

**Wyoming Department of Health  
Care Management Entity Program  
Managed Care Quality Strategy – 2023**

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## Managed Care State Quality Strategy

### Section I. Introduction

The Wyoming Department of Health (WDH) is pleased to present the 2023 Wyoming Managed Care State Quality Strategy. WDH administers Wyoming Medicaid, a joint federal and State government program that pays for medical care for some low-income and medically needy individuals and families. Although Wyoming Medicaid operates several programs, there is currently only one Medicaid managed care program in the State – the Wyoming Care Management Entity (CME) program. This Quality Strategy focuses on the CME program and serves as a blueprint for WDH to assess the quality of services that enrollees receive through the CME program and set forth goals for continuous quality improvement.

This Quality Strategy incorporates stakeholder feedback obtained via the following efforts:

- WDH posted a public and tribal notice of the 30-day public comment period; and
- WDH held five key informant interviews with leaders from WDH, Wyoming Medicaid, and Magellan Health, the CME Program vendor, to understand the quality-related strengths and areas of need for the program.

The 2023 Wyoming Managed Care Quality Strategy was drafted by Guidehouse Inc. on behalf of the Wyoming Department of Health.

#### A. Background

Wyoming's CME program provides targeted case management services via an evidence-based practice called high-fidelity wraparound (HFWA). The program's delivery model is a community based alternative to institutional care available for Medicaid eligible youth aged 4 – 20 years old with serious emotional disturbance (SED) or serious and persistent mental illness (SPMI) who are high utilizers of behavioral health services. Specifically, the CME program serves Medicaid-enrolled youth who are experiencing SED or SPMI and who meet criteria for Psychiatric Residential Treatment Facility (PRTF) or acute psychiatric stabilization hospital levels of care. The program also serves youth enrolled in Wyoming's Children's Mental Health (CMHW) 1915(c) Medicaid waiver who meet the clinical eligibility criteria.

Outside of the CME program, Medicaid youth with complex behavioral health conditions may receive fragmented care due to the involvement of various public and private entities in service delivery, contributing to poor outcomes and unnecessarily high costs. Youth may struggle because of gaps in service availability, required care coordination, family disruption, and distant out-of-home placements. This is partially due to ineffective, uncoordinated, and/or inappropriate service delivery. By focusing on bridging gaps in service delivery and coordinating care, youth with complex behavioral issues are better served, improving outcomes, while costs may also be reduced.

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

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

Following a seven-county CME pilot program launched in 2013, the Centers for Medicare and Medicaid Services (CMS) approved WDH’s application for a 1915(b) waiver to operate the CME program as a prepaid ambulatory health plan (PAHP) effective September 1, 2015. The PAHP initially served as a risk-based managed care arrangement in which WDH paid the contracted operator for the PAHP a capitated per member per month (PMPM) amount to provide covered services to eligible youth. To alleviate challenges associated with serving a small number of program enrollees, WDH transitioned the CME program from the capitated risk-based payment model to a non-risk fee-for-service (FFS) model in 2018. Figure 1 below illustrates the number of youths served from SFY 2016 to 2022.

**Table 1. CME Enrollment<sup>1</sup>**

Year	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
CME Youth Served	328	431	494	402	402	385	366

**B. Overview of Quality Management Structure**

The WDH Division of Healthcare Financing (DHCF) is the State-appointed entity for administration of Wyoming’s Medicaid program. WDH procured and oversees the statewide PAHP which operates the CME program. Table 2 below describes planned mechanisms to assess the CME’s performance.

**Table 2. Oversight Mechanisms**

Frequency	Oversight Activities
Annually	<ul style="list-style-type: none"> <li>• Review of consumer self-report data</li> <li>• Analysis of disparities by racial or ethnic groups</li> <li>• Utilization review</li> <li>• External Quality Review (EQR), conducted by an external quality review organization (EQRO)</li> </ul>
Quarterly	<ul style="list-style-type: none"> <li>• Data analysis, non-claims</li> <li>• Geographic mapping of provider network</li> </ul>

<sup>1</sup> CME Program Snapshot, SFY 2021. Received from the Wyoming Department of Health, November 19, 2021.

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Frequency	Oversight Activities
	<ul style="list-style-type: none"> <li>• Network adequacy assurance documentation</li> <li>• Performance measures reporting</li> </ul>
Other	<ul style="list-style-type: none"> <li>• Enrollee hotline operation (available 24/7)</li> <li>• Independent assessment of program impact, access, quality, and cost-effectiveness (Conducted for SFYs 2016-2017 and SFYs 2018-2020)</li> </ul>

**C. Federal Requirements for the Quality Strategy**

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

- Obtain input from individuals and other stakeholders in the development of the Quality Strategy;
- Make the Quality Strategy available for public comment prior to finalization;
- Submit the Quality Strategy to CMS;
- Annually submit reports on the implementation and progress of the Quality Strategy; and
- Update the Quality Strategy at least once every three years and consider EQR recommendations.

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

- Network adequacy and availability of services standards;
- Goals and objectives for continuous quality improvement;
- Quality metrics and performance measures;
- Performance improvement projects;
- External quality review;
- Transition of care policy;
- Plans to identify, evaluate, and reduce health disparities;
- Use of intermediate sanctions (applies to managed care organizations (MCOs) only);

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- Assessment of performance and quality outcomes (applies to primary care case management (PCCMs) entity only);
- Identification of persons who need long-term services and supports or persons with special health care needs;
- Non-duplication of EQR activities; and
- Definition of “significant change”.

## Section II. Quality Strategy Components

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

### A. Network Adequacy and Availability of Service Standards

The CME program standards for network adequacy and availability of services is atypical of other managed care entities. The CME program does not offer clinical services; enrollment in the program is based on the prospective enrollee’s clinical and functional outcomes as measured by three standardized eligibility assessment tools – Level of Care (LOC) assessment tool, Early Childhood Service Intensity Instrument (ECSII), Child and Adolescent Service Intensity Instrument (CASII), and Child and Adolescent Needs and Strengths (CANS).<sup>2</sup>

Pursuant to 42 CFR § 438.340(b)(1), WDH’s key efforts towards network adequacy and availability of services include, but are not limited to, the following:

- Requiring the CME to maintain geographic coverage throughout all regions of the State;
- Allowing the use of State-approved, HIPAA-compliant telehealth platforms to deliver services where and when appropriate;
- Establishing maximum provider-to-enrollee ratios, which vary by provider type;
- Requiring the CME to develop and adhere to documented processes for provider recruitment, retention, certification, re-certification, and nondiscrimination practices;
- Requiring network providers to maintain frequent and timely contact with enrollees (e.g., twice monthly contact; contacting new enrollees within three business days);

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

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

<sup>2</sup> Links to and additional information about the CME eligibility assessment tools can be found at the following website: <https://www.magellanofwyoming.com/>.

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- Offering accessibility options for enrollees from diverse backgrounds, including interpretation services and making information available in other languages;
- Offering accessibility options for enrollees with physical or mental disabilities, such as supplying free aids and making information available in other accessible formats; and
- Forging key partnerships with youth-facing stakeholders, including local school systems' counselors, principals, and superintendents to increase referrals of at-risk youth to the CME program.

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

## B. Program Goals, Objectives, and Outcome Measures

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Pursuant to 42 CFR § 438.340(b)(2), WDH's goals and objectives for continuous quality improvement of the CME program is to provide community-based alternatives to institutional care for Medicaid-covered youth (4-20 years of age), who experience SED or SPMI. Based on the authority granted under the Medicaid 1915(b) and 1915(c) waivers and State Plan Targeted Case Management Services, WDH contracts with a single CME who provides an evidence-based intensive care coordination model called "high fidelity wraparound".

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

1. National Wraparound Initiative, which promotes a comprehensive, holistic, family and community centric approach to supporting youth.<sup>3</sup>
2. System of care philosophy, which promotes coordinated networks for building meaningful partnerships and addressing members' needs in order to help them function better in all facets of their lives.<sup>4</sup>

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

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

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<sup>3</sup> National Wraparound Initiative. The Principles of the Wraparound Process. [https://nwi.pdx.edu/NWI-book/Chapters/Bruns-2.1-\(10-principles-of-wrap\).pdf](https://nwi.pdx.edu/NWI-book/Chapters/Bruns-2.1-(10-principles-of-wrap).pdf)

<sup>4</sup> Georgetown University Center for Child and Human Development. System of Care Definition and Philosophy. [https://gucchd.georgetown.edu/products/Toolkit\\_SOC\\_Resource1.pdf](https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf)

<sup>5</sup> Inpatient psychiatric treatment facilities include psychiatric residential treatment facilities (PRTF) and acute psychiatric hospitals.

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6. Assist enrolled youth in cultivating family partnerships and natural supports.

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

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

Several goals, objectives, and outcome measures of the CME program align with the goals set forth in national quality initiatives, including the U.S. Department of Health and Human Services (HHS) National Quality Strategy<sup>6</sup> and the CMS Quality Strategy<sup>7</sup>. Table 3 below demonstrates alignment between the CME program’s goals and objectives and national quality strategies.

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<sup>6</sup> Agency for Healthcare Research and Quality. National Quality Strategy. <https://www.ahrq.gov/workingforquality/about/index.html>.

<sup>7</sup> Centers for Medicare and Medicaid services. CMS Quality Strategy 2016. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-2016-Quality-Strategy-Slides.pdf>.



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**Table 3. Alignment with National Quality Strategies**

Objective		Quality Strategy
<b>Goal 1:</b> Reduce rate of admissions to inpatient psychiatric treatment facilities.		
1.	Decrease OOH placements of CME youth.	<ul style="list-style-type: none"> <li>• <b>HHS National Strategy:</b> Healthy People / Healthy Communities</li> <li>• <b>CMS Quality Strategy:</b> Promote Effective Prevention and Treatment of Chronic Disease</li> </ul>
<b>Goal 2:</b> Reduce frequency of readmissions to inpatient psychiatric treatment facilities.		
3.	Decrease recidivism of CME youth moving from a lower level of care to a higher level of care.	<ul style="list-style-type: none"> <li>• <b>HHS National Strategy:</b> Healthy People / Healthy Communities</li> <li>• <b>CMS Quality Strategy:</b> Promote Effective Prevention and Treatment of Chronic Disease</li> </ul>
4.	Decrease recidivism of youth who graduated from the CME program having met their goals and who are moving from a lower level of care to a higher level of care within six months of graduation from the CME program.	<ul style="list-style-type: none"> <li>• <b>HHS National Strategy:</b> Healthy People / Healthy Communities</li> <li>• <b>CMS Quality Strategy:</b> Promote Effective Prevention and Treatment of Chronic Disease</li> </ul>
<b>Goal 3:</b> Reduce length of stay in inpatient and residential psychiatric treatment facilities.		
2.	Decrease LOS for inpatient and residential treatment admissions for youth enrolled in the CME program.	<ul style="list-style-type: none"> <li>• <b>HHS National Strategy:</b> Healthy People / Healthy Communities</li> <li>• <b>CMS Quality Strategy:</b> Promote Effective Prevention and Treatment of Chronic Disease</li> </ul>
<b>Goal 4:</b> Reduce overall Medicaid cost of care for enrolled youth.		
6.	Decrease Medicaid costs compared to the target eligible population of non-CME enrolled youth with PRTF stays.	<ul style="list-style-type: none"> <li>• <b>HHS National Strategy:</b> Affordable Care</li> <li>• <b>CMS Quality Strategy:</b> Make Care Affordable</li> </ul>
<b>Goal 5:</b> Improve child and family integration into home and community life.		
<b>Goal 6:</b> Assist enrolled youth in cultivating family partnerships and natural supports.		
5.	Increase compliance with EPSDT / increase number of CME youth who have an identified primary care practitioner.	<ul style="list-style-type: none"> <li>• <b>HHS National Strategy:</b> Better Care</li> <li>• <b>CMS Quality Strategy:</b> Promote Effective Communication and Coordination of Care</li> </ul>
8.	Increase participation with the WFI-EZ, as measured by the number of WFI-EZ surveys received.	<ul style="list-style-type: none"> <li>• <b>HHS National Strategy:</b> Better Care</li> <li>• <b>CMS Quality Strategy:</b> Promote Effective Communication and Coordination of Care</li> </ul>
9.	Increase family and youth participation at State-level Advisory Committees.	<ul style="list-style-type: none"> <li>• <b>HHS National Strategy:</b> Better Care</li> <li>• <b>CMS Quality Strategy:</b> Strengthen Person and Family Engagement as Partners in Their Care</li> </ul>



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10.	Increase family and youth participation in communities (e.g., community advisory boards, support groups, other stakeholder meetings).	<ul style="list-style-type: none"> <li>• <b>HHS National Strategy:</b> Better Care</li> <li>• <b>CMS Quality Strategy:</b> Strengthen Person and Family Engagement as Partners in Their Care</li> </ul>
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**C. Quality Metrics and Performance Measures**

Pursuant to 42 CFR § 438.340(3i), the quality metrics and performance measures WDH uses to assess performance and improvement of the managed care entity is via two main reporting requirements:

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

A full list of CME’s operational requirements and outcome measures is found in Appendix B.

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

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

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

WDH will post this Managed Care State Quality Strategy once approved to the CME page of the Wyoming Department of Health’s website.<sup>8</sup> Outcome measures are also posted on the webpage.

#### **D. Performance Improvement Projects (PIPs)**

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Performance improvement projects (PIPs) are established to improve access, quality, or timeliness of care for enrollees and will arise from identified concerns in quarterly data reports, retrospective data analysis, and consideration of stakeholder input. WDH and the CME work collaboratively to identify areas for improvement, as described previously in Section II. C. Quality Metrics and Performance Measures. Pursuant to 42 CFR § 438.340(3ii), WDH requires the CME to report PIP status and results to WDH at least annually, including the following elements:

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

In 2020 to 2022, PIPs have focused on the topics identified in Table 4. Performance Improvements Projects (PIPs).

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<sup>8</sup> Care Management Entity’s page on the Wyoming Department of Health’s websites: <https://health.wyo.gov/healthcarefin/medicaid/care-management-entity/>.

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**Table 4. Performance Improvement Projects (PIPs)**

PIP Topic	PIP Aim	PIP Intervention
<b>Enrollment Initiative</b>	<ul style="list-style-type: none"> <li>▪ Identify whether early engagement attempts with WY State Medicaid members (aged 4-20 years old) admitted to a Psychiatric Residential Treatment Facility (PRTF)-level of care, result in a decrease readmission rate (PRTF and acute inpatient settings)</li> <li>▪ Identify whether early engagement attempts with WY State Medicaid members (aged 4-20 years old) who opt in for the enrollment initiative have a decreased length of stay (LOS) during the initial PRTF stay compared to those members who opt-out of the program</li> </ul>	<p>Educates potential CME members about the HFWA program when eligible youth are first enrolled in a PRTF-level of care. The initiative intends to prepare youth and their families for earlier member reintegration into the community to help decrease average length of stay in PRTFs and reduce readmissions to a PRTF-level of care.</p>
<b>Minimum Contacts</b>	<ul style="list-style-type: none"> <li>• Use education, training, and coaching, to improve provider adherence to the minimum contact requirement</li> </ul>	<p>Track providers' compliance with maintaining regular in-person and telephone contact with the enrollee and caregivers. The minimum contacts requirement is an integral part of the HFWA process, as it ensures enrollees and caregivers are consistently engaged and able to obtain full benefit from the program.</p>
<b>Engagement and Implementation (Provider Scorecard)</b>	<ul style="list-style-type: none"> <li>• Improve the percent of Wyoming Care Management Entity youth (ages 4-20 years old who were discharged during the measurement period) and their families reach engagement threshold (&gt;60 days)</li> </ul>	<p>Evaluate the impact of improving the authorization process on the share of discharged youth fully engaged in the CME Program (defined as greater than 60 calendar days of service) and fully implemented within the program (defined as greater than 180 calendar days of service).</p>

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PIP Topic	PIP Aim	PIP Intervention
	<ul style="list-style-type: none"> <li>Improve the percent of Wyoming Care Management Entity youth (ages 4-20 years old who were discharged during the measurement period) and their families reach implementation threshold (&gt;60 days) for Standard Fiscal Year 2021</li> </ul>	

WDH will continue to review the existing PIPs, assess their intended effectiveness, and determine whether modifications or complete project replacements are needed to improve access, quality, and timeliness of care for CME enrollees. As new opportunities for PIPs are identified, WDH will communicate these areas to the CME as needed.

**E. External Quality Review**

Pursuant to 42 CFR § 438.350, WDH conducts an annual external quality review (EQR) of the CME program. The purpose of the EQR is to analyze and evaluate the quality, timeliness, and access to healthcare services provided to Medicaid recipients.

WDH contracts with an external quality review organization (EQRO) to conduct the EQR and evaluate the CME program’s provision of healthcare services. To conduct the review, the EQRO typically engages in discussions with WDH and CME staff and analyzes documentation made available by WDH and the managed care entity. As set forth in 42 CFR § 438.358, the EQRs for State Fiscal Year (SFY) 18 to SFY 21 including four mandatory EQR activities:

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

The EQR activities in SFY 20 also included a review of the 2020 State Quality Strategy Implementation and an Information Systems Capabilities assessment.

The EQR findings provide a basis for WDH’s actions toward managed care compliance remediation or quality improvement. Review of the EQR findings from SFY 16 to SFY 21 showed the following areas in need of development, many of which WDH and the CME continue to develop:

- Needed expansion of the provider network available to enrollees and clarification of network adequacy requirements for all provider types;
- Opportunities for the CME to develop a new process to set performance measures goals; and

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- Opportunities to formalize and clearly document policies and procedures related to data collection and maintenance.

**F. Transition of Care Policy**

Pursuant to 42 CFR §§ 438.340(b)(5) and 438.62, the State’s transition of care policy ensures continued access to services during a transition to / from FFS to a managed care entity when an enrollee would suffer serious detriment to their health or be at risk of hospitalization or institutionalization in the absence of continued services.

The CME devotes an entire phase of its care model to successfully transitioning members out of the program. The “Transition to Discharge” phase includes developing a formal plan for ongoing services (e.g., creating a quality crisis plan, storing contact information for community supports, and other tasks), and assessing enrollee and caregiver readiness for transition via use of the Transition Assets Tool. The Transition Assets Tool evaluates whether youth and families have the eight primary skills generally needed for successful transition. Table 5 describes the eight components reviewed to determine an enrollee’s readiness to transition from the program.

**Table 5. Transition Assets Tool Components**

Component		Assessment Description of Enrollee or Family
1.	<b>Identifies own Vision, Needs, Sets Goals, and Develops Objectives</b>	<ul style="list-style-type: none"> <li>• Enrollee ability to:                             <ul style="list-style-type: none"> <li>▪ Assess their current status,</li> <li>▪ Identify their needs to better achieve the vision they hold for themselves and their family,</li> <li>▪ Prioritizes needs, and</li> <li>▪ Develop short term objectives to continually move forward.</li> </ul> </li> </ul>
2.	<b>Effectively advocates for their own needs</b>	<ul style="list-style-type: none"> <li>• Enrollee ability to:                             <ul style="list-style-type: none"> <li>▪ Identify their needs,</li> <li>▪ Ask directly and respectfully for what they need while listening and understanding an alternate point of view, and</li> <li>▪ Reflect on an approach that does not work and modify it to be more successful later.</li> </ul> </li> </ul>
3.	<b>Identifies, engages, and maintains support</b>	<ul style="list-style-type: none"> <li>• Enrollee ability to:                             <ul style="list-style-type: none"> <li>▪ Identify and engage with non-family individuals (both professionals and natural supports) who can specifically support their Behavior Change plan, and</li> <li>▪ Form Collaborative Partnerships with non-family individuals throughout the Behavior Change process.</li> </ul> </li> </ul>
4.	<b>Planning using culture of support</b>	<ul style="list-style-type: none"> <li>• Family ability to:                             <ul style="list-style-type: none"> <li>▪ Identify needed behavior changes,</li> <li>▪ Develop strategies to ask for and manage help from others in ways that fit their family’s culture.</li> </ul> </li> </ul>
5.	<b>Manages behavior change to ensure</b>	<ul style="list-style-type: none"> <li>• Enrollee ability to:                             <ul style="list-style-type: none"> <li>▪ Monitor effectiveness of the Behavior Change.</li> </ul> </li> </ul>

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Component		Assessment Description of Enrollee or Family
	<b>they are successful</b>	<ul style="list-style-type: none"> <li>▪ Use feedforward processes to address challenges and improve program engagement, motivation, and the Behavior Change plan, and</li> <li>▪ Celebrate accomplishments.</li> </ul>
6.	<b>Navigates system and accesses resources as needed</b>	<ul style="list-style-type: none"> <li>• Enrollee ability to:                             <ul style="list-style-type: none"> <li>▪ Understand the rules and mechanisms that surround access to needed resources,</li> <li>▪ Understand and use approaches to discover resources and the process for accessing the resources,</li> <li>▪ Identify obstacles in the system and finding ways to avoid or overcome them, and</li> <li>▪ Find natural supports (e.g., family organizations, and others) who have the experience to help find the resources to meet their needs.</li> </ul> </li> </ul>
7.	<b>Manages own family crisis and behavior challenges</b>	<ul style="list-style-type: none"> <li>• Family ability to:                             <ul style="list-style-type: none"> <li>▪ Identify, anticipate, and predict crisis and behavior challenges,</li> <li>▪ Assess challenges and potential challenges and take the necessary steps to prevent them,</li> <li>▪ Identify and use strategies to de-escalate challenges and to respond to crisis situations effectively, and</li> <li>▪ Know when and who to ask for help when needed.</li> </ul> </li> </ul>
8.	<b>Develops and maintains natural support system</b>	<ul style="list-style-type: none"> <li>• Enrollee ability to:                             <ul style="list-style-type: none"> <li>▪ Recognize the importance of natural supports for their identified areas of need,</li> <li>▪ Identify the reciprocal nature of relationships,</li> <li>▪ Assess whether they are following through on the needs of the natural supports and overcoming obstacles to maintain their relationships, and</li> <li>▪ Identify new natural supports without adequate support.</li> </ul> </li> </ul>

WDH requires the CME to incorporate transition of care policies related to transitioning out of the CME program when members no longer need HFWA services or reach the program’s maximum age limit. WDH requires the CME to describe applicable transition of care policies in the Member Handbook, including the following elements:

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

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- Estimated timeframes in accordance with the HFWA Transition to Discharge Phase.

CME is Wyoming's only managed care entity. Federal requirements for transitioning from one managed care entity to another are not applicable.

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

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Pursuant to 42 CFR § 438.340(b)(6), WDH conducts an annual analysis on enrollee demographics to identify, evaluate, and reduce potential health disparities based on age, race, ethnicity, sex, primary language, and disability status between enrollee demographics, statewide demographics, and provider demographics.

##### ***Identifying and Evaluating Disparities: Demographic Analysis***

The CME is required to report demographic data, outcomes measures, utilization and special needs population (target population) data to WDH annually. Demographic data reported to WDH for CME enrollees includes race / ethnicity, gender, and age. Data reported for CME providers includes race / ethnicity, and gender, and languages spoken.

WDH compares enrollee demographic data reported by the CME program to the demographics of Wyoming Medicaid and to the CME network providers. This disparity analysis is used to monitor the CME, implement performance measures for quality, access, and coordination of care, and improve information made available to CME youth. The findings of the annual demographic data report are included in the CME's performance evaluation.

##### ***Reducing Disparities: Corrective Actions***

WDH recommends corrective action on both the provider level and system-wide level to reduce health disparities identified in demographic data reports. Corrective actions may include, but are not limited to:

- Expanding demographic data analyses to include enrollee primary language and disability status;
- Collecting additional provider and enrollee demographic information through surveys and / or questionnaires to increase data available for health disparity analyses;
- Improving demographic data reporting to compare CME enrollee demographics to the State's overall demographics and to clearly demonstrate CME's ability to impact access demographic disparities within the program; and
- Improving recruitment efforts and identifying opportunities for partnerships in select regions of the State with limited access to care.

#### **H. Use of Intermediate Sanctions**

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



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### I. Assessment of Performance and Quality Outcomes

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

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

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

The requirements for additional services for enrollees with special health care needs is not applicable to the CME program based on the CME program's scope of services and delivery system. WDH's statewide CME program is limited to community-based high fidelity wraparound services (targeted case management provided via a HFWA delivery model) and respite for all enrolled youth, as well as youth and family training and support services provided to youth enrolled through the concurrent 1915(c) Children's Mental Health Waiver. Each enrollee maintains full access to all Medicaid State Plan services, and special health care needs will continue to be identified and treated through primary and specialty care providers in Medicaid FFS.

### K. Non-duplication of External Quality Review Activities

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

Wyoming's CME does not participate in a Medicare or private accreditation review and will not be exercising the option described in this section. However, should WDH determine that a private accreditation activity is comparable to the State's EQR activities, WDH would work with the EQRO to identify any areas in the private accreditation program that may be duplicative with the EQR and deem these activities accordingly.

### L. Definition of Significant Change

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Pursuant to 42 CFR § 438.340(b)(11), WDH defines "significant change" as a modification in the Medicaid program or managed care plans' operations that would materially affect service delivery or receipt of benefits, including adjustments in services, benefits, geographic service

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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.

WDH will evaluate the State Quality Strategy's effectiveness on an annual basis and update and resubmit the State Quality Strategy no less than once every three years.

## **Section III. Conclusion**

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

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

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

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**Appendices**

**A. Appendix A: Abbreviations and Acronyms**

<b><u>CANS</u></b>	Child and Adolescent Needs and Strengths
<b><u>CASII</u></b>	Child and Adolescent Service Intensity Instrument
<b><u>CFR</u></b>	Code of Federal Regulations
<b><u>CFT</u></b>	Child and Family Team
<b><u>CHIP</u></b>	Children’s Health Insurance Program
<b><u>CMHW</u></b>	Wyoming’s 1915(c) Children’s Mental Health Waiver
<b><u>CME</u></b>	Care Management Entity
<b><u>CMS</u></b>	Centers for Medicare & Medicaid Services
<b><u>DHCF</u></b>	Division of Healthcare Financing
<b><u>EPSDT</u></b>	Early and Periodic Screening, Diagnostic, and Treatment
<b><u>EQR</u></b>	External Quality Review
<b><u>EQRO</u></b>	External Quality Review Organization
<b><u>FCC</u></b>	Family Care Coordinator
<b><u>FFS</u></b>	Fee-For-Service
<b><u>FSP</u></b>	Family Support Partner
<b><u>HFWA</u></b>	High Fidelity Wraparound
<b><u>HHS</u></b>	U.S. Department of Health and Human Services
<b><u>HIPAA</u></b>	Health Insurance Portability and Accountability Act
<b><u>HLOC</u></b>	Higher Level of Care
<b><u>LOC</u></b>	Level of Care
<b><u>LOS</u></b>	Length of Stay
<b><u>LTSS</u></b>	Long-Term Services and Supports
<b><u>MCO</u></b>	Managed Care Organization
<b><u>OOH</u></b>	Out-of-Home
<b><u>PAHP</u></b>	Prepaid Ambulatory Health Plan
<b><u>PCCM</u></b>	Primary Care Case Management
<b><u>PCP</u></b>	Primary Care Provide
<b><u>PIHP</u></b>	Prepaid Inpatient Health Plan
<b><u>PIP</u></b>	Performance Improvement Project
<b><u>PMPM</u></b>	Per-Member Per-Month
<b><u>POC</u></b>	Plan of Care
<b><u>PRTF</u></b>	Psychiatric Residential Treatment Facility
<b><u>SED</u></b>	Serious Emotional Disturbance
<b><u>SFY</u></b>	State Fiscal Year
<b><u>SOW</u></b>	Statement of Work
<b><u>SPMI</u></b>	Serious and Persistent Mental Illness
<b><u>WDH</u></b>	Wyoming Department of Health
<b><u>WFI-EZ</u></b>	Wraparound Fidelity Index-Short Form
<b><u>YSP</u></b>	Youth Support Partner

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**B. Appendix B: Performance Measure Outcomes**

The following tables include CME’s operational requirements and outcome measures for SFY 21. WDH developed a new SOW with the CME vendor at the beginning of Q3 (i.e., January 2021), so the only performance data currently available for review is from Q3 and Q4 of SFY 21 (i.e., January 2021 – June 2021). All measures are state-developed and apply to all providers / enrollees in the program. Within the tables, “No Data” indicates that no values were collected for the measure.

**Table 6. Operational Requirements:**

Metric Name	Baseline Performance (SFY 21 Q3 – Q4)	Performance Target (SFY 21 Q3 – Q4)	Target Met? (Yes / No / N/A)
<b>Critical Incidents</b>			
The Contractor shall notify the Agency within two (2) business days of any critical incident event.	97%	N/A	N/A
<b>Complaints Received about the Contractor</b>			
The Contractor must respond to any complaint received directly or by the Agency in regard to Contractor performance within five (5) business days after receiving the complaint.	100%	N/A	N/A
<b>Enrollee grievance, appeal, and information about the right to a State fair hearings process</b>			
An appeal must be filed by an enrollee within sixty (60) calendar days from the date on the adverse benefit determination notice.	No Data	N/A	N/A
<b>Handling expedited resolutions of appeals</b>			
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 provider) within seventy-two (72) hours of receipt of the initial verbal or written request for appeal review.	No Data	N/A	N/A
<b>Complaints, Appeals &amp; Grievances</b>			
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	No Data	N/A	N/A

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Metric Name	Baseline Performance (SFY 21 Q3 – Q4)	Performance Target (SFY 21 Q3 – Q4)	Target Met? (Yes / No / N/A)
adverse action, the Contractor shall 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.			
Send enrollee grievances and other complaints			
Provide the enrollee or complainant with an acknowledgement of receipt of the grievance or complaint, within two (2) business days of receipt of the grievance or complaint. The acknowledgement shall include the timeframe for resolution.	100%	N/A	N/A
Send enrollee grievances and other complaints			
The Contractor must respond to enrollee grievances and other complaints, received directly or by the Agency in regard to Contractor performance, within five (5) business days after receiving the enrollee grievance or other complaint.	100%	N/A	N/A
Process all referrals received by the Contractor.			
Respond to any referral or request for enrollment within two (2) business days.	81%	N/A	N/A
Assist families with the application or admission process for children and youth			
The Contractor must report on the number of children and youth referred, and turnaround time for referrals as part of the Quarterly Report.	84%	N/A	N/A
Process all applications			
Process all enrollee applications within three (3) business days once application information is complete.	98%	N/A	N/A
Completed applications for the Children’s Mental Health Waiver (CMHW)			
Send all CMHW referrals to the Agency within two (2) business days of discovery	81%	N/A	N/A
Youth and/or the families of admission to the CME			

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Metric Name	Baseline Performance (SFY 21 Q3 – Q4)	Performance Target (SFY 21 Q3 – Q4)	Target Met? (Yes / No / N/A)
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.	91%	N/A	N/A
Client disenrollment if the enrollee meets criteria			
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.	85%	N/A	N/A
Review all evaluations, including the CASII and ECSII, for completeness			
Review one hundred percent (100%) of all initial and re-evaluations	100%	N/A	N/A
Member Handbook to all new enrollees and their guardians.			
Mailings/notifications	100%	N/A	N/A
FCC & Plan of Care (POC)			
# of POCs, all enrollees must have an FCC. A POC must be developed for each enrollee within forty-six (46) calendar days after enrollment.	85%	N/A	N/A
Authorize POCs			
The Contractor shall review and process one hundred percent (100%) of all POCs submitted.	100%	N/A	N/A
FCC & Contact with Parent and Youth twice a month in a quarter			
Minimum of two progress notes documenting FCC contacts per month for youth and/or caregiver	83%	N/A	N/A
Routine readiness assessments based on the pre-approved Transition Readiness Scale			
Assessments within 3 months.	14%	N/A	N/A
FCC holds regularly scheduled CFTs and updates to the POC			
POCs that have been updated	79%	N/A	N/A
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.	No Data	N/A	N/A

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Metric Name	Baseline Performance (SFY 21 Q3 – Q4)	Performance Target (SFY 21 Q3 – Q4)	Target Met? (Yes / No / N/A)
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.	27%	N/A	N/A
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 successful pass the certification process prior to providing any CME service.	100%	N/A	N/A

**Table 7. Outcome Measures:**

Metric Name	SFY 21 Q3 Performance	SFY 21 Q4 Performance	Performance Target	Target Met? (Yes / No / N/A)
Out-of-Home (OOH) Placements				
Youth enrolled in OOH	3%	4%	N/A	N/A
Decreased Length of Stay (LOS) for Inpatient and Residential Treatment admissions for youth enrolled in the CME				
LOS for CME enrolled youth in OOH placement	144	317	N/A	N/A
Recidivism				
Youth enrolled in a higher level of care (HLOC)	3%	10%	N/A	N/A
Recidivism (LOC) at six (6) months post CME graduation				
Graduated youth admitted to HLOC within 6 months	0%	4%	N/A	N/A
Primary Care Practitioner Access (EPSDT)				
CME enrolled youth with an identified Primary Care Practitioner	15%	13%	N/A	N/A
Cost Savings				
Average cost of CME youth (for 6 months)	\$5,005	\$5,753	N/A	N/A
Average cost of PRTF youth (for 6 months)	\$23,256	\$25,003	N/A	N/A
Fidelity to High-Fidelity Wraparound Model				



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Metric Name	SFY 21 Q3 Performance	SFY 21 Q4 Performance	Performance Target	Target Met? (Yes / No / N/A)
Fidelity to the HFWA model as measured by the Wraparound Fidelity Index (WFI-EZ)	80%	79%	N/A	N/A
Fidelity to the high fidelity wraparound (HFWA) Model	17	23	N/A	N/A
<b>Family and Youth Participation at State-level Advisory Committees</b>				
Family and youth to participate on State-level Advisory Committees.	No Data	No Data	N/A	N/A
<b>Family and Youth Participation in Communities</b>				
family and youth participation on the CME's community advisory boards, Support groups and other stakeholder meeting.	No Data	No Data	N/A	N/A

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**C. Appendix C: Network Adequacy Requirements**

Table 8 below describes WDH and the CME’s requirements relating to network adequacy and availability of services, established in 42 CFR 438.68 and 42 CFR 438.206.

**Table 8. Network Adequacy and Availability of Services Requirements**

CFR Reference	CFR Requirement	WDH and CME Requirements
<b>42 CFR 438.68 Network Adequacy Standards</b>		
42 CFR § 438.68 (a)	General rule. A State that contracts with an MCO, PIHP or PAHP to deliver Medicaid services must develop and enforce network adequacy standards consistent with this section.	See remainder of 42 CFR 438.68 below.
42 CFR § 438.68 (b)(1)	Provider-specific network adequacy standards. At a minimum, a State must develop <b>time and distance standards</b> for the following provider types, if covered under the contract: <ul style="list-style-type: none"> <li>(i) Primary care, adult and pediatric.</li> <li>(ii) OB/GYN.</li> <li>(iii) Behavioral health (mental health and substance use disorder), adult and pediatric.</li> <li>(iv) Specialist, adult and pediatric.</li> <li>(v) Hospital.</li> <li>(vi) Pharmacy.</li> <li>(vii) Pediatric dental.</li> <li>(viii) Additional provider types when it promotes the objectives of the Medicaid program, as determined by CMS, for the provider type to be subject to time and distance access standards</li> </ul>	<b>Not applicable.</b> This requirement does not apply to the CME program for two reasons: <ul style="list-style-type: none"> <li>• The community-based nature of the HFWA model involves providers traveling to the enrollees rather than enrollees traveling to a clinic or facility. The enrollee’s “child and family team,” which is a group of family members and other supports, decides meeting location and all meetings are scheduled at a time and place that works best for each enrollee. Therefore, travel time and distance do not impact enrollee access.</li> <li>• The CME program provides care coordination services only and does not provide any clinical services. Providers must be certified in HFWA, but do not fall into typical clinical provider categories. Therefore, clinical provider categories as specified in the federal regulation (e.g., primary care, specialists, hospital, pharmacy, etc.) do not apply to the CME program.</li> </ul>

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CFR Reference	CFR Requirement	WDH and CME Requirements
42 CFR § 438.68 (b)(2)	<p><b>Long-term Services and Supports (LTSS).</b> States with MCO, PIHP or PAHP contracts which cover LTSS must develop:</p> <ul style="list-style-type: none"> <li>(i) Time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services; and</li> <li>(ii) Network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services.</li> </ul>	<p><b>Not applicable.</b> Requirements regarding LTSS do not apply to the CME program, which delivers care coordination services to youth with complex behavioral needs.</p>
42 CFR § 438.68 (b)(3)	<p><b>Scope</b> of network adequacy standards. Network standards established in accordance with paragraphs (b)(1) and (2) of this section must include all <b>geographic areas</b> covered by the managed care program or, if applicable, the contract between the State and the MCO, PIHP or PAHP. States are permitted to have varying standards for the same provider type based on geographic areas.</p>	<p>WDH requires the CME to demonstrate availability of services in all eight regions and target populations in the State. The CME demonstrates compliance by submitting geographic mapping of provider and member locations on a quarterly basis.</p> <p>Additionally, WDH allows providers to leverage State-approved, HIPAA-compliant telehealth platforms to deliver care where and when appropriate and encourages incorporating telehealth into individual Plans of Care (POCs) as appropriate. Wyoming often faces challenges regarding the rural nature of the state (e.g., long distances between communities) or weather challenges (e.g., winter weather events, summer forest fires, rock slides).</p> <p>Telehealth may also be used to continue service delivery when these types of challenges arise.</p>

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<p>42 CFR § 438.68 (c)(1)</p>	<p>Development of network adequacy standards. States developing network adequacy standards consistent with paragraph (b)(1) of this section must consider, at a minimum, the following elements:</p> <ul style="list-style-type: none"> <li>(i) The anticipated Medicaid enrollment.</li> <li>(ii) The expected utilization of services.</li> <li>(iii) The characteristics and health care needs of specific Medicaid populations covered in the MCO, PIHP, and PAHP contract.</li> <li>(iv) The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services.</li> <li>(v) The numbers of network providers who are not accepting new Medicaid patients.</li> <li>(vi) The geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees.</li> <li>(vii) The ability of network providers to communicate with limited English proficient enrollees in their preferred language.</li> <li>(viii) The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities.</li> <li>(ix) The availability of triage lines or screening systems, as well as the use of</li> </ul>	<p>WDH takes the following factors in consideration when developing network adequacy standards:</p> <ul style="list-style-type: none"> <li>• <b>Anticipated Medicaid enrollment:</b> WDH maintains a listing of potential enrollees who appear to meet the CME program’s eligibility criteria.</li> <li>• <b>Expected utilization of services:</b> WDH requires the CME to perform utilization management, including assessment of disenrollment trends as well as patterns in utilization.</li> <li>• <b>Characteristics and health care needs of specific Medicaid populations covered in the PAHP contract:</b> Enrollees’ plans of care are required to identify enrollees’ needs, strengths, and preferences.</li> <li>• <b>Numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services:</b> WDH requires the CME to maintain compliance with provider-to-enrollee ratios, which indirectly dictate the number of network providers needed. Additionally, each CME provider must possess certain qualifications and undergo HFWA training, as outlined in the provider handbook.</li> <li>• <b>Numbers of network providers who are not accepting new Medicaid patients:</b> The provider directory may indicate whether a provider is accepting new patients. If a requested provider’s caseload is full, the enrollee may select another provider or wait until the desired provider is available.</li> <li>• <b>Geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by</b></li> </ul>
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CFR Reference	CFR Requirement	WDH and CME Requirements
	<p>telemedicine, e-visits, and/or other evolving and innovative technological solutions.</p>	<p><b>Medicaid enrollees:</b> WDH requires the CME to demonstrate availability of services in all eight regions of the State. The CME demonstrates compliance by submitting geographic mapping of provider and member locations on a regular basis. Additionally, telehealth is available for use throughout the State and may be incorporated into individual Plans of Care (POCs) as appropriate. CME providers work with each enrollee to coordinate meeting locations and times that work best for the enrollee.</p> <ul style="list-style-type: none"> <li>• <b>Ability of network providers to communicate with limited English proficient enrollees in their preferred language:</b> WDH requires provision of free interpretation services to enrollees.</li> <li>• <b>Ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities:</b> The CME offers free aids and services to enrollees with disabilities, such as sign language and written language in other accessible formats. The CME does not maintain physical offices, so the applicability of physical access accommodations is limited. Availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions: The CME provides a toll-free phone line and telehealth services.</li> </ul>

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CFR Reference	CFR Requirement	WDH and CME Requirements
42 CFR § 438.68 (c)(2)	<p>States developing standards consistent with paragraph (b)(2) of this section must consider the following:</p> <ul style="list-style-type: none"> <li>(i) All elements in paragraphs (c)(1)(i) through (ix) of this section.</li> <li>(ii) Elements that would support an enrollee's choice of provider.</li> <li>(iii) Strategies that would ensure the health and welfare of the enrollee and support community integration of the enrollee.</li> <li>(iv) Other considerations that are in the best interest of the enrollees that need LTSS.</li> </ul>	<p><b>Not applicable.</b> These requirements apply to LTSS, which is not provided by the CME program.</p>
42 CFR § 438.68 (d)(1)	<p>Exceptions process. To the extent the State permits an exception to any of the provider-specific network standards developed under this section, the standard by which the exception will be evaluated and approved must be:</p> <ul style="list-style-type: none"> <li>(i) Specified in the MCO, PIHP or PAHP contract.</li> <li>(ii) Based, at a minimum, on the number of providers in that specialty practicing in the MCO, PIHP, or PAHP service area</li> </ul>	<p><b>Not applicable.</b> The provider-specific network standards do not apply to this program, and therefore there are not exemptions to the provider-specific network standards.</p>

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



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

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CFR Reference	CFR Requirement	WDH and CME Requirements
42 CFR § 438.206 (b)(3)	Provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	<b>Not applicable.</b> The CME does not provide clinical services.
42 CFR § 438.206 (b)(4)	If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP, or PAHP must adequately and timely cover these services out of network for the enrollee, for as long as the MCO, PIHP, or PAHP's provider network is unable to provide them.	<b>Not applicable.</b> The CME does not cover services delivered by out of network providers. The services within the scope of the contract must be delivered by Medicaid providers who meet certain qualifications and undergo HFWA training, as outlined in the provider handbook.
42 CFR § 438.206 (b)(5)	Requires out-of-network providers to coordinate with the MCO, PIHP, or PAHP for payment and ensures the cost to the enrollee is no greater than it would be if the services were furnished within the network.	<b>Not applicable.</b> The CME does not cover services delivered by out of network providers. The services within the scope of the contract must be delivered by Medicaid providers who meet certain qualifications and undergo HFWA training, as outlined in the provider handbook.
42 CFR § 438.206 (b)(6)	Demonstrates that its network providers are credentialed as required by §438.214.	<p>WDH requires the CME to “develop and adhere to a documented process for the recruitment and retention of providers, certification, recertification and nondiscrimination practices for providers who have signed sub agreements.”</p> <p>The CME requires providers to meet specific educational and/or experience requirements, as well as basic background qualifications and screenings. The CME also requires providers to complete initial training and certification, depending on provider role. Additional credentialing requirements are outlined in the provider agreement, including not employing providers excluded from participation in Federal health care programs.</p>

**Managed Care State Quality Strategy**

CFR Reference	CFR Requirement	WDH and CME Requirements
42 CFR § 438.206 (b)(7)	Demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services.	<b>Not applicable.</b> The CME does not provide family planning services.
42 CFR § 438.206 (c)(1)	<p>Furnishing of services. The State must ensure that each contract with a MCO, PIHP, and PAHP complies with the following requirements.</p> <ul style="list-style-type: none"> <li>(1) Timely access. Each MCO, PIHP, and PAHP must do the following:                             <ul style="list-style-type: none"> <li>(i) Meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.</li> <li>(ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees.</li> </ul> </li> </ul>	WDH requires the CME to submit documentation to the State that demonstrates it offers timely access to services. In particular, WDH and the CME evaluate frequency and timeliness of provider contact with enrollee, both in-person and via telephone. For example, new referrals should be contacted by providers within three business days. Additionally, providers shall contact enrollee or designated caregiver or legal guardian at least two times per month, based on the family’s preferred contact method.

**Managed Care State Quality Strategy**

CFR Reference	CFR Requirement	WDH and CME Requirements
42 CFR § 438.206 (c)(2)	<i>Access and cultural considerations.</i> Each MCO, PIHP, and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex.	<p>WDH requires that the provider network is “sufficient to provide adequate access to all services covered under the contractual agreement for all enrollees, including those with limited English proficiency or physical or mental disabilities.” Additionally, WDH requires that information is made available in other languages and translation services are offered. Finally, WDH requires the CME to maintain an adequate array of culturally and linguistically diverse providers that reflect the overall diversity of CME youth.</p> <p>The CME reports provider network demographics, although this information is voluntarily submitted by network providers. The CME leverages Learning Opportunities, provider one to one calls, newsletters, and all Monthly Provider calls to educate providers on the importance of self-reporting demographic information to ensure that services are delivered in a culturally competent manner.</p>
42 CFR § 438.206 (c)(3)	<i>Accessibility considerations.</i> Each MCO, PIHP, and PAHP must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.	The CME offers free aids and services to enrollees with disabilities, such as sign language and written language in other accessible formats. Additionally, many meetings with enrollees occur at a location which works best for the enrollee, and providers honor enrollees’ location requests unless the request presents a danger; therefore, the applicability of physical access accommodations is limited.