evaluation provided to the CFT/total # of POCs); G. Percentage of POC (or modifications) that are completed at least annually and when CASII/ECSII, CANS, level of care or other evaluation demonstrate a change in the youth's/enrollee's needs (total # of waiver plans completed at least annually and when CASII/ECSII, CANS, level of care or other assessment/evaluation demonstrate a change in the youth's/enrollee's needs/ total # of plans); H. Percentage of plans of care in which services and supports are provided in the type specified in the plan (# of plans in which services and supports are provided in the type specified in the plan / by total # of plans); I. Percentage of plans of care in which services and supports are provided in the amount specified in the plan (# of plans in which services and supports are provided in the amount specified in the plan / by total # of plans); J. Percentage of plans of care in which services and supports are provided in the frequency specified in the plan (# of plans in which services and supports are provided in the frequency specified in the plan / by total # of plans); K. Number and percent of services delivered according to the scope authorized in the plan of care (# and % of services delivered according to the scope authorized in the plan of care service plan/total # of plans); L. Number and percent of services delivered according to the duration authorized in the plan of care (# and % of services delivered	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		according to the duration authorized in the plan of care service plan/total # of plans); M. Percentage of applications with a fully executed freedom of choice statement (document) prior to approval (total # of applications with a fully executed freedom of choice statement/document prior to approval/ total # of applications approved); N. The percentage of enrollees (or families/legal guardians) who received training and education on how to identify and report abuse, neglect, exploitation and unexplained death (The number of enrollees (or families/legal guardians) who received training and education on how to identify and report abuse, neglect, exploitation and unexplained death/ total # of waiver participants); O. 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); P. Number of Youth and Family Training and Support (YFT) service units authorized versus number of units of YFT services provided to C waiver youth during the reported quarter taking into account claims lag between service authorization and actual service utilization; Q. Number of critical incidents where the root cause was identified/number of critical incidents received; R. Number and percent of unauthorized restraints and restrictive interventions, including seclusion, addressed according to the process in the approved	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		waivers/Total number of reported restraints, incidents involving seclusion, and unauthorized restrictive interventions; S. Number of participants who have identified a Primary Care Provider at the first POC authorization/Number of youth enrolled in the waiver program; and T. Total number of annual reevaluations conducted on or prior to the expiration date of the previous clinical eligibility evaluation/Total number of reevaluations conducted. This metric must be reported as a percentage.	
Ops 8-37	Data Management and Reporting	Provide an Annual Report to the Agency that includes, at minimum: A. Enrollee demographic data (including racial/ethnic data); B. Conformance with outcomes measurements included in the executed Contract; C. A summary of all quarterly findings presented in previous Quarterly Reports for that year; D. Expanding availability of providers and service capacity from the past year; E. Program improvement plans in accordance with the quality assurance process; F. Youth and family satisfaction survey results (annual WFI-EZ summary); G. Provider, care coordination, and youth support personnel by race, ethnicity, gender, and geography; H. Measurement of disparities by racial and ethnic groups; I. Identification of opportunities for improvement and to assess compliance with utilization policies and procedures at the	January – March, 2021, report is due May fifteenth (15th), unless an extension of time is approved by the Agency

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		provider and Contractor level; J. Summary of compliance and status of Medicaid-enrolled CME network providers, and K. Annual summary of all 1915(c) waiver youth metrics as outlined in the quarterly and annual reporting requirements.	
Ops 8-38	Financial Management	Provide an independently audited financial statement that attests to the fair and accurate presentation of the Contractor's financial position. The audited financial statement must include, but is not limited to: A. Cash flow statement; B. Statement of activities/income statement and statement of financial position; C. Or, balance sheet and expenses specific to this contract to demonstrate solvency.	The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards and to the Agency on an annual basis.
Ops 8-39	Financial Management	The Contractor must work with the Agency to identify improper payments and process any adjustments to its PMPM claims.	
Ops 8-40	Financial Management	The Contractor will track and bill its PMPM claims to the MMIS for each enrollee enrolled at least monthly.	

CME Enrollee Management

The Contractor must provide CME services for all children and youth qualifying for the program and meeting initial targeting criteria. This includes:

1. Medicaid youth ages four (4)-twenty (20) at risk of out-of-home placement (defined as youth with two hundred (200) days or more of behavioral health services within a single State fiscal year); or
2. Medicaid youth ages four (4)-twenty (20) who currently meet Psychiatric Residential Treatment Facility (PRTF) level of care or who are placed in a PRTF; or
3. Medicaid youth ages four (4)-twenty (20) who currently meet acute psychiatric

stabilization hospital level of care; had an acute hospital stay for mental or behavioral health conditions in the last three hundred sixty-five (365) days; or are currently placed in an acute hospital stay for mental or behavioral health conditions; or

4. Youth enrolled in the Children's Mental Health (CMH) waiver (Social Security Act Sec. 1915(c) waiver, WY 0451.R02.00 and subsequent amendments); or
5. Medicaid youth ages four (4)-twenty (20) referred to the Contractor (who meet defined eligibility).

Medical Eligibility Criteria – as a condition for enrollment after initial targeting criteria has been met:

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

The Agency reserves the right to add additional populations to the Contractor's target population. Should the Agency elect to add a group to the Contractor's target population, the parties must agree in writing and negotiate a payment methodology for the population in good faith. All contracted rates must be certified by the Agency and any updates to the Contract must be approved by CMS. Any changes to this Contract will be reflected in an approved and fully executed Contract Amendment.

Each youth must meet minimum score criteria for the Contractor to enroll. The Contractor must conduct outreach in accordance with the approved Stakeholder Engagement and Outreach Plan to encourage participation for eligible children and youth. The Contractor must submit outreach materials to the Agency for review and approval prior to distribution. Outreach shall refrain from any door-to-door, telephone, e-mail, texting, or other cold-call marketing activities directly to children and youth that isn't generated from a referral. The Contractor must not seek to influence enrollment in any way, such as in conjunction with the sale or offering of any private insurance.

If a youth meeting the targeting criteria is referred to the program, the Contractor must contact the youth and family to help them choose a Family Care Coordinator and schedule a third-party independent assessment (CASII/ECSII) as part of the clinical eligibility determination. This process provides for an independent determination of the youth's eligibility. These third-party assessments confirm clinical eligibility and shall be billed Fee for Service (FFS) to the State. The Contractor is not responsible for payment related to these assessments.

Once the assessment is complete, the family and youth or their Family Care Coordinator will provide a completed copy of the assessment and score to the Contractor. The youth/family or their Family Care Coordinator must also provide clinical documentation from a qualified mental health professional that confirms the presence of an Axis 1 diagnosis, validating that the youth

meets the federal qualifying criteria for a serious emotional disturbance (SED) or serious mental illness (SMI). The youth/family may also provide appropriate authority for the evaluator to send the assessment results directly to the Contractor. The submission of these components to the Contractor will serve as confirmation of the medical eligibility component required for enrollment. The Contractor is prohibited from discriminating against individuals eligible under the medical eligibility criteria on the basis of health status or need for health care services. The Contractor must maintain copies of the assessments and documentation for State review during periodic quality assurance audits. Once a youth is enrolled, the youth may begin receiving CME services provided by the Contractor's provider network.

The Contractor must promptly notify the Agency when it receives any information related to a change in an enrollee's circumstances that may affect the enrollee's eligibility including changes in the enrollee's residence or the death of the enrollee. The Contractor must submit an updated list of enrolled youths to the Agency as deemed necessary to effectively manage the enrollment and eligibility process. The Contractor will be able to utilize existing tools to help support this process, including the 270/271 Transaction Set, eligibility registries, and Medicaid Provider Agreements. This list will help the Agency determine any changes to eligibility and help mitigate enrollment discrepancies between the Agency and the Contractor.

The Contractor shall be responsible for the following Enrollee Management responsibilities and comply with requirements in Table 9.

Table 9 – Enrollee Management Responsibilities and Requirements

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
EM 9-1	Enrollee Eligibility and Enrollment	Enroll all youth who are evaluated and meet the initial target population criteria, as outlined by the Agency.	
EM 9-2	Enrollee Eligibility and Enrollment	Provide a tracking mechanism in accordance with the approved Referral Process to track all referrals received by providers and external sources. The tracking mechanism must date-stamp each referral received, along with the action taken for that referral.	
EM 9-3	Enrollee Eligibility and Enrollment	Process all referrals received by the Contractor.	Respond to any referral or request for enrollment within two (2) business days.
EM 9-4	Enrollee Eligibility and Enrollment	Assist families with the application or admission process for children and youth in accordance with the approved Policies and Procedures.	The Contractor must report on the number of children and youth referred, and turnaround time for referrals as part of the

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
			Quarterly Report.
EM 9-5	Enrollee Eligibility and Enrollment	Process all applications in accordance with the approved Policies and Procedures once information is complete.	Process all enrollee applications within three (3) business days once application information is complete.
EM 9-6	Enrollee Eligibility and Enrollment	Triage all completed applications to the Agency that meet the Children's Mental Health Waiver (CMHW) criteria to the Agency for processing. Authorize providers upon receipt of Agency approval for services.	Send all CMHW referrals to the Agency within two (2) business days of discovery.
EM 9-7	Enrollee Eligibility and Enrollment	Notify the youth and/or the families of admission to the CME	Notify a youth and/or family of enrollment within two (2) business days of the final eligibility determination or date of the notification email from the Agency.
EM 9-8	Enrollee Eligibility and Enrollment	Support the referral to enrollment process during the initial application period as an enrollee transitions to a networked provider	
EM 9-9	Enrollee Eligibility and Enrollment	Process client disenrollment if the enrollee meets any of the following criteria: A. All of the goals of the family/enrollee have been met; B. No evidence of POC in place or engagement with the family for care coordination; C. Lack of cooperation by family/enrollee in POC development, implementation, refusal to sign or abide by the POC, including the refusal of critical services; D. If the enrollee is no longer Medicaid eligible; E. The enrollee moves out of state; F. The enrollee ages out of program;	Provide a thirty (30) calendar day advance notification to the enrollee and the enrollee's FCC prior to implementing a change in program eligibility and/or service amount, duration, or frequency. With exception of loss of Medicaid eligibility.

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		G. The enrollee is incarcerated; H. Enrollment with an alternate State Waiver/ Program (DD Waiver); I. The enrollee is no longer financially eligible; J. The enrollee is no longer clinically eligible; K. The enrollee is determined eligible for any excluded program/population; L. The enrollee is in an out-of-home placement longer than one hundred eighty (180) calendar days; M. Family/enrollee's choice to terminate waiver services; or N. Death of participant. The Contractor may not request disenrollment because of a change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Contractor's ability to furnish services to the enrollee or other enrollees).	
EM 9-10	Enrollee Eligibility and Enrollment	For applicants deemed ineligible for services, provide information about alternative support resources, as appropriate for the family.	
EM 9-11	Enrollee Eligibility and Enrollment	Notify the Agency of all disenrollments by sending a copy of the disenrollment notice to the Agency.	Provide disenrollment notices to the Agency within seven (7) business days of discharge.
EM 9-12	Enrollee Eligibility and Enrollment	Review all evaluations, including the CASII and ECSII, for completeness by an appropriately qualified mental health professional (QMHP) or otherwise qualified evaluator according to Agency criteria. Escalate any concerns or incomplete evaluations to the State.	Review one hundred percent (100%) of all initial and re-evaluations.

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
EM 9-13	Enrollee Eligibility and Enrollment	Develop a Member Handbook that includes, at minimum, the following information: A. Overview of the program and HFWA services; B. Information to assist in the selection of services and providers; C. Crisis planning information; D. Enrollee rights and confidentiality statements; E. Reference to the enrollee grievances, appeals, and State fair hearings process and information on how an enrollee would file a grievance directly with the State if he or she experiences issues; F. An overview of the phases of HFWA and transition approach; and G. References to additional community resources.	Provide the Member Handbook for the Agency review and approval within ninety (90) calendar days after the Contract Effective Date.
EM 9-14	Enrollee Eligibility and Enrollment	Provide enrollees with transition of care policies and procedures as part of the Member Handbook. The transition of care policies must include: A. Information to enrollees informing them that they have access to services consistent with the access they previously had under their previous network provider; B. Availability of assistance in finding another network service provider that has access to historical data when appropriate; C. 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 D. Estimated timeframes in accordance with the HFWA Transition to Discharge Phase.	
EM 9-15	Enrollee Eligibility	Provide a copy of the Member	The Member Handbook may

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
	and Enrollment	Handbook to all new enrollees and their guardians upon enrollment activation in the Contractor's EHR. The EHR processes the enrollment, generates an enrollment letter, and sends the enrollment letter to each new enrollee within two (2) business days of enrollment. The enrollment letter contains a link to the electronic version of the member handbook. Members who want a paper copy may request a hard copy from the Contractor.	be in the form of an electronic copy if the enrollee or their guardian agrees to receive the information by email. Requested hard copies shall be mailed to the enrollee's mailing address.
EM 9-16	Plan of Care (POC)	Ensure the FCC works with the enrollee, their family, and CFT at the start of the wraparound process to develop a Plan of Care (POC) based on the individual family and enrollee's needs, strengths and preferences. The FCC must collaborate with child and family serving agencies that are involved with the enrollee and his or her family. Each POC shall align with the HFWA phases and requirements, such as SNCD, and crisis planning. All POC's must include team member signatures, specifically youth (if age appropriate), family, and FCC at minimum.	All enrollees must have an FCC. A POC must be developed for each enrollee within forty-six (46) calendar days after enrollment.
EM 9-17	Plan of Care (POC)	Authorize all POCs in the Contractor deployed system, addressing enrollee's assessed needs, health and safety risk factors, and personal goals. POCs shall be sufficient in service type, amount, duration, or scope to reasonably achieve the purpose for which services are furnished.	The Contractor must review and process one hundred percent (100%) of all POCs submitted for prior authorization.
EM 9-18	Plan of Care (POC)	Incorporate the use of telehealth services through the Contractor's HIPAA-compliant platform as appropriate for the individual POCs.	
EM 9-19	Plan of Care (POC)	The FCC must contact every enrollee and/or family within three (3) business days after being chosen as the FCC to begin the application process.	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
EM 9-20	Plan of Care (POC)	The FCC shall maintain regular contact with the enrollee or their designated caregiver or legal guardian at least two (2) times per month.	The FCC shall contact the enrollee or designated caregiver or legal guardian at least two (2) times per month based on the preferred contact type identified in the enrollee's electronic health record
EM 9-21	Plan of Care (POC)	Offer Family and Youth Peer Support to all youth in order to enhance their ability to set goals for quality of life and transition to adulthood, achieve greater independence in advocating for themselves, and manage their own wellness goals, while increasing resilience. FSP and YSP services when chosen include, but are not limited to: A. Strategic sharing of lived experience to decrease peer isolation; B. Encouraging youth to share their own experiences in order to self-advocate and drive their own goals and planning; C. Supporting youth caregivers to identify triggers and barriers and to develop their own wellness plans; D. Supporting youth and caregivers to make informed decisions over all the domains of their life; E. Assisting youth and caregivers with participating in crisis prevention planning activities and to understand their own crisis plans; F. Supporting youth and caregivers in forming or maintaining community connections and informing youth of opportunities for leadership trainings or systems level engagement including, but not limited: I. Wellness groups. II. Advisory groups. III. Focus groups.	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		IV. Regional planning activities. G. Supporting youth in navigating and understanding public and community resources and how to access them.	
EM 9-22	Plan of Care (POC)	Conduct routine readiness assessments based on the pre-approved Transition Readiness Scale throughout the enrollment period to assess an enrollee's readiness to graduate from Wraparound.	Conduct transition readiness assessments every three (3) months of a child or youth's enrollment.
EM 9-23	Plan of Care (POC)	Ensure the FCC holds regularly scheduled CFTs and updates to the POC based on the needs of the enrollee and their family, in accordance to the Agency-defined timeframes.	The FCC must update the POC within the last thirty (30) calendar days of a ninety (90) day authorization period.
EM 9-24	Plan of Care (POC)	Respite shall only be authorized for one enrollee per respite provider per instance at a time unless the CME reviews and approves additional youth. Exception may be made for sibling groups.	Respite is provided on a one to one ratio (one provider to one enrollee) unless otherwise approved by the CME.
EM 9-25	Plan of Care (POC)	Respite services shall be restricted to a maximum of four hundred sixteen (416) hours per calendar year for each enrolled and qualified youth.	
EM 9-26	Plan of Care (POC)	Coordinate the scheduling of CFT meeting and emergency meetings with the entire team. The enrollee or their family selects the meeting location unless the FCC is unwilling to attend due to safety concerns. In the event of safety concerns, the family and FCC shall work out an alternative location.	
EM 9-27	Plan of Care (POC)	Track attendees for all CFT meetings in the Contractor-deployed IT solution.	
EM 9-28	Plan of Care (POC)	Provide a process for assisting families in identifying a Primary Care Physician (PCP) when the enrollee or family chooses. Document in the enrollee's	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		health record.	
EM 9-29	Plan of Care (POC)	Prompt and oversee that families complete the Agency's WFI-EZ and prepare families to submit six months after enrollment.	The FCC shall prompt the enrollee and their family thirty (30) calendar days before the WFI-EZ assessment date. This shall be documented in the Contractor's deployed system.
EM 9-30	Plan of Care (POC)	FCCs shall communicate an out-of-home placement and work with the family of enrollees who are in out-of-home placements to determine if services and supports can be safely, effectively, and appropriately provided in the community.	
EM 9-31	Plan of Care (POC)	The Agency reserves the right to attend any meetings with enrollees at any time with the permission of the enrollee or their guardian.	
EM 9-32	Coordination of Care	Demonstrate that the FCC coordinates with and invites the DFS case worker to family meetings when appropriate.	
EM 9-33	Coordination of Care	Demonstrate that the FCC coordinates with and invites the identified PCP to family meetings when appropriate.	
EM 9-34	Coordination of Care	Document procedures to interface with the Agency's UM vendor.	
EM 9-35	Coordination of Care	Upon receipt of a continued stay review from UM contractor or referral information, participate in collaboration meetings with the UM contract if requested by the Agency.	
EM 9-36	Coordination of Care	Along with Agency, Develop strong, positive relationships with the local school systems and courts as a part of the development of a strong system of care.	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
EM 9-37	Coordination of Care	Engage the enrollee's school and local school system in the CFT and care planning process to the extent the schools and their processes will allow.	

CME Provider Management

The Contractor must develop a strong network of providers to deliver services reflective of goals and objectives of the CME program. The Contractor must continue to monitor the CME provider network and scale its provider network to meet the needs and required service capacity for enrolled youth. The Contractor must provide a comprehensive and flexible provider training program as agreed to in the approved Training Plan Deliverable that reflects HFWA training requirements to assist providers in meeting initial and continuing certification requirements. This training program shall include online and on-demand training options to help providers fulfill CME program requirements.

A key area of the Contract is developing and managing a comprehensive provider training program. This includes both initial training and certification, as well as re-certification of providers on an annual basis. Initial training and certification as an FCC, FSP or YSP must be complete before a provider can execute a sub-agreement with the CME. Tier One training is made available remotely to individuals or groups upon request.

Network providers who have completed the Tier One process, have access to advanced training on curriculum and topics that support their practice. This is known as Tier Two training and is necessary to complete in order for Family Care Coordinators to increase their provider to client ratio. The additional training topics may be delivered through remote learning opportunities and teleconference or e-learning technologies and recorded for later viewing. Topics range from ethics in practice, generating referrals, recognizing and reporting abuse/neglect, documentation standards, and information on working with children and youth with specific diagnoses or Medicaid documentation standards. All training should be made available to providers as part of a tool-kit approach to provider development, retention, and quality improvement. Providers may request training on specific topics and peer to peer learning is also encouraged.

Coaching is required for completion of Tier One and Two training activities. Coaching is geared towards the HFWA process and requirements, while the supervision role used by HWFA agencies has more focus on accountability to the CME and Medicaid agreements with HFWA principles and process in mind. Note that supervisors are employed by the HWFA agency and are not a required role by the Contractor. Coaching activities and requirements are outlined in the approved Contractor's Training Plan.

HWFA Coaches contract with the CME after a selection process that includes an application, interview, and demonstration of skill. HFWA Coaches are required to have a minimum of one-

year experience providing HFWA services and be in good standing with the CME. New coaches shadow the CME's Lead Trainer and other coaches to gain experience and for quality assurance purposes. The coaching certification process utilizes Agency approved approaches that include National Wraparound Initiative and other evidence-based curriculum and processes with a train the trainer approach. A HFWA Coach may also be an active HFWA provider (FCC, FSP, YSP) and should scale the number of providers they are coaching based on the size of their current case load to maintain balance between coaching and provider duties and responsibilities.

Each network provider shall enroll as a Medicaid provider prior to execution of a sub-agreement with the Contractor. The Agency will conduct the CMS required verification and background checks for each individual provider, including those providers enrolling through a group practice or organization. Per CMS, as part of the Medicaid enrollment process, network providers shall submit to the Agency the following information to allow the Agency to evaluate an ownership of 5 percent or more interest of any persons as it relates to the Contractor:

- Name and address for corporate providers that includes the business address, every business location, and P.O. Box address
- Date of birth and Social Security Number (SSN)
- Tax identification number
- Information on persons related to the provider with ownership or control interest in the Contractor, such as a spouse, parent, child, or sibling

Services to providers will be paid at an agreed-upon amount, as specified in the Contract. The Contractor's Network Providers must submit claims for FFS reimbursements directly to the Agency for services delivered under the program.

The Contractor must be responsible for the following Provider Management responsibilities and comply with requirements in Table 10.

Table 10 – Provider Management Responsibilities and Requirements

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
PM 10-1	Provider Management	Develop a network of providers to ensure access to a broad array of services and supports, including peer and natural supports, and management utilization, quality and outcomes at the child and family level. Network sufficiency includes geographic sufficiency, but also an adequate array of HCBS providers, culturally and linguistically diverse providers, providers who are available on weekends and after-hours. Services Management functions include: A. Family Care Coordination, Family and Youth Peer support and	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		advocacy, and respite providers; B. Provider network development and management; C. Ability to manage formal (e.g. clinical) and informal supports (e.g. neighbors); D. Crisis response capacity; E. Develop new services (scalability); and F. Diverse service capacity.	
PM 10-2	Provider Management	The provider network must be 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.	The Contractor's Network Management Plan must address this requirement and any deficiencies related to provider network adequacy.
PM 10-3	Provider Management	Timely follow up by the CME regarding interested provider inquiries to expedite the network provider onboarding process.	The receipt of the interested provider form to mailing of a CME provider application shall not exceed five (5) calendar days.
PM 10-4	Provider Management	Conduct initial provider training and certification as an FCC, FSP, YSP, or respite provider prior to being activated to provide CME service.	All providers shall complete and successfully pass the onboarding and initial certification process prior to providing any CME service. Training shall be completed for each provider within ninety (90) calendar days of the start of the training for ninety-five percent (95%) of network providers.
PM 10-5	Provider Management	Enter into sub agreements with each provider	Provide the Agency a weekly and quarterly report showing an accounting of all active network providers. Submit data and information to show active network provider counts and changes as part of the Quarterly Report.
PM 10-6	Provider	Develop a Provider Handbook that	Submit the Provider Handbook within sixty (60) calendar days

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
	Management	includes, at minimum: A. An overview of CME services, including HFWA and its principles, and service areas; B. Minimum provider requirements around services and contact; C. Provider training and certification requirements and opportunities; D. Provider contracting process; E. Provider assistance and support avenues, such as Contractor customer service options; F. Overview and references for any Contractor-deployed IT solutions; G. Provider documentation requirements and minimum documentation thresholds; H. Program integrity and quality controls; I. Outcome measurement and Provider Score Card process; J. Enrollee grievances, and appeals policies and procedures; and K. Any additional provider-related information identified by the Contractor or Agency.	after the Contract Effective Date.
PM 10-7	Provider Management	Develop a process for evaluating the geographic location of providers and Medicaid enrollees, considering distance, and access for Medicaid enrollees with disabilities.	
PM 10-8	Provider Management	The networked providers must meet the State standards for timely access for services taking in to account the urgency of need for services. The Contractor's network of providers must offer hours of operation that are no less than the hours offered to commercial enrollees or are comparable to Medicaid fee-for-service, if the provider services only Medicaid enrollees.	All CME network providers should be available during their defined business hours.

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
PM 10-9	Provider Management	Establish mechanisms in order to monitor providers regularly, ensuring the network providers comply with the timely access requirements	If providers fail to comply with the timely access requirements, the Contractor must take corrective action in accordance with the approved QAPI.
PM 10-10	Provider Management	Help identify and develop a network of formal and informal supports in the community for each enrollee to address the needs identified in each POC.	
PM 10-11	Provider Management	The Contractor must implement a regional approach to its provider network as approved by the Agency.	Submit evidence as part of the Quarterly Report to the Agency demonstrating that the Contractor offers an appropriate range of services in all eight (8) regions of the state 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 in the service area at the time it enters in to a Contract with the Agency and any time there is a significant change (as defined by the Agency) in the Contractor's operations that impacts services.
PM 10-12	Provider Management	Oversee that contracted providers maintain documents to verify services were provided in the amount, duration, and frequency reflected in the POC and the claims data submitted to the Agency.	Documents shall be retained according to the Medicaid record keeping and retention policies specified in the most current version of the CMS 1500 Provider Policy manual.
PM 10-13	Provider Management	Oversee the recertification of each network provider annually, as outlined in the approved Training Plan.	Each network provider shall be recertified annually. If the provider fails to maintain certification as an active provider, the provider's families shall be reassigned. Family Care Coordinator's completion of Tier 2 for advanced practice is voluntary. Completion of this additional training allows

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
			FCC's to be eligible for a ratio increase to 1:15 instead of the standard 1:10 provider to client ratio. The maximum provider to client ratio for Youth and Family Support Partners is 1:25 Provide updates on the training and recertification process as part of the Quarterly report.
PM 10-14	Provider Management	Allow providers to use the Contractor-provided or another State-approved HIPAA compliant telehealth platform to deliver services where and when appropriate.	
PM 10-15	Provider Management	The Contractor must ensure continuity of care for any youth enrolled with network providers who are unable to deliver authorized services for any reason.	Provide written notice to enrollees regarding their network provider status, evidence of engagement, and request updated network provider documentation to continue access to care. When no documentation is present to allow continued enrollment, the contractor will provide thirty (30) calendar days for the enrollee to make another choice of provider and continue enrollment in the CME uninterrupted. If no response is received from the enrollee within thirty (30) calendar days, the enrollee will be disenrolled for no evidence of engagement and can reapply anytime eligibility criteria is met.
PM 10-16	Provider Management	Conduct an exit interview with each provider leaving the network to understand challenges and recommendations.	Report a summary of findings or trends from interviews of those leaving or have left the network as part of the Quarterly Report.
PM 10-17	Provider Management	Provide written notice of the reason for the Contractor's decision when it declines to include individual or groups of providers, who have applied, to the	Provide a notice through email to the Agency within two (2) business days of declining an

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		Contractor for enrollment as a network provider.	individual or agency as a network provider.
PM 10-18	Provider Management	Develop and implement practice guidelines in accordance with the core values and principles of HFWA.	Disseminate the guidelines to all network providers and, upon request, to enrollees, and potential enrollees. Guidelines shall be made available in the Provider Handbook and accessed from the Contractor's website.
PM 10-19	Provider Management	Develop and maintain a provider directory. Make the provider directory available on the Contractor's website in a machine-readable file and format as specified by the Secretary and in 42 CFR 438.10(h). If an enrollee requests a paper copy of the provider directory, a copy of the current directory will be mailed to the enrollee within five (5) business days from the date of request.	The Contractor is responsible for ensuring provider changes are accurately and timely captured in the published provider directory. Update the provider directory no later than thirty (30) calendar days after the Contractor receives updated provider information.
PM 10-20	Provider Management	Develop policies and procedures demonstrating that the Contractor does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	CME will develop policies and procedures that follow the agency's targeting criteria and clinical eligibility determinations process for enrollment into the program. Network providers do not determine clinical eligibility for enrollment.
PM 10-21	Provider Management	Conduct background check process during a provider's initial certification and annually thereafter in accordance with the approved Network Management Plan.	Provider's sign an attestation that they have requested and completed a background check.
PM 10-22	Provider Management	Provide a Provider Report Card Procedure as part of the Policies and Procedures that at minimum: A. Defines and tracks provider measures and outcomes related to:	Publish the de-identified Provider Scorecards on an annual basis for all active network CME HFWA providers.

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		I. Quality Process II. Fidelity to Wraparound Principles III. Administrative Efficiency IV. Outcomes of Wraparound B. Provides transparent reporting and measurement of outcomes; C. Allows providers an objective way to measure their quality and performance against other providers; D. Reports de-identified data; and E. Establishes routine reporting against a baseline to demonstrate change in performance.	
PM 10-23	Provider Management	Develop a Provider Report Card Manual for providers that includes, but is not limited to: A. Assistance on using the Wyoming Provider Scorecard by defining the source and calculations for each of the measures in the scorecard; and B. Defines measures and calculations for providers	
PM 10-24	Provider Management	The Contractor is responsible for ensuring providers capture the appropriate level of documentation, in accordance with the Provider Handbook and Policies and Procedures. At minimum, providers must document: A. Any attempted or successful contact with enrollees and families; B. The extent of the services and care; C. The family and youth's successes, the informal supports; D. The family and/or youth role in making decisions and that the people working with the enrollee and their family are working together; E. Validation of conversations with the enrollee and family related to report abuse, neglect and exploitation. F. Other documentation requirements as	

REQ ID	CATEGORY	REQUIREMENT	PERFORMANCE EXPECTATIONS
		determined by the Contractor or Agency.	
PM 10-25	Provider Management	CME shall have a requirement in their network provider agreement that Providers shall track and request documentation reviews with clinical team whenever there is: A. OOH placement; B. Change to timelines for return home; C. Lengths of stay beyond 18 months in HWFA; D. Before youth turns 18-year-old; and E. Any other time as necessary when additional support is needed.	

Operational Deliverables

The Contractor must provide the following Deliverables throughout the CME Operations Phase, in accordance with Deliverable Management Requirements included in Table 11 and the approved Project Work Plan.

Table 11 – Operational Deliverables

ID	REQUIREMENT CATEGORY	DELIVERABLE	SUBMISSION REQUIREMENTS
Del 11-1	General Operational Requirements	Revised Training Plans, as needed	Revise training plans and documents upon identification of recommendations and findings from Annual Summary Report, as directed by the Agency within thirty (30) calendar days upon delivery of the Annual Summary Report.
Del 11-2	General Operational Requirements	Weekly Operational Meeting Agendas	Provide weekly meeting agendas within one (1) business day of the meeting.
Del 11-3	General Operational Requirements	Weekly Operational Meeting Minutes	Provide minutes within two (2) business days of the meeting.
Del 11-4	General Operational Requirements	Survey outlines	Submit the outline of the draft surveys for system usability, provider, and enrollee satisfaction, as well as any other ad hoc surveys to the Agency for review and approval ten (10) business days

ID	REQUIREMENT CATEGORY	DELIVERABLE	SUBMISSION REQUIREMENTS
			prior to release.
Del 11-5	General Operational Requirements	Summary and detail level survey results from surveys	Report summary and detail-level results of the Surveys to the Agency in the next quarterly report.
Del 11-6	General Operational Requirements	Weekly Reports	Provide weekly reports to the Agency.
Del 11-7	General Operational Requirements	Quarterly Reports	Provide quarterly reports to the Agency by the forty-fifth (45th) calendar day following the end of the quarter.
Del 11-8	General Operational Requirements	Annual Reports	Provide annual reports to the Agency by the forty-fifth (45th) calendar day following the end of the state fiscal year.
Del 11-9	General Operational Requirements	Audited financial statement which is certified by the Contractor's CFO per 42 CFR 438.604(a)(4)	Submit annually, in accordance with the agreed upon timeframe.
Del 11-10	System and Technology	Penetration and Vulnerability Testing	Provide the Agency with the detailed report from penetration and vulnerability testing and include results in the following quarterly report.
Del 11-11	Enrollee Management	Draft Outreach Materials	Submit all materials to the Agency for approval prior to distribution. The Contractor must not distribute outreach materials without first obtaining Agency approval.
Del 11-12	General Requirements	Ad Hoc Reports	Provide Ad Hoc reports no later than five (5) business days from time of request. The Contractor may request an extension from the Agency on the timeframe based on the complexity of the request.

1.6. Expectations of State by Contractor

The Agency will support the Contractor provide the following responsibilities in support of CME

services:

Table 12 – Agency Responsibilities

CATEGORY	AGENCY RESPONSIBILITY
Phase Specific	Participate in Project Kick-Off and provide feedback to the Contractor on deliverables and plans.
Phase Specific	Orient external stakeholders and other agencies on the goals and objectives of the CME, the HFWA process, the role of the CME, and the importance of coordination across agencies
Phase Specific	Provide overview and training of the applicable Agency systems
Phase Specific	Provide a contract manager who will track and monitor the Contractor's performance according to the Scope of Work and Contract
Phase Specific	Facilitate communications between the Contractor, and external stakeholders, as necessary.
Phase Specific	Provide appropriate program policy training to the Contractor in accordance to the agreed upon Training Plan.
Phase Specific	Attend any Contractor conducted training as identified by the Agency.
Phase Specific	Identify Medicaid training and support requirements that may be needed by the Contractor or their network providers.
General Operational Functions	Coordinate with the Contractor on changes required as a result of relevant federal or State requirements
General Operational Functions	Advise the Contractor on website content and information to support enrollee and provider customer service, as appropriate.
General Operational Functions	Participate in weekly operational meetings. Perform quality control on all quality reporting analyses, reports, and required deliverables provided by the Contractor. Review and approve all Contract deliverables. Process invoices based on the completion of required deliverables, adherence to project requirements, and services rendered to the children and youth served.

CATEGORY	AGENCY RESPONSIBILITY
General Operational Functions	Review and approve all proposed Change Requests.
General Operational Functions	Initiate any Contract amendments, as appropriate.
General Operational Functions	Participate in all Contract meetings and other related meetings.
General Operational Functions	Designate risk and issue priorities and participate in risk and issue management
General Operational Functions	Respond to Contractor ad hoc report request and work with the Contractor to refine the timeframe for delivery.
General Operational Functions	Validate data quality in delivered reports.
General Operational Functions	Work with the Contractor to classify any incidents and identify resolutions, as appropriate.
General Operational Functions	Educate the Contractor regarding the external clinical assessment tool needs and process.
General Operational Functions	Participate in design sessions and IT discussions.
General Operational Functions	Review data entered into Agency systems for data quality purposes and outcomes monitoring.
General Operational Functions	Review Agency license agreements, as needed.
General Operational Functions	Provide State security policies, procedures, and standards as needed.
General Operational Functions	Review and approve all key staff replacements.

CATEGORY	AGENCY RESPONSIBILITY
General Operational Functions	Provide the Contractor with the State's QRS.
General Operational Functions	Coordinate external review needs and timeframes with the Contractor.
General Operational Functions	Oversee the grievance and appeals process.
General Operational Functions	Manage all State Hearings resulting from grievances and appeals.
General Operational Functions	Work with the Contractor to review and approve the appropriate templates for reporting purposes.
General Operational Functions	Review and approve reports regarding the CME's progress.
General Operational Functions	Track expenditures based on data reported by the CME and based on claims processed through the MMIS to independently verify cost savings.
General Operational Functions	Coordinate with the Contractor on eligibility, enrollment, disenrollment information, claim issues, and concerns.
General Operational Functions	Coordinate with Contractor and provide necessary training and access to the Agency systems.
General Operational Functions	Work with the Medicaid Fiscal Agent to monitor the claims management, reporting and auditing for CME PMPM and FFS claims related to this contract.
Enrollee Management	Make the final clinical eligibility determination on the children's mental health waiver youth being served through the CME based on clinical eligibility criteria.
Enrollee Management	Review and approve all outreach materials prior to submission.
Enrollee Management	Inform the Contractor on recommended conferences and state forums for outreach.
Enrollee Management	Provide HFWA guidance as needed, according to the HFWA and SOC principles adopted by the Agency.

CATEGORY	AGENCY RESPONSIBILITY
Enrollee Management	Provide guidance on use of the Agency's selected clinical eligibility assessment tools.
Enrollee Management	Provide Children's Mental Health Waiver enrollment and participation criteria to the Contractor.
Enrollee Management	Receive and process Children's Mental Health Waiver applications submitted by the Contractor and notify the Contractor of enrollment activation.
Provider Management	Monitor the provider network enrollment and service utilization reports for services delivered by the Contractor's provider network.
Provider Management	Ensure the Contractor and its active network providers are enrolled as Medicaid providers.
Provider Management	Monitor network adequacy to help ensure the Contractors provider network is adequate to provide comprehensive and integrated services to address the healthcare needs of enrolled children and youth.
Provider Management	Participate in calls with the Contractor, providers, and families to discuss any area of concern or specific needs.

1.7. Change Requests

The Contractor will follow defined change management procedures to ensure the quality and timeliness of changes.

If unforeseen circumstances arise where a dispute resolution might be needed, Contractor will submit in writing a description of the problem and proposed resolution to the Agency's primary point of contact for their consideration. In the event it is determined that a change to the SOW is required, a Contract amendment shall be made to the Contract in accordance with State of Wyoming contract process.

2. OUTCOMES

The Contractor must meet all outcome requirements included in Table 13 below. The Contractor must submit information and data in its Quarterly Report to the Agency to demonstrate compliance with the requirements listed in this section. The Contractor must label each outcome measurement appropriately in its report. For example, data necessary to show compliance with operational requirement two should be labeled as "OP-2."

Failure to comply with the outcome requirements or provide a data reports to the Agency as specified documenting compliance with each requirement may result in Agency notification to

the Contractor of non-compliance. The Contractor must submit a formal corrective action plan for approval by the Agency within thirty (30) calendar days of the non-compliance notification.

Table 13 – Outcome Requirements

ID	CATEGORY	OUTCOME	MEASUREMENT	PENALTIES
OUT 13-1	Enrollee Management	**Out-of-Home (OOH) Placements** The Contractor must, report the number of OOH placements of Contractor youth OOH=Out of Home (PRTF, or Acute Psychiatric Stabilization)	Report quarterly for the previous quarter the Denominator - number of youth enrolled with the CME Contractor and the Numerator – number of CME youth in OOH placement	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next reporting period (following quarter)
OUT 13-2	Enrollee Management	**Decreased Length of Stay (LOS) for Inpatient and Residential Treatment admissions for youth enrolled in the CME.**	Report quarterly for the previous quarter the Average LOS for CME enrolled youth in OOH placement. The Contractor must report the overall length of stays for inpatient psychiatric treatment (PRTF and Acute Psychiatric Stabilization) for youth enrolled in the CME. Average LOS is equal to the average of PRTF and acute psychiatric hospitalization stays.	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next reporting period (following quarter)
OUT 13-3	Enrollee Management	**Recidivism** The Contractor must decrease the recidivism of youth served by the Contractor moving from a lower level of care to a higher level of care.	Report quarterly for the previous quarter the Denominator - number of youth enrolled with the Contractor and the Numerator - number of youth moved to a higher level of care while served by the Contractor LOC hierarchy = PRTF	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next reporting period (following

ID	CATEGORY	OUTCOME	MEASUREMENT	PENALTIES
			level of care	quarter)
OUT 13-4	Enrollee Management	**Recidivism (LOC) at six (6) months post CME graduation** The Contractor must report recidivism of youth served by the Contractor and who graduated from the CME program as having met goals, who are moving from a lower LOC to a higher LOC within six (6) months of graduation from the CME.	Report annually quarterly on the previous quarter in the following fiscal year no earlier than the end of the third quarter to assure any higher LOC claims are available for inclusion, the Denominator - number of youth graduated from the CME and the Numerator - number of graduated youth moved to a higher level of care (PRTF) within six (6) months of graduation from the CME	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next reporting annual period (following year)
OUT 13-5	Plan of Care	**Primary Care Practitioner Access (EPSDT)** The Contractor must report the number of CME enrolled youth who have an identified Primary Care Practitioner.	Report quarterly on the previous quarter the Denominator - number of youth enrolled in the CME and the Numerator - number of CME enrolled youth with an identified Primary Care Practitioner.	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next reporting period (following quarter)
OUT 13-6	Financial Management	**Cost Savings (Healthcare Costs)** The Contractor must report healthcare costs to Medicaid for the CME enrolled youth.	Average total Medicaid healthcare costs per CME enrolled youth as compared to the total Medicaid costs for the target eligible population of non-CME enrolled youth with PRTF stays.	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next annual reporting period (following year)
OUT 13-7	Plan of Care	**Fidelity to the high fidelity wraparound**	Report quarterly for the previous quarter the percentage of fidelity to	If the Contractor fails to provide this report, the PMPM for every

ID	CATEGORY	OUTCOME	MEASUREMENT	PENALTIES
		(HFWA) Model The Contractor must report fidelity to the HFWA model as measured by the Wraparound Fidelity Index (WFI-EZ)	the HFWA compared to the SFY16 baseline of seventy-two percent (72%) which is the national fidelity average for this time frame	youth enrolled with the Contractor will be decreased by one quarter of a percent (0.25%) and the decreased PMPM will continue until the next reporting period (following quarter)
OUT 13-8	Plan of Care	**Fidelity to the high fidelity wraparound (HFWA) Model** The Contractor must report the number of WFI-EZ surveys received to capture a valid and representative sample of the experiences of enrollees served.	Report quarterly the number of WFI-EZ surveys received during the quarterly period compared to the same quarter in the previous year.	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by one quarter of one percent (0.25%) and the decreased PMPM will continue until the next reporting period (following quarter)
OUT 13-9	Enrollee Management	**Family and Youth Participation at State-level Advisory Committees** The Contractor must work with Agency to identify and invite family and youth to participate on State-level Advisory Committees.	Report quarterly for the previous quarter the Denominator - number of state-level Advisory attendees who represent family and youth enrollees and the Numerator - number of CME enrollees.	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%). The decreased PMPM will continue until the next reporting period (following quarter)
OUT 13-10	Enrollee Management	**Family and Youth Participation in Communities** The Contractor must report family and youth participation on the CME's community advisory boards, Support groups and other stakeholder meetings facilitated by the	Report quarterly for the previous quarter the Denominator - number of family and youth participants attending advisory boards, support groups and other stakeholder meetings facilitated by the contractor and the Numerator - number of CME enrollees	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%). The decreased PMPM will continue until the next reporting period (following quarter)

ID	CATEGORY	OUTCOME	MEASUREMENT	PENALTIES
		Contractor.		

3. SERVICE LEVEL AGREEMENT

Table 14 below contains the Service Level Agreements (SLAs) for the Contract. Liquidated damages, if assessed, shall constitute the State's sole remedy for the applicable failure giving rise to the failed SLA. Contractor shall not be assessed liquidated damages for any SLA failure if such failure is not solely caused by Contractor.

In the event that multiple SLA failures are caused by or the result of the same occurrence, event, or act or omission (as applicable), the Agency shall only be entitled to the assessment of the liquidated damages associated with the SLA with the highest liquidated damages. Contractor must deliver monthly reporting of the status of all SLAs defined below.

The table below lists the SLAs, how they are measured, and liquidated damages.

Table 14 –SLA Requirements

ID	CATEGORY	REQUIREMENT	LIQUIDATED DAMAGE
SLA 14-1	Ongoing Operations: System and Website and Provider Portal Availability	The Contractor must maintain websites and provider portal (FEHR) uptime of 99.0%. For every 1.0% of time the system(s) is down (excluding scheduled downtime), the Agency, without further notice, may assess liquidated damages for each month. Updates shall be made outside of normal working hours, which are 8:00 AM to 5:00 PM, MT, Monday through Friday, with the exception of State Observed Holidays, or at times agreed to by the Agency. Planned downtime shall not exceed five (5) hours per month during normal working hours.	$1,000.00 per month if unplanned downtime exceeds one percent (1.0%) annually.
SLA 14-2	Staff Resource Management	Key Personnel positions may not be open for more than fourteen (14) calendar days without a qualified substitute (temporary replacement). A qualified substitute must be in place no more than fourteen (14) calendar days after the separation date of the original resource. The definition of a qualified substitute is having experience in the position, meeting the requirements of the position and understanding of the	$2,500.00 liquidated damages per week after the second calendar week a key personnel position is not filled by a qualified substitute.

ID	CATEGORY	REQUIREMENT	LIQUIDATED DAMAGE
		CME SOW. The Contractor will have sixty (60) calendar days to fill this position with a more permanent replacement.	
SLA 14-3	Ongoing Operations: Training Effectiveness	Feedback from trainees will be collected through a survey to determine the effectiveness of the training and materials. Training survey responses should demonstrate at least an overall eighty-five percent (85%) annual satisfactory level with the Provider training. All training surveys should be evaluated and feedback provided to the Agency on a quarterly basis. The Contractor must work with the Agency to put in place a corrective action plan to address training deficiencies reported in surveys.	$1,000.00 per month if corrective action plan is not executed within one (1) calendar month of annual report submission.
SLA 14-4	Security Incidents	Zero percent (0%) of security incidents affecting five hundred (500) or more clients annually. For any Security incidents affecting a population of five hundred (500) Wyoming Medicaid enrollees or more, the Contractor will work collaboratively with the Agency to gather, analyze and report findings to the Office Civil Rights (OCR). The Contractor will receive sanctions, if any, determined by Office Civil Rights (OCR) and be responsible for OCR and other associated costs such as call center costs, credit reporting, publications, and media centers. A security incident is defined for purposes of this Contract in 45 CFR Part 164.304.). All Security Incidents involving Wyoming Medicaid enrollees must be reported. SLA will be determined after sufficient technical evaluation is complete to verity the number of Wyoming Medicaid enrollees potentially affected.	Cost of mitigation plus $50,000.00 per occurrence for any security incident affecting five hundred (500) or more Wyoming Medicaid enrollees that results from actions attributed to Contractor's performance of the Contract based on State’s discretion.
SLA 14-5	Compliance with Applicable	Adhere to applicable State and federal laws, rules, regulations, guidelines,	Cost Incurred to Agency

ID	CATEGORY	REQUIREMENT	LIQUIDATED DAMAGE
	Regulations	policies, and procedures relating to information systems, information systems security and privacy, physical security, PHI confidentiality and privacy. Zero percent (0%) out of compliance. If the system is out of compliance, a mitigation plan to regain compliance is due to the agency within ten (10) business days with mitigation to be complete and testing to be complete in timeframe defined in the mitigation plan. The Contractor will assume all liabilities including any incurred cost to the Department for the violation of applicable State and Federal laws, rules, regulations, guidelines, policies, and procedures relating to information systems, information systems security and privacy, physical security, PHI confidentiality and privacy.	
SLA 14-6	Security Awareness Training	Conduct annual HIPAA and security training with Contractor's network providers. This training can be part of the onboarding processes and the documentation will be consolidated and submitted annually to the Agency.	$1,000.00 per instance for Contractor failure to report as required in SOW

3.1 SLA Reporting

The Contractor must submit data, attestations, or other evidence demonstrating compliance with each SLA as part of its quarterly report to the Agency for review and approval. The template for the SLA report must be approved by the Agency prior to the first report submission.

The Agency's primary point of contact may request additional performance reports throughout the reporting period, if there is evidence of non-compliance with any of the performance expectations described in this SLA.