

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The Youth and Family Training and Support (YFTS) service is evolving to include individual service provision in addition to the group service modality already in place. The YFTS service rate is also changing to align with the peer support services rate provided under the State Plan's Targeted Case Management for children with SED as the YFTS service providers are credentialed peer support partners or Family Care Coordinators who aren't facilitating for the youth/family receiving the YFTS service. The individual rate for YFTS services will increase to \$14.04 per fifteen minute unit and the individual modality will be reimbursed at \$7.02 per fifteen minute unit. The rate change and addition of the individual service modality is anticipated to increase utilization of the YFTS service as providers will be compensated the usual and customary rate for peer support and waiver children served in more remote areas will be able to receive the service regardless of the availability of other qualified waiver youth to form a group.

The performance measures have been updated based on feedback from the evidentiary report and collaboration with other state waivers serving similar populations.

The cost limit has been removed and Attachment #1: Transition Plan has been updated detailing the revision. The Agency does not anticipate any impact to clients.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

- A.** The **State of Wyoming** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):

Children's Mental Health Waiver

- C. Type of Request:** **renewal**

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

3 years 5 years

Original Base Waiver Number: WY.0451

Waiver Number: WY.0451.R04.00

Draft ID: WY.008.04.00

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

07/01/24

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

[Empty text box for hospital subcategories]

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

[Empty text box for nursing facility subcategories]

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

1915 (b): Wyoming Medicaid’s Youth Initiative – A High Fidelity Wraparound (HFWA) Community-Based Alternative for Youth with Serious Emotional/Behavioral Challenges will be submitted to CMS concurrent to the submission of this amended 1915 (c) waiver. Both waivers are were submitted with a proposed effective date of July 1, 2024.

Specify the §1915(b) authorities under which this program operates (check each that applies):

§1915(b)(1) (mandated enrollment to managed care)

§1915(b)(2) (central broker)

§1915(b)(3) (employ cost savings to furnish additional services)

§1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

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

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

Additional CMHW goals are to:

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

Organizational Structure:

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

Service Delivery:

Youth and Family Training and Support services (aka “waiver services”) are required to be delivered by family care coordinators, family support partners and/or youth support partners who are trained and credentialed in delivering targeted case management services through a HFWA service delivery model in an individual or group setting. These provider types are geographically dispersed in various locations through the state to provide non-clinical behavioral health support services to enrolled youth/families. The CMHW Child and Family Team (CFT) may include the youth/family, CMHW high fidelity wraparound (HFWA) providers in addition to other support team members identified by the youth and family for participation in the program (natural supports), local representatives from other child serving agencies (Department of Education, Department of Family Services) and community mental/behavioral health providers. The CFT works collaboratively to ensure that all available community-based services are utilized. CMHW services are not duplicative of other services available to the participant, but rather build on community, agency and home-based individual and/or family therapy provided by local/regional community health centers or privately licensed behavioral health professionals. If Youth and Family Training and Support services are being delivered by a Family Care Coordinator (FCC), the FCC delivering Youth and Family Training and Support services cannot be the FCC assigned to the waiver enrollee’s plan of care (or rather the FCC that developed the youth’s plan of care. Adherence to this requirement ensures the entity responsible for the development of the individualized plan of care for an enrollee is not a direct service provider for that enrollee as well. Waiver services are provided as detailed in the plan of care drafted by the CFT under advisement of the youth/family. Projected service utilization is detailed within the plan, and delivered by qualified and credentialed network providers.

Quality Management:

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

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

No. This waiver does not provide participant direction opportunities. *Appendix E is not required.*
- F. Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable**
- No**
- Yes**
- C. Statewide.** Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

No

Yes

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

Geographic Limitation. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.

Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita

expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee

schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

All federally recognized tribes as well as the general public in the State of Wyoming were notified of this waiver amendment and have had the opportunity to review and comment on the waiver amendments proposed pursuant to organization change and the error regarding service frequency. The official tribal consultation and public notice was released on March 28, 2024, and closed on April 28, 2024.

The Department intends to continue with appropriate and periodic consultation with the Tribal Health Directors, Tribal Health System and Public Health Authority and Business Council members as the program continues to move forward.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Stout

First Name:

Brenda

Title:

CMHW Program Manager

Agency:

Wyoming Department of Health, Division of Healthcare Financing

Address:

Address 2:

City:

State: **Wyoming**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Wyoming**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

brenda.stout1@wyo.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are *readily* available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Wyoming**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select*

one):

The waiver is operated by the state Medicaid agency.

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

The Medical Assistance Unit.

Specify the unit name:

Wyoming Department of Health, Division of Healthcare Financing

(Do not complete item A-2)

Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

[Empty text box for division/unit name]

(Complete item A-2-a).

The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.

Specify the division/unit name:

[Empty text box for division/unit name]

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

[Empty text box for section a]

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

PAHP:

The Wyoming Department of Health (WDH), Division of Healthcare Financing (DHF), the State appointed entity for administration of Wyoming's Medicaid program, procured a statewide PAHP for youth with complex behavioral conditions. The PAHP supports WDH's efforts to better serve youth in their homes and communities by providing the necessary services and supports. The PAHP serves as an entry point for Wyoming's eligible youth with behavioral health needs so that the youth and their family can achieve the goals of safety, permanency, and well-being in their communities using high fidelity wraparound (HFWA).

Medicaid youth with complex behavioral health conditions may receive fragmented care due to the involvement of various public and private entities in service delivery, contributing to poor outcomes and unnecessarily high costs. Youth may struggle because of gaps in required care coordination, family disruption, and distant out-of-home placements. National and state spending on youth with complex behavioral health conditions is high. This is partially due to ineffective, uncoordinated, and/or inappropriate service delivery. By focusing on bridging gaps in service delivery and coordinating care, youth with complex behavioral issues will be better served, improving outcomes, while costs may also be reduced. Wyoming is striving to provide youth and their families the services necessary to allow the youth to reside in their community, participate in routine daily activities, and experience long term health and longevity.

Medicaid youth with SED/SMI and youth with a level of care requiring services from an inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160 generally have more frequent emergency room visits, significantly higher utilization of psychotropic drugs at doses that often exceed national parameters, frequent disruption of family and youth resiliency, and higher service costs. With the various parties typically involved with these youth, and the potential of out-of-home placement, the WDH recognizes the need to improve service delivery and increase the coordination of care for youth with SED/SMI in order to improve health outcomes, decrease recidivism, and contain costs.

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

MMIS Fiscal Agent and Provider Enrollment Contractors:

The SMA has a contract for the operation and management of the MMIS system to review and pay all claims submitted by the PAHP. The SMA utilizes a separate contractor for provider enrollments (required for all providers contracted in the PAHP provider network) and the execution of provider agreements. The provider enrollment contractor processes the Medicaid provider enrollment applications after the applicable PAHP training and credentialing requirements have been met and issues a letter to the enrolling provider to present to the provider enrollment contractor upon enrollment. The provider enrollment contractor retains hard copies of all original provider agreements executed and is responsible for performing all federally required periodic and ongoing background and database verification for waiver providers (excludes Central Registry and Federal Bureau of Investigation/Division of Criminal Investigation background checks to be required and monitored by the PAHP contractor).

Electronic Medicaid Waiver System (EMWS):

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

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

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

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

Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

PAHP:

As part of the concurrent 1915 (b) quality monitoring strategy, the State has required (through its contract with the PAHP) that all performance measures and data elements captured and reviewed as a component of any monitoring strategy be summarized and reported to the SMA through various required deliverables including quarterly and annual reports. The following methodologies have also been detailed in the concurrent 1915 (b) and (c) waivers as planned mechanisms for assessing ongoing PAHP contractor performance: Accreditation for non-duplication (Once, upon PAHP procurement and initial contracting);

- Consumer self-report data (Annually);
- Data analysis (non-claims: denials of referral requests, grievance and appeals data) (quarterly);
- Enrollee hotlines (available 24/7);
- Geographic mapping (quarterly);
- Independent assessment of the concurrent 1915 (b) & (c) waivers (per CFR requirements);
- External Quality Review (Annually);
- Measuring and monitoring disparities by racial or ethnic groups (annually);
- Network adequacy assurance by plan (quarterly);
- Performance measures (quarterly); and
- Utilization review (annually)

MMIS:

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

EMWS:

The Division of Healthcare Financing oversees the contractor responsible for maintaining and supporting the EMWS. The Division maintains oversight and direction of system enhancements, maintenance, role access, testing, the accuracy of data and user training needs and also oversees the system interfaces between EMWS, and the MMIS.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment		
Waiver enrollment managed against approved limits		
Waiver expenditures managed against approved levels		
Level of care evaluation		
Review of Participant service plans		
Prior authorization of waiver services		
Utilization management		
Qualified provider enrollment		
Execution of Medicaid provider agreements		
Establishment of a statewide rate methodology		

Function	Medicaid Agency	Contracted Entity
Rules, policies, procedures and information development governing the waiver program		
Quality assurance and quality improvement activities		

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Total percentage of policies, procedures, provider manuals, family manuals, handbooks, letters of education, or other PAHP- produced materials reviewed and approved by the State prior to distribution (Total # of materials reviewed and approved prior to distribution/Total # of policies, etc. released).

Data Source (Select one):

Other

If 'Other' is selected, specify:

State Agency Program Manager Data Files

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

Performance Measure: Total number and percentage of policies, procedures, provider manuals, family manuals, handbooks, letters of education, or other PAHP- produced materials reviewed and approved by the State prior to distribution (Total # of materials reviewed and approved prior to distribution/Total # of policies, etc. released).

Data Source (Select one):

Other

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Methods for remediation with contractors:
 Include verbal and/or written notification to the contractor detailing any concerns or contract provisions that have not been fulfilled. Communication shall be immediate upon discovery of the issue and additional education may be provided to the contractors as a means of addressing the gap. The initial contract language may also be modified and amended to clarify any State expectations that were not clearly detailed. If the contract performance does not increase, the contractor may be put on a brief corrective action plan that specifies the desired corrective action and time frame to complete, if no remedy is found the contract may be terminated or other financial withholds/ penalties assessed.

Methods for policy remediation – internal:
 Feedback may be provided from the Senior Leadership/ State Medicaid Agent regarding the contractor or contract manager performance and/or progress toward meeting the clearly defined performance expectations related to the operation of the waiver. If that communication is not successful in resolving the concern, the State Medicaid Agent can present program concerns and issues at the Senior Leadership meetings or in a more casual follow-up with the internal contract managers.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged		<input type="checkbox"/>	<input type="checkbox"/>
		Disabled (Physical)		<input type="checkbox"/>	<input type="checkbox"/>
		Disabled (Other)		<input type="checkbox"/>	<input type="checkbox"/>
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury		<input type="checkbox"/>	<input type="checkbox"/>
		HIV/AIDS		<input type="checkbox"/>	<input type="checkbox"/>
		Medically Fragile		<input type="checkbox"/>	<input type="checkbox"/>
		Technology Dependent		<input type="checkbox"/>	<input type="checkbox"/>
Intellectual Disability or Developmental Disability, or Both					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Autism			
		Developmental Disability			
		Intellectual Disability			
Mental Illness					
		Mental Illness	18	21	
		Serious Emotional Disturbance	4	17	

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

Targeting Criteria - Initial:

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

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

- Youth ages 6 - 21 must have a minimum Child and Adolescent Service Intensity Instrument (CASII) composite score of twenty (20), and youth ages 4 & 5 must have an Early Childhood Service

Intensity Instrument (ECSII) score of eighteen (18) to thirty (30) OR the appropriate social and emotional assessment information provided to illustrate level of service need; and

- Must have a DSM Axis 1 or ICD diagnosis that meets the State’s diagnostic criteria.

Excluded Populations:

- Youth residing in a Nursing Facility or ICF/MR;
- Youth enrolled in another managed care program;
- Youth enrolled in another HCBS waiver, specifically those waivers listed below:
 - o Supports Waiver – WY Waiver # 1060
 - o Comprehensive Waiver – WY Waiver # 1061
 - o Community Choices Waiver – WY Waiver # 0236
- Retroactive Eligibility (Medicaid beneficiaries for the period of retroactive eligibility);
- Any youth, who during enrollment or participation in the waiver, is determined eligible for any other excluded population (i.e. waiver listed above, nursing facility, or ICF/MR); or
- Other: Any other youth, upon application, whose primary need is determined to be for services that are more habilitative in nature vs. the intensive rehabilitative nature of HFVA services. This need will be determined by a level of co-occurrence indicated as “4” or “5” in Dimension III on the CASII or a rating of “4” or “5” on the ECSII assessment, section IV, including children and youth who are unlikely to be admitted to an inpatient psychiatric facility due to serious developmental and/or medical needs.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's

maximum age limit.

Specify:

Enrolled youth are no longer eligible for services when they reach the end of the month of their twenty-first (21st) birthday. However, all plans of care must begin the development of a plan objective(s) for the transition goals. Objectives must be measurable and contain specific action steps the team will follow to support the youth and family during their transition off the waiver. The team’s goal will be to identify and secure as many community based resources as available to promote independence and self-reliance for the youth and his/her family. This strategy may include the identification, referral to and inclusion of public and private sector programming options. For older youth, the CFT may include the participation of an adult mental health care manager who can assist with the transition as well. The individual plan of care will specify time frames and milestones for establishing transition links, and appropriately document program referrals.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is (*select one*)

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is (select one):

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (check each that applies):

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	135
Year 2	135
Year 3	135
Year 4	135
Year 5	135

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

The state does not limit the number of participants that it serves at any point in time during a waiver year.

The state limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	75
Year 2	75
Year 3	75
Year 4	75
Year 5	75

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

Purposes	
Medicaid Eligibility Churn:	
To provide continuity of care and/or Crisis response:	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (*provide a title or short description to use for lookup*):

Medicaid Eligibility Churn:

Purpose (*describe*):

1) Medicaid Churn: The CMHW is being operated concurrent to a 1915 (b) waiver that will provide for HFWA to Medicaid-enrolled youth as a targeted case management state plan service through the PAHP. However, should a youth lose Medicaid eligibility they also lose the ability to continue with the HFWA individual plan of care with noted service objectives and goals. By having access to reserve capacity through the CMHW, these youth can be immediately transitioned to the waiver for continued program participation, rather than disenrolled and put at risk for institutionalization or acute psychiatric stabilization; and

Describe how the amount of reserved capacity was determined:

The reserved capacity was determined through a detailed analysis of SFY 2013 churn within the Care Management Entity Pilot (movement off the program due to loss of Medicaid eligibility. Among the pilot population (targeted population), there were five (5) youth per year who met the desired criteria.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4	5
Year 5	5

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (provide a title or short description to use for lookup):

To provide continuity of care and/or Crisis response:

Purpose (describe):

The State is requesting reserve capacity for the following scenario:

Crisis: The State would like to reserve CMHW capacity for youth who apply in the midst of a crisis seeking immediate service delivery to prevent an institutional placement, other out-of-home relocation (i.e. corrections or foster care) or harm to self or others. It has been demonstrated through successful programs, nationally, that immediate access to HFWA services in a crisis can often times provide the youth and family with appropriate strategies for de-escalating and avoiding more costly out-of-home placements.

Describe how the amount of reserved capacity was determined:

The reserved capacity was determined through a detailed analysis of SFY 2023 high priority, expedited, application requests due to youth in crisis. Among the pilot population (targeted population), there were five (5) youth per year who met the desired criteria.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4	5
Year 5	5

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among

local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Should the number of waiver participants reach the maximum capacity approved, individuals determined eligible shall be placed on a waiting list. The status of the wait list is updated by the CMH Waiver Program Manager. The applicants will be listed in two wait lists – the first prioritized by combined CASII/ECSII scores from highest to lowest as well as a threat of not remaining in their home and/or school expulsion. The second list prioritized by the overall length of time spent on the wait list.

When there is an available funding opportunity, eligible waitlist applicants will be funded using the following criteria:

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

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

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

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

§1634 State

SSI Criteria State

209(b) State

2. Miller Trust State.

Indicate whether the state is a Miller Trust State (*select one*):

No

Yes

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional state supplement recipients**Optional categorically needy aged and/or disabled individuals who have income at:***Select one:***100% of the Federal poverty level (FPL)****% of FPL, which is lower than 100% of FPL.**Specify percentage: **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)****Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)****Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)****Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)****Medically needy in 209(b) States (42 CFR §435.330)****Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)****Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)***Specify:*

- 42 CFR 435.110 (parents and other caretaker relatives), 435.116 (pregnant women), and 435.118 (infants and children under age 19).
- Foster Care Children: 42 CFR, 435.145; 1902(a)(10)(A)(ii)(VIII); and 42 CFR 435.222
- * Former Foster Care Children: 1902(a)(10)(A)(i)(IX)

Special home and community-based waiver group under 42 CFR §435.217 Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.**Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.***Select one and complete Appendix B-5.***All individuals in the special home and community-based waiver group under 42 CFR §435.217****Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217***Check each that applies:***A special income level equal to:***Select one:***300% of the SSI Federal Benefit Rate (FBR)****A percentage of FBR, which is lower than 300% (42 CFR §435.236)**Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the state elects to (select one):

Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

The following formula is used to determine the needs allowance:

Specify:

The maintenance needs allowance is equal to the individual's total income as described under the post-eligibility process which includes income that is placed in a Miller Trust.

Other

Specify:

[Empty text box]

ii. Allowance for the spouse only (select one):

Not Applicable

The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

[Empty text box]

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

[Empty text box]

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised

The following formula is used to determine the needs allowance:

Specify formula:

The maintenance needs allowance is equal to the individual's total income as described under the post-eligibility process which includes income that is placed in a Miller Trust.

Other

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.

The state does not establish reasonable limits.

The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The state requires (select one):

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

Waiver services will be furnished at least once per quarter. Progress notes included in the plan of care must detail progress toward meeting objectives, identified challenges and strengths and changes recorded in the Child and Adolescent Needs and Strengths (CANS) assessment or other evaluation/assessment scores as the youth and family progress. The family care coordinator will be responsible for including the required service information in the progress notes and sharing them with the child and family team.

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

The Medicaid agency's state program manager performs the initial level of care evaluation review as part of the clinical eligibility determination process. The PAHP contractor completes any subsequent level of care reviews that may be required.

Initial Evaluation:

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

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

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

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

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

The qualifications of the individuals who are performing the level of care evaluations are specified in B-6-c.

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the

educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

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

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

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

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

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

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

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

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

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

Annual Re-Evaluation:

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

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

The current State criteria utilized for confirmation of medical necessity for an acute psychiatric or residential placement follow guidance provided in 42 CFR 441.152 and include the following:

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

The CASII/ECSII as detailed is a service intensity instrument/ tool designed and promoted by the American Academy of Child and Adolescent Psychiatrists. Used properly, the s

Contributing to the overall scores reflected by the CASII/ECSII are specific environmental stressors such as a lack of resources and details on services that can be reasonably expected to improve the recipient’s condition.

All of these latter criteria are also used in the State’s evaluations for institutional services funded under State plan.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The PAHP contractor gathers the waiver application information submitted and, once complete, forwards to the state program manager for review and entry into the EMWS. Once the youth has been determined eligible and a funding opportunity is available, the state program manager contacts the PAHP contractor with the waiver activation information and a copy of the funding letter that went via certified mail to the family of the child or youth who is enrolling. Youth that are age of majority receive their own funding letter.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

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

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.

Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (*specify*):

The PAHP Contractor is responsible for ensuring the annual re-evaluations occur before the expiration of the previous evaluations/assessments. If annual reevaluations are not completed timely, the PAHP will be ineligible for payment during the time when no current evaluation is on file. The PAHP Contractor uses a utilization management system that tracks the ECSII/CASII assessments and level of care evaluations for each enrollee. Prior to the expiration of the current assessment or level of care evaluation, the PAHP reminds network providers to assist the family to obtain an updated assessment and level of care evaluation as a condition of continued participation in the waiver. Should there be non-compliance or a delay in completing the required annual evaluations, an administrative hold is placed on the POC authorization and the PAHP contractor follow up to arrange for the necessary evaluations to keep service provision going while putting the network provider on a corrective action plan for late or missing documentation. The PAHP Contractor will consult with the youth and family and may assist them to select another provider if appropriate.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

- a. Sub-assurance:** *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The percent of all LOC denials with documentation supporting the reason for denial (total LOC denial with documentation supporting the reason for denial/total number of LOC denials)

Data Source (Select one):

Other

If 'Other' is selected, specify:

EMWS

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Total number of applicants who received a LOC evaluation (total number of applicants who received a LOC evaluation/ total # of applicants)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Medicaid Waiver System (EMWS)

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and	Other

	Ongoing	Specify: <input style="width: 100px; height: 20px;" type="text"/>
	Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100px; height: 20px;" type="text"/>

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. *Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The percent of CASII/ECSII evaluations that are completed in accordance with AACAP guidelines and standards (total # of CASII/ECSII evaluations completed in accordance with AACAP guidelines and standards/ total # of CASII/ECSII evaluations completed).

Data Source (Select one):

Other

If 'Other' is selected, specify:

Initial: EMWS Re-Evaluation: PAHP Contractor Provider Data Files

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>

	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

The percent of CASII/ECSII and LOC evaluations that are completed by a qualified evaluator/ QMHP (total # of CASII/ECSII and LOC evaluations completed by a qualified evaluator/ QMHP/ total # of CASII/ECSII and LOC evaluations completed).

Data Source (Select one):

Other

If 'Other' is selected, specify:

Initial: EMWS Re-Evaluations: PAHP Contractor Provider Data Files

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input type="text"/>

Performance Measure:

Applicants whom were provided with appeal rights according to state requirements for appeal of LOC denials (Number of applicants who were provided with appeal rights according to state requirements for appeal of LOC denials/number of applicants with a LOC denial)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Initial: EMWS Re-Evaluations: PAHP Contractor Provider Data Files

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

Percent of LOC evaluations that are completed using the instruments and process specified in the approved waiver (LOC evaluations completed using the instruments and process specified in the approved waiver/LOC evaluations submitted)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Initial: EMWS Re-Evaluations: PAHP Contractor Provider Data Files

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample

		Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

No

Yes

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

The waiver program manager assures that a LOC is in place during the initial application process. This information is stored in the EMWS and an application cannot move forward with approval of clinical eligibility without a qualifying LOC in place. The PAHP contractor provides quarterly reports regarding the annual LOC assurance metrics with an annual summary. The PAHP contractor will not approve a waiver POC for service authorization until the annual LOC is in place. A waiver provider has 25 days from the date of request to obtain and upload the annual LOC evaluation into the PAHP contractor's EHR. If this timeline is not met, the PAHP outreaches the waiver provider to obtain the LOC eval. or, help the waiver participant identify another waiver provider that they would like to work with and who will obtain the annual LOC evaluation immediately in order to move forward with service authorization and prevent any disruption to waiver services for the participant. The state is responsible for the initial LOC and state's contract with the PAHP contractor holds the Contractor and their network providers responsible for assuring completion of the annual LOC reevaluations.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

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

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

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

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

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

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

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance

to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The provision of access to waiver program information and services for people with limited English proficiency focuses specifically on targeting the program’s general information, the application process and on-going assistance to support full participation in the waiver program.

As detailed in the concurrent 1915 (b) waiver, the State will require the PAHP contractor to develop and print all program informational handbooks in English as well as any additional language spoken by approximately 6.6% or more of the potential enrollee/ enrollee population. For any language services required that are not encompassed in this 6.6% language prevalence metric, the State currently holds a contract with Passport to Languages through whom written translation and oral interpretation services are available to all Medicaid clients (including waiver clients), upon request.

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

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Other Service	Youth and Family Training and Support		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Youth and Family Training and Support

HCBS Taxonomy:

Category 1:

13 Participant Training

Sub-Category 1:

13010 participant training

Category 2:

09 Caregiver Support

Sub-Category 2:

09020 caregiver counseling and/or training

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

[Empty rectangular box]

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Training, services, and activities specifically identified in the POC that support and enhance the youth's/enrollee's overall service goals.

These services are provided in an individual or group setting and may include, but are not limited to:

- Skill development and training to support appropriate social interaction;
- Skill development and training to support successful family interactions;
- Intervention coaching to support the development of coping skills and techniques;
- Techniques for strength-based behavior management and/or support;
- Specific training on successfully accessing community, cultural, and recreational activities;
- Training and education directly related to helping the youth and family through objectives and action planning identified in the individualized POC;
- Providing instruction regarding health and safety issues;
- Training on waiver procedures associated with service provision and waiver responsibilities;
- Planning and/or crisis intervention training specific to the POC;
- Supporting the youth and family with the development of skills leading to better self-advocacy in the Family Care Team;
- Support with skill development related to the identification of services and resources pertinent to youth and family needs.
- Explaining and interpreting policies, procedures, and relationships that have an impact on the youth and family's ability to access services and/or
- Providing monthly reporting to the Family Care Coordinator regarding successes and challenges.
- This service may require collaboration with a qualified licensed mental health professional in service design and evaluation.

The PAHP contractor, under contract specifications with the State, will verify and attest that the Youth and Family Training and Support service is not duplicative under the State Medicaid Plan.

Services may be provided in the participant's home, provider agency location or community locations that are non-facility based. The allowable community settings include non-institutional or non-congregate or facility-based community locations to include but not limited to stores, playgrounds, activity centers and parks.

This service may not be provided in order to train paid caregivers unless the POC clearly outlines the goal for these services.

Youth and Family Training and Support services are required to be delivered by family care coordinators, family support personnel, or other staff authorized.

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

[Empty rectangular box]

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Family Care Coordinator who meets all State Plan Requirements for the provision of HFWA services
Individual	Youth Support Partner who meets all State Plan requirements for the provision of HFWA services
Individual	Family Support Partner who meets all State Plan requirements for the provision of HFWA services
Agency	Agencies who employ or contract with Family Care Coordinators, Family Support Partners, and/or Youth Support Partners

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Youth and Family Training and Support

Provider Category:

Individual

Provider Type:

Family Care Coordinator who meets all State Plan Requirements for the provision of HFWA services

Provider Qualifications

License (*specify*):

None.

Certificate (*specify*):

Bachelor’s Degree in a human service (or related) field, or two (2) years of work/personnel experience in providing direct services or linking of services for youth experiencing serious emotional disturbance (SED)

Other Standard (*specify*):

- At least 21 years of age;
- Completion of all PAHP contractor and State required training components;
- Possess a valid driver’s license, appropriate auto insurance and reliable transportation;
- CPR and First Aid Certification;
- Under contract (or other employment agreement) with the PAHP contractor for the provision of waiver services;
- Completion of all PAHP contractor and State required HFWA credentialing processes;
- Enrolled as a Wyoming Medicaid provider through the State’s Fiscal Agent; and
- Successful completion of all Central Registry and FBI/DCI background screenings.

Verification of Provider Qualifications

Entity Responsible for Verification:

PAHP Contractor, State Agency and MMIS Fiscal Agent

Frequency of Verification:

Upon enrollment with Medicaid and annually thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Youth and Family Training and Support

Provider Category:

Individual

Provider Type:

Youth Support Partner who meets all State Plan requirements for the provision of HFWA services

Provider Qualifications

License (specify):

None.

Certificate (specify):

High school diploma (or GED equivalent) with behavioral health needs or someone who has experience overcoming various systems and obstacles related to mental and behavioral health challenges.

Other Standard (specify):

- Ages 18-26;
- Completion of all PAHP contractor and State required training components;
- CPR and First Aid Certification;
- Under contract (or other employment agreement) with the PAHP contractor for the provision of waiver services;
- Completion of all PAHP contractor and State required HFWA credentialing processes;
- Enrolled as a Wyoming Medicaid provider through the State’s Fiscal Agent; and
- Successful completion of all Central Registry and FBI/DCI background screenings.

Verification of Provider Qualifications

Entity Responsible for Verification:

PAHP Contractor, State and MMIS Fiscal Agent

Frequency of Verification:

Upon enrollment with Medicaid and annually thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Youth and Family Training and Support

Provider Category:

Individual

Provider Type:

Family Support Partner who meets all State Plan requirements for the provision of HFWA services

Provider Qualifications

License (specify):

None.

Certificate (specify):

High school diploma (or GED equivalent) who is a parent or caregiver of a child with behavioral health needs or someone with two (2) years experience working closely with children with serious emotional/behavioral challenges and their families.

Other Standard (specify):

- Minimum of two (2) years experience in a behavioral health setting as a parent, client or family advocate;
- At least 21 years of age;
- Completion of all PAHP contractor and State required training components;
- Possess a valid driver’s license, appropriate auto insurance and reliable transportation;
- CPR and First Aid Certification;
- Under contract (or other employment agreement) with the PAHP contractor for the provision of waiver services;
- Completion of all PAHP contractor and State required HFWA credentialing processes;
- Enrolled as a Wyoming Medicaid provider through the State’s Fiscal Agent; and
- Successful completion of all Central Registry and FBI/DCI background screenings.

Verification of Provider Qualifications

Entity Responsible for Verification:

PAHP Contractor, State and MMIS Fiscal Agent

Frequency of Verification:

Upon enrollment with Medicaid and annually thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Youth and Family Training and Support

Provider Category:

Agency

Provider Type:

Agencies who employ or contract with Family Care Coordinators, Family Support Partners, and/or Youth Support Partners

Provider Qualifications

License (specify):

Must be under active contract with the PAHP contractor and in good standing.

Certificate *(specify):*

Family Care Coordinators: Bachelor’s Degree in a human service (or related) field, or two (2) years of work/personnel experience in providing direct services or linking of services for youth experiencing serious emotional disturbance (SED)

Family Support Partners: High school diploma (or GED equivalent) who is a parent or caregiver of a child with behavioral health needs or someone with two (2) years experience working closely with children with serious emotional/behavioral challenges and their families.

Youth Support Partners: High school diploma (or GED equivalent) with behavioral health needs or someone who has experience overcoming various systems and obstacles related to mental and behavioral health challenges.

Other Standard *(specify):*

Family Care Coordinators:

- At least 21 years of age;
- Completion of all PAHP contractor and State required training components;
- Possess a valid driver’s license, appropriate auto insurance and reliable transportation;
- CPR and First Aid Certification;
- Under contract (or other employment agreement) with the PAHP contractor for the provision of waiver services;
- Completion of all PAHP contractor and State required HFWA credentialing processes;
- Enrolled as a Wyoming Medicaid provider through the State’s Fiscal Agent; and
- Successful completion of all Central Registry and FBI/DCI background screenings.

Family Support Partners:

- Minimum of two (2) years experience in a behavioral health setting as a parent, client or family advocate;
- At least 21 years of age;
- Completion of all PAHP contractor and State required training components;
- Posses a valid driver’s license, appropriate auto insurance and reliable transportation;
- CPR and First Aid Certification;
- Under contract (or other employment agreement) with the PAHP contractor for the provision of waiver services;
- Completion of all PAHP contractor and State required HFWA credentialing processes;
- Enrolled as a Wyoming Medicaid provider through the State’s Fiscal Agent; and
- Successful completion of all Central Registry and FBI/DCI background screenings.

Youth Support Partners:

- Ages 18-26;
- Completion of all PAHP contractor and State required training components;
- CPR and First Aid Certification;
- Under contract (or other employment agreement) with the PAHP contractor for the provision of waiver services;
- Completion of all PAHP contractor and State required HFWA credentialing processes;
- Enrolled as a Wyoming Medicaid provider through the State’s Fiscal Agent; and
- Successful completion of all Central Registry and FBI/DCI background screenings.

Verification of Provider Qualifications

Entity Responsible for Verification:

PAHP Contractor and State Agency

Frequency of Verification:

Upon initial contract execution with PAHP contractor and annually thereafter.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

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

The PAHP Contractor's Family Care Coordinators are responsible for conducting case management functions with and on behalf of waiver participants.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Types of Positions for which investigations must be conducted: All waiver service providers.

Scope of Investigation: All waiver service providers must successfully complete and pass a central registry check, a Federal Bureau of Investigation (FBI)/Division of Criminal Investigation (DCI) background screening, and an Office of the Inspector General (OIG) background screening. All waiver providers are enrolled with the Medicaid Agency and monitored routinely by all screening and background evaluations conducted for all Medicaid providers.

Process for Ensuring that Mandatory Investigations have been conducted: Documentation of successful background screening/evaluations is required (contractually) of the PAHP contractor prior to executing a provider network agreement for services. Documentation of successful background screening/evaluation is also required at the time of Medicaid provider enrollment. Once enrolled with Medicaid (via the State Fiscal Agent), all waiver service providers are subject to monthly/on-going (as required per the Affordable Care Act) background screening and monitoring.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The entity responsible for maintaining the abuse registry: The Wyoming Department of Family Services (DFS), in collaboration with the Division of Criminal Investigation (DCI) maintain the abuse registry for the State of Wyoming.

Types of Positions for which abuse registry screenings must be conducted: All waiver service providers.

The Process for Ensuring Mandatory Screenings have been conducted: Documentation of successful abuse registry screening is required (contractually) of the PAHP contractor prior to executing a provider network agreement for services. Documentation of successful abuse registry screening is also required at the time of Medicaid provider enrollment. Once enrolled with Medicaid (via the State Fiscal Agent), all waiver service providers are subject to monthly/on-going (as required per the Affordable Care Act) background screening and monitoring.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Self-directed

Agency-operated

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. **Methods for Discovery: Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percentage of waiver providers that meet all initial provider credentialing and qualification requirements (total # of waiver providers that meet all provider credentialing and qualification requirements/ total # of waiver providers enrolled).

Data Source (Select one):

Other

If 'Other' is selected, specify:

PAHP Contractor Provider Data Files

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="PAHP Contractor"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percentage of waiver providers that meet all ongoing provider credentialing and qualification requirements (total number of waiver providers that continue to meet all ongoing provider credentialing and qualification requirements as specified in the approved waiver/total number of enrolled waiver providers)

Data Source (Select one):

Other

If 'Other' is selected, specify:

PAHP Contractor Provider Data Files

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="PAHP Contractor"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percentage of waiver service providers that meet all ongoing training requirements as specified in the waiver. (total # of waiver providers that meet all ongoing training requirements as specified in the waiver/ total # of waiver providers enrolled).

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample

		Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="PAHP Contractor"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

The percentage of PAHP contracted providers that receive training on abuse, neglect

and exploitation identification and reporting procedures annually as part of the re-certification process (total # of providers that receive training on abuse, neglect and exploitation identification and reporting procedures annually as part of the re-certification process/ total # of contracted providers).

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="PAHP Contractor"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="PAHP Contractor"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percentage of waiver service providers that meet all initial training requirements as specified in the waiver. (total # of waiver providers that meet all initial training requirements as specified in the waiver/ total # of waiver providers enrolled).

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="PAHP Contractor"/>	Annually	Stratified Describe Group:

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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

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

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="PAHP Contractor"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

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

No

Yes

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

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR

03/28/2024

441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

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

Reason for Compliance Review of HCB Settings

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

Summary of Compliance for CMH Waiver Settings

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

Plan for Monitoring Continued Compliance of HCB Settings

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Individual Plan of Care (IPC)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Family Care Coordinator:

- Bachelor’s Degree in a human service (or related) field, or two (2) years of work/personal experience in providing direct services or linking of services for youth experiencing serious emotional disturbance (SED);
- At least 21 years of age;
- Completion of all PAHP contractor and State required training components;
- Posses a valid driver’s license, appropriate auto insurance and reliable transportation;
- CPR and First Aid Certification;
- Under contract (or other employment agreement) with the PAHP contractor for the provision of waiver services;
- Completion of all PAHP contractor and State required HFWA credentialing processes;
- Enrolled as a Wyoming Medicaid provider through the State’s Fiscal Agent; and
- Successful completion of all Central Registry and FBI/DCI background screenings.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

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

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Youth and Family Training and Support services are required to be delivered by family care coordinators, family support partners and/or youth support partners who are trained and credentialed in delivering targeted case management services through a HFWA service delivery model. If Youth and Family Training and support services are being delivered by a Family Care Coordinator (FCC), the FCC delivering Youth and Family Training and Support services cannot be the FCC assigned to the waiver enrollee's plan of care (or rather the FCC that developed the youth's plan of care).

Families/youth are provided two forms upon enrollment that require review with their Family Care Coordinator and their signature indicating they understand the information provided. The provider chosen by the family also signs the freedom of choice form. These forms include a "freedom of choice" form and a "Family Rights and Responsibilities" form that outline freedom of choice of providers, controlling content and goals of the individual service plans, assessments, selection of services available [also in the member handbook and on the website], frequency and duration of services provided, and details regarding each enrollee and their families rights and responsibilities under the program. As well as their right to disagree with authorized services and request a review.

A Family Care Coordinator (one of many individuals responsible for monitoring the service plan implementation and participant health and welfare) MAY NOT provide other direct waiver services to the participant. However, the premise of high fidelity wraparound as a successful service delivery model is the emphasis and acknowledgment of family/youth choice when selecting Family Support and Youth Support Partners to be included in the child and family team. A Family Care Coordinator's Agency may employ credentialed and qualified Family and Youth Support Partners within the same Agency selected by the family for inclusion and participation in the youth's team and plan of care.

The state agency has safeguards in place to provide oversight and periodic evaluation of the PAHP's service plan development and authorization process as well as the direct provision of services. When an entity is responsible for the person-centered plan development as well as the provision of direct services, there is direct oversight of the process and periodic evaluation by the Agency.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process:

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

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

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

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

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

Meeting dates are set with input from the youth/family to assure their attendance and participation.

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan;

and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) who develops the plan, who participates in the process, and the timing of the plan: Once a youth has been determined eligible for the CMHW, all demographic and clinical files will be transferred to the PAHP. In addition to receiving notification via certified mail from the State program staff, the PAHP must notify a child and/or family of enrollment within two (2) working days of the final eligibility determination. The PAHP is responsible for assisting the family with provider identification and final selection. Data showing compliance with this requirement shall be included in the quarterly data report. The PAHP will demonstrate (via youth/guardian attestation or other State-approved process) each enrolled family had a free choice of any willing and contracted provider. Once selected by the family, the family care coordinator (FCC) must contact every child, youth and/or family within three (3) working days after being chosen as the FCC to arrange the first child and family team (CFT) meeting, which must be within sixty (60) days of FCC selection. The PAHP shall include specific performance data on all timeframes from initial contacts to first CFT meetings and report performance metrics to the State at least quarterly. Reports must include the date the child was enrolled, the date of FCC selection, the method of initial contact and the date of the initial CFT meeting. The PAHP must ensure the Strengths, Needs and Cultural Discovery (SNCD) assessment is completed by the FCC prior to the first CFT meeting. The FCC, under direction of the youth and youth's family, is the responsible individual for coordinating the development of the plan. The youth, the youth's family and/or legal guardian, chosen waiver service providers, family and/or youth support partners, as well as all other natural supports identified by the family are invited to participate in the development of the care plan in the CFT venue. The FCC works with the family to identify a meeting date and location based on the availability of the youth and family. Written meeting notification is sent by the FCC to members of the CFT with sufficient advance notice for team members to make arrangements to attend (approximately 2-3 weeks ahead of time). Assessments to be completed for the planning meeting (i.e. SNCD and crisis plan) are submitted to the identified stakeholders on the CFT by the FCC prior to the first meeting. By contract with the PAHP, the plan of care must be developed within sixty (60) days after the initial family contact. The FCC must hold a CFT meeting and update the plan of care at least every ninety (90) days to capture progress and modifications depending on the needs of the family. The FCC must also coordinate the scheduling of CFT meetings and emergency meetings with the entire team.

(b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status:

The initial plan of care is developed utilizing the waiver application, level of care information, eligibility assessments (CASII/ECSII or CANS), the SNCD and other assessments completed by members of the CFT specific to their area of expertise and service provision. Under contract with the State, the PAHP must ensure the CFTs and families interface with a Primary Care Physician (PCP). As part of the PCP function, the medical provider will confirm and manage Early Periodic Screening, Diagnosis, Treatment (EPSDT) requirements. The PCP and the FCC must maintain ongoing communications to ensure appropriate tracking of EPSDT requirements and coordination of care. The FCC will notify the family and CFT of Medicaid requirements including, but not limited to, EPSDT and other assessments as necessary.

Assessment needs (i.e. CANS, CASII/ECSII) for the bi-annual plan of care reviews are

identified by members of the CFT and FCC and are completed following established time lines in preparation for review and consideration during the scheduled CFT meetings.

(c) how the participant is informed of the services that are available under the waiver:

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

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

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

(e) how waiver and other services are coordinated:

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

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

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

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

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

Through periodic re-evaluations and assessments of the youth's progress toward meeting specified objectives, any significant changes in the needs of the youth

and family will be captured and the plan of care updated.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

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

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

The youth's behavioral and/or health concerns are discussed during each team meeting and the plan of care is updated to provide the youth's current status as well as any changes to the Behavior Support Plan and/or Crisis plan.

Mitigation of risk factors is addressed by the participant and team. In order to develop an overall system of both natural and provider supports, the team will evaluate the youth's and family's unique needs and circumstances to determine what situations may arise where the youth may need additional supports. The teams risk assessment and mitigation process may include crisis plans related to any identified or unexpected health/medical issues, safety issues at home, in the community, at school or work, financial issues, natural disasters, accidents, fire, flood, etc.

Appropriate contact names and telephone numbers are available in the plan as well as in a visible area in the youth's primary residence for immediate access.

Under contract with the State, the PAHP also must ensure the CFTs and families interface with a Primary Care Physician (PCP). As part of the PCP function, the medical provider will confirm and manage Early Periodic Screening, Diagnosis, Treatment (EPSDT) requirements.

Early identification of potential escalation or crisis will be documented and communicated with the PCP. If the PCP or primary behavioral health provider determines that the youth cannot be served safely in the community, consideration must be given to short-term acute psychiatric stabilization services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

A description of services available and detailed family/youth expectations for the high fidelity wraparound (HFWA) model are detailed in the PAHP contractor's Participant & Family Handbook. Once a youth has been determined eligible for the CMHW, all demographic and clinical files will be transferred to the PAHP. In addition to receiving notification via certified mail from the State program staff, the PAHP must notify a child and/or family of enrollment within two (2) working days of the final eligibility determination. The PAHP is responsible for assisting the family with provider identification and final selection. The PAHP will demonstrate (via youth/guardian attestation or other State-approved process) each enrolled family had a free choice of any willing and contracted provider. Once selected by the family, the family care coordinator (FCC) must contact every child, youth and/or family within three (3) working days after being chosen as the FCC to arrange the first child and family team (CFT) meeting, which must be within thirty (30) days of FCC selection. The PAHP shall include specific performance data on all timeframes from initial contacts to first CFT meetings and report performance metrics to the State at least quarterly. Reports must include the date the child was enrolled, the date of FCC selection, the method of initial contact and the date of the initial CFT meeting.

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The plan of care components, inclusions and exclusions (SNCD), behavioral support plan, crisis plan, EPSDT monitoring requirements, etc.) are subject to the approval of the Medicaid agency and have been approved in accordance with this requirement. The State program has access to the electronic plan of care management system housing all approved plans of care and will perform a minimum of 5% random sample quality assurance reviews of plans approved for service delivery. The State Medicaid Agency has defined the HFWA training curriculum for each provider type to be implemented by the PAHP, and contractually requires the PAHP to meet all service delivery model requirements for assured fidelity. While the PAHP is responsible for the implementation and maintenance of the service plans as established by the State, the State Medicaid Agency has defined and implemented all infrastructure and operational requirements to support the service plans as developed for each enrolled youth.

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

Service authorizations and/or adverse action notifications as a result of the concurrent review must be issued 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 PAHP justifies the need for additional information and how the extension is in the enrollee's best interest. If the PAHP 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 in he or she disagrees with the decision. If the provider indicates or the PAHP 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 PAHP must make an authorization decision and provide notice no later than three (3) working days after receipt of the request for service (plan of care). This may be extended up to fourteen (14) calendar days if the enrollee requests an extension or the PAHP justifies a need for additional information and is able to demonstrate how the extension is in the enrollee's best interest. If the PAHP's review results in an adverse action, the PAHP 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 unless the change in program eligibility was due to the youth or their guardian failing to complete the financial eligibility waiver renewal process within the specified time frame necessary to cover the lapse in eligibility in which case the Medicaid Long Term Eligibility Unit would issue a denial of Medicaid eligibility per CFR requirements and would close the case in the EMWS due to failure to timely renew which would result in a disenrollment from the waiver. The completed review of the plan of care and any comments or corrections needed are documented within the PAHP contractor's electronic plan of care management system and the plan is rolled-back to the Family Care Coordinator for appropriate revision.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

[Empty text box for specifying other schedule]

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

Medicaid agency

Operating agency

Case manager

Other

Specify:

PAHP Contractor and Family Care Coordinator

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

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

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

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

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

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

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

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

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

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

The minimum required direct, in-person contact with the youth/family guidelines in combination with the plan and service monitoring schedules allow for the identification and follow-up of problems and concerns. Input from youth and

family is solicited as part of the monitoring process and used to monitor follow-up of issues identified.

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

Under contract with the State, the PAHP (through the FCC) must ensure the CFTs and families identify their Primary Care Physician (PCP). As part of the PCP function, the medical provider will confirm and manage Early Periodic Screening, Diagnostic, and Assessment (EPSDT) services. If a primary behavioral health provider determines that the youth cannot be served safely in the community, consideration must be given to short-term acute psychiatric stabilization services.

b. Monitoring Safeguards. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

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

Each plan of care developed by the Family Care Coordinator will be submitted and reviewed by the PAHP contractor. Under contract with the State, the PAHP contractor will review each plan noting the roles and services being requested by the Family Care Coordinator. The PAHP will evaluate any potential issues with service plan implementation and/or health and welfare concerns of the participant. Any concern or significant issue identified by the PAHP contractor will be referred to the State for review and referral to the Program Integrity unit for the evaluation of necessary provider sanction, payment suspension/recovery up to and including provider enrollment suspension.

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

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

- Use of Continuous Quality Improvement: The PAHP contractor's quality management plan promotes continuous quality improvement and uses an enhanced Plan Do Study Act (PDSA) methodology with an added task "Re-measure";
- Active Children, Youth and Family Involvement: The PAHP contractor will include active participation from children, youth, families, and their advocates. The PAHP contractor will ensure that the local Quality Improvement Advisory Committees will be comprised of at least 51 percent families, children, and youth.
- Close Collaboration with the Community: The PAHP contractor will include feedback and representation from the key State agencies working with children, youth and families, such as the Department of Family Services (DFS), Department of Corrections (DOC), Department of Workforce Services (DWS), Department of Education (WDE), and the State. The PAHP contractor will use learning communities, town hall meetings at regional sites, advisory committees, the current HFWA providers, and community forums as some of the means for outreach and involvement in community programs.
- Fidelity to HFWA Principles: The PAHP contractor will ensure

that all of its operations are in line and reflective of the ten HFWA principles. The PAHP contractor will utilize a system of care (SOC) approach, initial and ongoing provider and facilitator training, active participation by children, youth and families in the service delivery process, and the use of tools such as WIFI-EZ to define and implement a program that is fully responsive to the diverse needs of the children, youth, and families who access services.

- **Integrated Information Technology Infrastructure:** The PAHP contractor will use its Quality Management Integrated Data Platform, a centralized system to collect, integrate, and manage data from various sources. This Integrated Data Platform allows the PAHP contractor to aggregate all data metrics and create a singular, comprehensive quality management process across all components of its operation and SOC.
- **Well-Defined Outcomes and Utilization Measures:** As part of its monitoring plan, the PAHP contractor will develop and use a variety of outcomes and utilization measures to ensure the quality of the services managed.
- **Formal Grievance Process:** The PAHP contractor will maintain a formal grievance process.
- **Ongoing contract monitoring performed by the State level program manager.**

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

Under contract with the State, the PAHP (through the FCC) must ensure the CFTs and families identify a Primary Care Physician (PCP). If the PCP or primary behavioral health provider determines that the youth cannot be served safely in the community, consideration must be given to short-term acute psychiatric stabilization services.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number/percent of POC that reflect participant'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 participant's assessed needs, risks, and personal goals as detailed in the clinical eligibility assessments or any other applicable evaluation provided to the CFT/total # of POCs)

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

PAHP Contractor's Plan of Care Management System

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1191 1264 1272" type="text"/>
Other Specify: <input data-bbox="408 1415 644 1460" type="text" value="PAHP Contractor"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1415 1264 1496" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1639 1264 1720" type="text"/>
	Other Specify: <input data-bbox="718 1863 954 1944" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: PAHP Contractor	Annually
	Continuously and Ongoing
	Other Specify:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Subassurance has been deleted per the March 12, 2014 CMS guidance.

Data Source (Select one):

Other

If 'Other' is selected, specify:

N/A

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number/percent of plans of care (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)

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

PAHP Contractor's Plan of Care Management System

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other	Annually	Stratified

Specify: <input type="text" value="PAHP Contractor"/>		Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

d. Sub-assurance: *Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to

analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percentage 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)

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1126 1264 1205" type="text"/>
Other Specify: <input data-bbox="408 1350 647 1391" type="text" value="PAHP Contractor"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1350 1264 1429" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1574 1264 1653" type="text"/>
	Other Specify: <input data-bbox="719 1798 954 1877" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: PAHP Contractor	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

Number and 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).

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify:	Annually	Stratified Describe Group:

PAHP Contractor		
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

Number and 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).

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for	Frequency of data	Sampling Approach
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data collection/generation <i>(check each that applies):</i>	collection/generation <i>(check each that applies):</i>	<i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="PAHP Contractor"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="PAHP Contractor"/>	Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percentage of services delivered according to the duration authorized in the plan of care (# and % of services delivered according to the duration authorized in the plan of care service plan/total # of plans)

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="PAHP Contractor"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other	

	Specify: <input style="width: 100%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text" value="PAHP Contractor"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

Number and 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).

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample

		Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="PAHP Contractor"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percentage of approved plans of care that confirm via signature or another method that the youth and/or guardian had choice of HCBS services and choice of provider offered (total # of plans of care with verification of choice included / total # of plans approved)

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="PAHP Contractor/ PAHP Contractor's Plan of Care Management System"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other	

	Specify: <input style="width: 100%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text" value="PAHP Contractor"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

Number and percentage of waiver applications with a fully executed freedom of choice statement (document) prior to approval (total # of waiver applications with a fully executed freedom of choice statement/document prior to approval/ total # of waiver applications approved).

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Medicaid Waiver System (EMWS).

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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

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

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 5px 0;">PAHP Contractor</div>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

c. Timelines

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

No

Yes

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request):*

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Individuals are notified and afforded the opportunity to request a Fair Hearing when the following occurs:

- An applicant does not meet the eligibility requirements for the waiver;
- An applicant is not provided the choice of home and community-based services as an alternative to institutional care;
- A participant is denied the service(s) of their choice or the provider(s) of their choice; or
- A participant's services are denied, suspended, reduced or terminated.

If the initial eligibility determination results in a denial, the youth and/or family are notified in writing (via certified mail) and detailed information is included on the process for requesting a Fair Hearing, in accordance with Wyoming Medicaid Rule. The person is also informed that he/she may have an attorney, relative, friend, or other spokesperson represent them at the hearing if he/she chooses. The applicant has a specified time frame to request a fair hearing in writing to the State program manager within the State Medicaid Agency.

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

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

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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

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

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

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

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

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

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

The following information shall be included in the hearing request:

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

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

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

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

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

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

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

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Critical Event and/or Incident Reporting and Management Processes are operated by the PAHP contractor, according to specific guidelines and requirements as set forth in the operational contract.

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

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

Abuse with respect to a child means inflicting or causing physical or mental injury, harm or imminent danger to the physical or mental health or welfare of a child other than by accidental means, including abandonment, excessive or unreasonable corporal punishment, malnutrition or substantial risk thereof by reason of intentional or unintentional neglect, and the commission or allowing the commission of a sexual offense against a child as defined by law (W.S. § 14-3-202.)

Per Wyoming Adult Protective Services Act (WS 35-20-103): "Any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, sexually abused, neglected, exploited, intimidated, abandoned or is committing self-neglect, shall report the information immediately..."

Under contract as a provider in the PAHP network, all waiver service providers and provider staff are required to submit critical incident reports to the PAHP contractor, State level program manager, the Wyoming Department of Family Services - Protective Services Unit, Protection & Advocacy Systems Inc., the Family Care Coordinator, the guardian as required by law, and to law enforcement if a crime may have been committed. Reports must be filed immediately after assuring the health and safety of the participant and other individuals, and include the following categories:

- Suspected abuse, including intimidation;
- Suspected Sexual abuse;
- Suspected neglect;
- Suspected self-neglect;
- Suspected self-abuse;
- Suspected abandonment;
- Suspected exploitation;
- Police involvement;
- Injuries caused by restraints, including drugs used as restraints, physical restraints, and mechanical restraints;
- Injury to the participant;
- Crime committed by a participant;
- Death; or
- Elopement.

In addition to the categories above, all waiver providers and provider staff are required to report any incidence restraint utilization within three (3) business days, using the incident reporting processes and mechanisms implemented and maintained by the PAHP contractor. The only exception to this reporting process is if the restraint is a result of suspected abuse, neglect or other re-portable category listed above. In these cases the incident must also be reported to the Wyoming Department of Family Services - Protective Services Unit (DFS), Protection & Advocacy Systems Inc., the FCC, the guardian as required by law, and to law enforcement if a crime may have been committed.

Providers filing incident reports must file them through the PAHP contractor's system using the incident reporting processes and mechanisms implemented and maintained by the PAHP contractor. Participants, guardians, and families may contact the PAHP contractor to report an incident, although they are also encouraged to report directly to the Department of Family Services Protective Services unit so DFS can gather pertinent information for their investigation. If the participant, guardian or family does not want to contact DFS, the PAHP contractor or State level program manager may file the report with DFS on their behalf.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including

how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

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

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

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

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

If criminal charges are filed against a waiver provider, the State Medicaid Agency and PAHP contractor immediately suspend the provider's contract/enrollment pending the outcome of the criminal case. If the provider is convicted, they are immediately de-certified (contracted terminated with the PAHP contractor) as a waiver provider. If criminal charges are filed against provider staff, the provider is required to immediately remove the staff from providing direct care services pending the outcome of the criminal case. DFS investigates suspected abuse, sexual abuse, neglect, exploitation, self-neglect or abandonment and has an intake and referral process when incidents are reported. DFS has the statutory authority to substantiate cases, resulting in a person being listed on the Abuse Central Registry and informs the State Medicaid Agency when a substantiation occurs involving a waiver provider or provider staff.

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

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

Upon the PAHP contractor's receipt of an incident that identifies suspected abuse, sexual abuse, neglect, exploitation, self neglect or abandonment, PAHP contractor staff contact the State level program manager, the Wyoming Department of Family Services (DFS), Protective Services

Unit to determine if DFS is going to open a case or if there is police involvement. If there is police involvement, or if DFS determines a reported incident is within their statutory authority to investigate, neither the PAHP nor the State level program manager can complete follow-up on the specific incident until the investigation is complete. The PAHP contractor will immediately follow-up with the provider if there is a potential that the participant involved in the incident and/or other participants are at risk due to the provider's non-compliance with rules, regulations and policies.

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

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department of Family Services, Protective Services unit (DFS) is responsible for overseeing and responding to critical incidents that identify suspected abuse, sexual abuse, neglect, exploitation, self-neglect, intimidation or abandonment. DFS has the authority to pursue criminal charges per Wyoming State Statute 35-20-111, which states, "any person or agency who knows or has sufficient knowledge which a prudent and cautious man in similar circumstances would have to believe that a vulnerable adult is being or has been abused, neglected, exploited, intimidated or abandoned, or is committing self-neglect, and knowingly fails to report in accordance with this act is guilty of a misdemeanor punishable by imprisonment for not more than one (1) year, a fine of not more than one thousand dollars (\$1,000.00), or both."

When a waiver provider delays reporting an incident, they are required to explain the reason for the delay in the incident report being filed. DFS reviews this information to determine if the provider knowingly failed to report the incident, and determines if further action is needed by DFS.

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

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

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

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The CMHW program is a “no restraint program” given the targeted population is youth ages 4-21. If a restraint is used, the PAHP contractor’s critical incident reporting policy is enacted and a formal report documenting the application of restraint must be submitted. This will allow the PAHP contractor to ensure immediate follow-up and/or action to address the restraint used. The PAHP contractor will initiate an investigation, corrective action, and/or any other action or sanction deemed necessary.

The PAHP contractor monitors compliance with the no restraint policy through the plan of care approval process, provider re-certification process, incident-reporting process, and complaint process. The focus of this monitoring is to ensure restraint utilization is not occurring and if it does happen, is reported immediately to the PAHP contractor.

Plan of Care Approval Process:

PAHP contractor staff review and approve each plan bi-annually, or as changes are requested by the Family Care Coordinator in collaboration with the Child and Family Team. This review includes a review of the positive behavior support plan, making note that a restraint is not included and that the plan of care is not approved if a restraint technique has been detailed in the proposed plan of care.

Provider Re-certification Process:

The re-certification process includes monitoring the incidents recorded to ensure there is no use of restraints. This monitoring includes:

- Interviews with providers and provider staff about restraint usage;
- A review of the provider’s incident reports; and
- A review of each provider’s policies and procedures on behavioral intervention techniques.

Incident and Complaint Processes:

The unauthorized use of restraints and the use of seclusion can be discovered through any number of processes listed above. If the unauthorized use of restraints is confirmed, the provider is required to immediately put safeguards in place to ensure there are no more restraints used until the team is able to evaluate the reason for the unauthorized restraint and to identify appropriate follow up actions. If the use of seclusion as a form of behavioral restraint/punishment is confirmed, the provider is notified to immediately stop the practice. The PAHP contractor will complete an onsite investigation to confirm seclusion is not being unlawfully utilized.

If a restraint incident is reported through the PAHP contractor incident reporting process or through a complaint, the PAHP will promptly investigate the provider and associated incidents within 10 business days. As applicable, a corrective action procedure will commence. Corrective action plans are due to the PAHP contractor within 15 business days if the investigation identifies concerns with health, safety or participant rights and will be due within 30 calendar days for all other concerns. The PAHP contractor must review and approve the corrective action plan and monitor its implementation. The type of monitoring completed upon implementation and immediately thereafter may include an onsite visit, request for documentation, follow-up interviews with participants, provider and/or provider staff, or additional follow-up activities initiated during the next provider re-certification. The PAHP will require the Family Care Coordinator to review and develop a stronger behavior support plan/crisis intervention plan if the current one is not sufficient in preventing the use of restraints and seclusion. If a provider is found to be non-compliant with rules, regulations or policies, including the continued utilization of unauthorized restraints, the PAHP will take all action deemed appropriate to suspend and/or terminate the provider agreement.

Safeguards for restraint usage are written into Wyoming State Statute 35-1-625 and 626, which mandate participants must be free from physical restraints and isolation except for emergency situations or when isolation or restraint is a part of a treatment program; and isolation or restraint of a participant may be used only when less restrictive measures are ineffective or not feasible for the welfare of the participant and shall be used for the shortest time possible. The Medicaid agency, under the Department of Health, is the primary agency the responsible for conducting oversight of any restraint or seclusion that fall under these statutes.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. (*Select one*):

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

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

Restrictive interventions include:

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

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

Restrictive interventions must be included in the plan of care and reviewed and approved by the participant, guardian and the PAHP contractor clinical staff. The plan of care must also include a plan to restore rights and periodic reviews of the restrictions. The PAHP contractor has specific safeguards in place concerning the use of restrictive interventions, which include:

- least restrictive measures must be attempted first; and,
- when restrictive interventions are identified in the plan of care, a positive behavior support plan must be developed that focuses on positive interventions.

Providers are required to document that the participant has been consulted regarding alternatives he or she prefers prior to the development of the behavior support plan that includes the use of restrictive interventions, when the participant can express preferences. Consent must be obtained from the person authorized to sign the plan of care and can be changed by that person in writing as well. The Family Care Coordinator will formally submit such modifications to the plan of care through the appropriate mechanisms of the PAHP contractor's electronic plan of care management system.

All restrictions of a youth's rights in the plan of care, including restrictive interventions, have to identify the following:

- 1) Why the restriction is imposed;
- 2) How it is imposed;
- 3) A plan to restore rights;
- 4) A date to review restrictions;

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

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

Providers and provider staff are required to receive participant specific training, including training on the restriction of youth rights and restrictive interventions. Providers are required to document the use of restrictive interventions as an incident following the provider's internal incident reporting policy. Analysis of the utilization of restrictive interventions occurs on the participant level, provider level and at the PAHP contractor level.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

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

Plan of Care Approval Process:

The PAHP contractor clinical staff review and approve each plan semi-annually, at minimum. This review includes a review of restrictive interventions written in the plan of care to be sure the restrictive intervention has been approved by the guardian and participant, least restrictive measures were attempted first, and a positive behavior support plan is included in the plan of care that focuses on positive interventions. Any variances from this process are reported to the State level program manager.

Provider Re-certification Process:

Providers are initially certified for one year and are required to complete a re-certification annually. The provider re-certification process includes monitoring the use of restrictive interventions to ensure that state requirements are being followed and to detect unauthorized, inappropriate or ineffective use of restrictive interventions. This monitoring includes:

- Review of provider/provider staff files to verify the provider has current training on restrictive interventions written into each participant's plan of care;
- Interviews with providers and provider staff about use of restrictive interventions to assure they are only used when necessary and are written into the participant's plan of care;
- Review of the PAHP's provider management system results of the analysis of restrictive intervention use to ensure trends are being identified and areas of concern are addressed at the provider level.

Incident and Complaint Processes:

When use of restrictive interventions is reported through incidents or complaints, the PAHP contractor reviews the participant's plan of care to ensure the use of restrictive interventions is authorized and that a positive behavior support plan and crisis intervention plan is in place and was followed. The unauthorized or inappropriate use of restrictive interventions can be uncovered through any of the processes listed above.

When this occurs the provider is required to immediately put safeguards in place to ensure there are no more restrictive interventions used until the team is able to evaluate the reason for the unauthorized restrictive intervention and to identify appropriate follow up actions.

If a provider is non-compliant with rules, regulations or policies, including the unauthorized use of restrictive interventions, the provider is required to submit a corrective action plan that identifies the area of noncompliance, the action steps to be taken by the provider to address the non-compliance, the time frame for addressing each action step, and the responsible party for each action step. Corrective Action plans are due to the PAHP contractor within 15 business days if the recommendation identifies concerns with health, safety or participant rights and within 30 calendar days for all other concerns. The PAHP contractor must review and approve the corrective action plan, and monitor implementation of the plan. The type of monitoring

completed on the implementation of the corrective action plan may include an on-site visit, request for documentation, follow-up interviews with participants, provider and/or provider staff, or follow-up during the next provider re-certification. The PAHP contractor will collect and report data on restraints and restrictive interventions to the State level program manager on a quarterly basis.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. (Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to

WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The CMHW program is a “no restraint or seclusion program” given the targeted population is youth ages 4-21. If a restraint or seclusion is used, the PAHP contractor’s critical incident reporting policy is enacted and a formal report documenting the application of restraint or use of seclusion must be submitted. This will allow the PAHP contractor to ensure immediate follow-up and/or action to address the seclusion technique used. The PAHP contractor will initiate an investigation, corrective action, and/or any other action or sanction deemed necessary.

The PAHP contractor monitors compliance with the no restraint or seclusion policy through the plan of care approval process, provider re-certification process, incident-reporting process, and complaint process. The focus of this monitoring is to ensure restraint and/or seclusion utilization is not occurring and if it does happen, is reported immediately to the PAHP contractor.

Plan of Care Approval Process:

PAHP contractor staff review and approve each plan bi-annually, or as changes are requested by the Family Care Coordinator in collaboration with the Child and Family Team. This review includes a review of the positive behavior support plan, making note that a restraint and/or seclusion is not included and that the plan of care is not approved if a restraint and/or seclusion technique has been detailed in the proposed plan of care.

Provider Re-certification Process:

The re-certification process includes monitoring the incidents recorded to ensure there is no use of restraints or seclusion techniques. This monitoring includes:

- Interviews with providers and provider staff about restraint usage;
- A review of the provider’s incident reports; and
- A review of each provider’s policies and procedures on behavioral intervention techniques.

Incident and Complaint Processes:

The unauthorized use of restraints and/or seclusion can be discovered through any number of processes listed above. If the unauthorized use of restraints or seclusion is confirmed, the provider is required to immediately put safeguards in place to ensure there are no more restraints used until the team is able to evaluate the reason for the unauthorized restraint and/or seclusion and to identify appropriate follow up actions. If the use of seclusion as a form of behavioral restraint/ punishment is confirmed, the provider is notified to immediately stop the practice. The PAHP contractor will complete an onsite investigation to confirm seclusion is not being unlawfully utilized.

If a restraint or seclusion incident is reported through the PAHP contractor incident reporting process or through a complaint, the PAHP will promptly investigate the provider and associated incidents within 10 business days. As applicable, a corrective action procedure will commence. Corrective action plans are due to the PAHP contractor within 15 business days if the investigation identifies concerns with health, safety or participant rights and will be due within 30 calendar days for all other concerns. The PAHP contractor must review and approve the corrective action plan and monitor its implementation. The type of monitoring completed upon implementation and immediately thereafter may include an onsite visit, request for documentation, follow-up interviews with participants, provider and/or provider staff, or additional follow-up activities initiated during the next provider re-certification. The PAHP will require the Family Care Coordinator to review and develop a stronger behavior support plan/crisis intervention plan if the current one is not sufficient in preventing the use of restraints and/or seclusion. If a provider is found to be non-compliant with rules, regulations or policies, including the continued utilization of unauthorized restraints, the PAHP will take all action deemed appropriate to suspend and/or terminate the provider agreement.

Safeguards for seclusion usage are written into Wyoming State Statute 35-1-626, which mandate participants must be free from isolation or restraint except for emergency situations or when isolation or restraint is a part of a treatment program; and isolation or restraint of a participant may be used only when less restrictive measures are ineffective or not feasible for the welfare of the participant and shall be used for the shortest time possible. The state Medicaid Agency, under the Department of Health is the primary agency responsible for conducting oversight of any seclusion that fall under the statute.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are

available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

No. This Appendix is not applicable (*do not complete the remaining items*)

Yes. This Appendix applies (*complete the remaining items*)

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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

Not applicable. (*do not complete the remaining items*)

Waiver providers are responsible for the administration of medications to waiver participants who

cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the state:

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and 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)

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">PAHP contractor</div>	Annually	Stratified Describe Group:

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

Data Aggregation and Analysis:

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

Performance Measure:

The percentage of incidents regarding abuse, neglect, exploitation and unexplained death that were addressed according to both the state statute and the approved waiver (# of abuse, neglect, exploitation, and unexplained death incidents addressed according to both the state statute and the approved waiver / # incidents received)

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for	Frequency of data	Sampling Approach
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data collection/generation <i>(check each that applies):</i>	collection/generation <i>(check each that applies):</i>	<i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="PAHP Contractor"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="PAHP Contractor"/>	Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number/percent of waiver participants (or families/legal guardians) who received training and education on how to identify and report abuse, neglect, exploitation and unexplained death (The number of waiver participants (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).

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="PAHP Contractor"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>

	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/> PAHP Contractor	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

b. Sub-assurance: *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The number and percent of critical incidents where the root cause was identified (number of critical incidents where the root cause was identified/number of critical incidents received).

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="PAHP Contractor"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="text" value="PAHP Contractor"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

and % of unauthorized restraints and restrictive interventions, including seclusion, addressed according to the process in the approved waiver (# and % of unauthorized restraints and restrictive interventions, including seclusion, addressed according to the process in the approved waiver/total # of reported restraints, incidents involving seclusion, and unauthorized restrictive interventions)

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		<input type="text"/>
Other Specify: <input type="text" value="PAHP Contractor"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The percentage of participants who have identified a Primary Care Provider (PCP) by submission of their first plan of care for authorization. (# of participants with an identified PCP at first POC authorization/# of youth enrolled in the waiver program)

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="PAHP Contractor"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text" value="PAHP Contractor"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 30px;" type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The PAHP contractor's critical incident form directs network providers to submit incident reports to the PAHP and the state CMHW program manager for review and follow up. Most critical incidents are straight forward, however, some issues identified are more complex and require additional review by the clinical team and other stakeholders involved with the youth which may include DFS. The PAHP's provider training and program procedures call for the Family Care Coordinator to review the current crisis plan and plan of care to address any needed changes or addition of supports required to prevent further incidents. Critical incidents are reviewed individually and in aggregate to detect trends by provider, youth served, geographic area or any other notable characteristics that can assist the PAHP and the network provider to assist the youth and their family avoid or manage issues that may lead to a critical incident report. The PAHP's quarterly reports track incidents over the quarter and YTD. Additional training by the PAHP on critical incident reporting has led to a modest increase in reports.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Critical incidents are reported to the PAHP contractor. The incident reports are recorded in the PAHP contractor’s electronic plan of care management system. All providers are also required to send a copy of the critical incident to the guardian, Family Care Coordinator, DFS, and Protection and Advocacy (as required by law). PAHP contractor staffs are responsible for assigning a category to the incident depending on the severity and what it entails. DFS reviews all critical incidents that are filed and complete full investigations when it is suspected that abuse, neglect, or exploitation might have occurred, or when restriction of rights might have been violated. The PAHP provides training to network providers on the state's child protective statute (Title 14) as part of the abuse, exploitation & neglect training.

Providers are also required to report to the PAHP contractor any restraint that results in an injury using the same process as used for the initial incident report submission. Injuries that are a result of a restraint must also be reported to DFS, the guardian, and the FCC. If a restraint is used on a participant that does not result in an injury, it still must be reported to the PAHP contractor, but does not need to be reported to DFS. This includes any emergency restraints that are used on a participant. PAHP contractor staff are responsible for reviewing all restraint utilization to ensure provider compliance.

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

De-certifying the provider, requiring additional training, imposing civil monetary penalties, and/or imposing a monitor within the provider organization. When providers receive a recommendation, which can occur through the re-certification process, complaint process, or incident reporting process, the information is entered into the PAHP contractor’s electronic plan of care management system. The PAHP contractor will track and monitor the status of all corrective action plans.

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="320 1697 743 1742" type="text" value="PAHP Contractor"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="815 1966 1238 2047" type="text"/>

c. Timelines

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

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able

to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i.** Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

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

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

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

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

Accreditation for Non-Duplication:

- Applicable program: PAHP
- Personnel: State
- Description: If the PAHP selected through the competitive procurement meets NCQA, URAC, JCAHO, CARF, or COA standards for accreditation, the state will deem that the state-specific standards required in 42 CFR 43 Subpart D are met.
- Frequency: Once, initial contracting
- Information: Accreditation information is used to monitor the following: timely access, provider selection, and quality of care.

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

Consumer Self-Report Data:

- Personnel: State and PAHP
- Description: The State will conduct a consumer satisfaction survey for its enrolled population.
- Frequency: Annually. A random sample for each survey is drawn from Medicaid enrollees who received a covered service in the previous year.
- Information: The survey information is used to monitor the following: disenrollment, timely access, information to beneficiaries, and quality of care.

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

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

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

- Personnel: State and PAHP
- Description: The PAHP is required to track disenrollment requests by enrollee from the plan, denials or referral requests, and grievance and appeals data. This data is included in a quarterly report from the PAHP to the State.
- Frequency: Quarterly.
- Information: The data is used to monitor the following: quality of care, enrollment/disenrollment, coordination/continuity, coverage/authorization and grievances

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

Enrollee Hotlines operated by PAHP:

- Personnel: PAHP and State
- Description: The PAHP is required to have staff available by 800 number 24 hours a day/365 days a year to respond to enrollee calls. Interpreter services are available for the hearing impaired and for non-English speakers. The 800 number is printed in the enrollee benefit book and associated materials. The 800 number shall include telephone crisis intervention, risk assessment, and consultation to callers which may include family members or other community agencies regarding behavioral health services.
- Frequency: 24 hours a day, every day.
- Information: The 800 number is used to monitor the following: information to beneficiaries, grievance, timely access, coordination/continuity, and quality of care

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

Geographic Mapping of Provider Network:

- Personnel: PAHP
- Description: Through geographic mapping, distribution of provider types across the state is identified.
- Frequency: Quarterly.
- Information: Geographic mapping information is used to monitor marketing, information to beneficiaries, PCP/Specialist Capacity, choice, timely access, coordination/continuity, coverage/authorization, quality of care and Provider Selection. Referral and subsequent enrollment patterns can be mapped to ensure appropriate marketing in all geographic areas.

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

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

- Personnel: An independent third party will be contracted to perform this activity/audit.
- Description: The State will hire an independent assessor to assess quality of care, access to services, and cost-effectiveness of this new HFWA delivery system as required by the waiver.
- Frequency: One time per waiver period for the first two renewal cycles.
- Information: The independent assessment will be used to monitor timely access and quality of care.

The assessment is used to monitor the above topics. The data collected is used to 1) analyze the effectiveness of the new program; 2) develop a quantitative understanding of access to the new behavioral health care service delivery system; 3) identify needs for further contracting; and/or 4) identify processes and areas of quality of care for detained study through on-going performance measures. The analysis is part of the PAHP's evaluation. The

State discusses the findings to identify opportunities for improvement and if deficiencies are noted the Contractor must perform corrective action until compliance is met.

Disparities by Racial or Ethnic Groups:

- Personnel: PAHP
- Description: The PAHP is required to report demographic data (including racial/ethnic data), outcomes measures, utilization and special needs population (target population) data to the State.
- Frequency: Annually.
- Information: The measurement of any disparities by racial or ethnic groups will be used to monitor timely access and coverage and authorization of care.

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

Network Adequacy Assurance Submitted by Plan (PAHP):

- Personnel: PAHP
- Description: The PAHP submits documentation to the State that it offers an appropriate range of services that is adequate for the anticipated number of enrollees and maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the enrollees.
- Frequency: Quarterly.
- Information: Network

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

Performance Measures:

- Personnel: PAHP And State
- Description: The State has established a comprehensive list of performance measures, entitled Startup Requirements, Operational Requirements, and Outcome Measurement and Credits.
- Frequency: The performance measures are reported on quarterly, or as otherwise stated in the Requirements.
- Information: The performance measures provide information on all listed categories.

Data on performance measures is reported to the State quarterly or as otherwise listed in the Requirements. The quarterly reports to the State aid in the identification of opportunities for quality improvement and the assessment of initiative effectiveness. The contract also establishes expectation around continuous quality improvement that includes participating in the development of measures of performance and collecting and reporting baseline data on identified performance indicators, and development and implementation of improvement plans. The results are reported to the State and the State discusses the findings and identifies opportunities for improvements. In addition, this information aids in the assessment of the effectiveness of the quality improvement process. The data from all sources is analyzed for compliance. The identified aspects are integrated into the implementation of continuous quality improvement processes.

Utilization Review:

- Personnel: PAHP
- Description: The PAHP conducts a statistically valid sample review. The Contractor shall perform ongoing monitoring of UM data, on site review results, and claims data review. The designated IT staff will review the Contractor's utilization review process
- Frequency: Utilization reviews occur at intervals, first within the initial treatment period and then regularly thereafter. Data related to the utilization review are reported to the State and reviewed annually at minimum.
- Information: Utilization management data can be used to monitor program integrity, choice, marketing,

enrollment/disenrollment, timely access, coordination/continuity, provider selection, quality of care and coverage/authorization.

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

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
<p>Other Specify:</p> <div style="border: 1px solid black; padding: 2px; width: fit-content;">PAHP Contractor</div>	<p>Other Specify:</p> <div style="border: 1px solid black; padding: 2px;">Various - Specific frequencies are noted for each assessment method.</div>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

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

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

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

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

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

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

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

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

Wraparound Fidelity Index, Short Version (WFI-EZ). The Wraparound Fidelity Index, short form (WFI-EZ) is a brief, survey which can be completed on paper or telephonically. The survey takes approximately 10 minutes to complete and respondents answer questions in three categories: Experience in Wraparound, Outcomes, and Satisfaction. Data result in quantitative summaries of fidelity, satisfaction, and outcomes.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

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

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

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

Medicaid's Program Integrity Unit reviews a random statistically valid sample of provider waiver claims. Samples are selected at the ninety-five percent (95%) confidence level with a +/-5% confidence interval. The sampling method, including the size of the sample, the selection of the samples and any extrapolation from the results of the sample, shall be in accordance with Department approved statistical procedures in accordance with Generally Accepted Auditing Standards (GAAS) and Statement on Accounting Standards (SAS). The auditing of claims is done by random selection as well as targeted claims which meet certain criteria. The auditing process is done on a periodic basis for utilization review and quality assurance purposes. The Wyoming policies for Medicaid's Program Integrity Unit are outlined in Wyoming Medicaid Rule, Chapter 16. Medicaid also participates in the Payment Error Reporting Measurement (PERM) program to ensure accuracy of the claims reimbursement process. Providers are required to submit all documentation of services within an identified time period. If it is found that documentation is not complete, re-education or recoveries will be completed. Any concerns with documentation are reported to the Division's Program Integrity Unit. The Program Integrity Unit, in collaboration with the PAHP contractor, determines the appropriate response to the documentation concerns, which can include re-education of the provider, recovery of funds, and/or referral to the Medicaid Fraud Control Unit. The Program Integrity Unit may conduct a post payment review of all claims submitted by the provider for six (6) years from the paid date under the following conditions: (i) Complaints; 16-14 (ii) Investigations; (iii) Medicaid program compliance; or (iv) Violation of Medicaid, Department, or other state or federal statute, rule, or law relating to provisions of services. The Program Integrity Unit also reserves the right to conduct pre-payment review. Onsite reviews may be conducted by either or both Program Integrity and the MFCU if it is believed that the onsite review is the best way to obtain sufficient evidence that can be developed to support the recovery of overpayments, the imposition of sanctions or any other civil or criminal action permitted by law.

The Medicaid Program Integrity Unit has an electronic referral process in place to receive potential fraud, waste, and abuse referrals from: Medicaid Programs, third party vendors that are contracted with the State agency, and the general public. The Program Integrity Unit also manages the fraud hotline. A designated individual is tasked with receiving and conducting an initial interview to ascertain the pertinent information. If an error is identified, it is reported directly to the Medicaid Program Integrity through the above identified channels. Program Integrity then coordinates with MFCU and

other fraud, waste, and abuse agencies as necessary. Programmatic errors are discussed within the State Medicaid Agency via regularly occurring coordination meetings between the units tasked with oversight. If data analysis or a review conducted by the Program Integrity Unit results in a determination that there is a credible allegation of fraud, the Program Integrity will refer to the Medicaid Fraud Control Unit (MFCU) or other law enforcement agency for investigation. MFCU may institute criminal or civil cases against a provider. In accordance with 42 CFR §455.23, Medicaid payments may be suspended while credible allegations of fraud are investigated.

In addition, the State agency coordinates and collaboratively executes the beneficiary verifications (EOMBs) process. The data analytics personnel within Program Integrity creates an annual schedule for the mailing of EOMBs. This is done through the evaluation of category of service and expenditure. The EOMB pull by COS may include CMHW youth and may not depending on the COS-related criteria and PI focus. Each month a total of 500 EOMBs are submitted to beneficiaries. The results of the EOMBs are received by the contracted fiscal agent and if issues are identified the fiscal agent initiates contact with the State agency to take action on and investigate the identified issue. The State agency tracks the number of EOMBs that receive responses from beneficiaries and the average return rate is approx. 50 % year. There have been no issues noted or cases generated related to waiver service expenditures. Waiver claims are included in the Explanation of Medical Benefits (EOMB) sample sent to participants. This random sample of participants requests the participant verify that the services listed on the EOMB were actually received by them. Responses to the EOMB that indicate services were not received are reviewed by the Program Integrity Unit. Waiver claims are included in the Explanation of Medical Benefits (EOMB) sample sent to participants. This random sample of participants requests the participant verify that the services listed on the EOMB were actually received by them. Responses to the EOMB that indicate services were not received are reviewed by the Program Integrity Unit.

The PAHP contractor provider network manager and staff will complete periodic documentation reviews for each provider. Results of the documentation reviewed are recorded in the PAHP contractor's electronic provider management system. If concerns are found, the issues and concerns are recorded in the PAHP contractor's electronic provider management system as needed. The PAHP's onsite visits and reviews of their provider network may include, but are not limited to:

- Examination of records;
- Interviews of providers, associates, and employees;
- Interviews of program clients;
- Verification of the professional credentials of providers, their associates, and their employees;
- Examination of any equipment, stock, materials and other items used in or for the treatment of clients in the program;
- Audit of provider or agency financial records for reimbursement;
- Determination of whether the health care provided is medically necessary; and/or
- Random sampling of invoices submitted by and payments made to providers.

Rules outlining Wyoming's required oversight are found in Chapters 3, 4, 16 and 47 of the Department of Health's Medicaid Rules.

Title XIX of the Social Security Act, federal regulations, the Wyoming Medicaid State Plan, state regulations, and contracts establish record maintenance and retention requirements for Medicaid services. Providers must maintain files for each waiver participant, and are required to retain records that document the services provided and support the claims submitted for a period of six years. Records must be maintained for a minimum of six years, and records must be maintained longer than six years as required to resolve any pending matters such as an ongoing audit or litigation.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
 (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of claims that are coded and paid for in accordance with the reimbursement methodology approved in the waiver and only for services rendered (# of claims submitted and paid according to the reimbursement methodology in the approved waiver and only for services rendered / total # of claims paid)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid MMIS, COGNOS DSS and provider progress notes.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">95% +/- 5%</div>
Other <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<i>Annually</i>	<i>Stratified</i> <i>Describe Group:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<i>Continuously and Ongoing</i>	<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of provider payment rates that are consistent with rate methodology approved in the original waiver application or subsequent amendment (# of payments consistent with approved waiver rate methodology / total # of claims paid)

Data Source (Select one):

Other

If 'Other' is selected, specify:
MMIS and COGNOS DSS

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> Confidence Interval = <input type="text" value="95% +/- 5%"/>
<i>Other Specify:</i> <input type="text"/>	<i>Annually</i>	<i>Stratified Describe Group:</i> <input type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other Specify:</i> <input type="text"/>
	<i>Other Specify:</i> <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other Specify:</i>	<i>Annually</i>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/>	
	Continuously and Ongoing
	Other Specify: <input type="checkbox"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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

<i>Responsible Party</i> (check each that applies):	<i>Frequency of data aggregation and analysis</i> (check each that applies):
	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>

c. Timelines

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

No

Yes

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rate Setting Method:

The SMA, WDH HCF, calculated new reimbursement rates in SFY23. The SMA identified appropriate hourly wages using information from the Bureau of Labor Statistic (BLS and the Occupational Employment and Wage Statistics (OEWS) for Wyoming. Wages were then adjusted based off of employee benefits, supervisory codes, administrative and overhead costs, program support costs, transportation costs, and a productivity adjustment. The rate review was conducted by a consulting firm and oversight was conducted by WDH HCFS.

The SMA took SFY2022 CME unit counts by procedure codes to identify the rate increase and change. For Family Youth and Family Training Support services, the new rate identified for SFY24 is \$14.68, a \$0.64, or 0.5% increase from the previous rate.

Assumptions & Adjustments

-For youth and family and training there were several assumptions, including: Wages were based on a 67/33% split between the median wages for Child, Family, and School Social Workers and Social and Human Service Assistants.
-The weighted wage used to trend data used BLS CES increases for child and youth service personnel. Employee benefits, administrative overhead costs, program support costs, and productivity adjustments were drawn from the Comprehensive and Supports Waiver Rate Study. Supervisory time utilized was based on interview data.
-For transportation, the cost portion was based on the IRS mileage reimbursement rate and the distance portion assumes two patient visits a month for 8 patients that travel an average of 40MPH for two hours.

The last rate review was conducted in SFY18. Reviews are conducted every 5 years.

For more detail regarding the public input process for this amendment please refer to the Main Section 6-1.

Notifying the public:

Information on payment rates are available to participants as part of the regular team meetings, are posted on the Division's website, and are available upon request.

Wyoming plans to conduct public notice of the rate review during the public notice of this drafted waiver. The rates will implement with the approval of this waiver. Rates will be made available online.

Public Input Process (as described in Main section 6-1):

All federally recognized tribes as well as the general public in the State of Wyoming were notified of this waiver amendment and have had the opportunity to review and comment on the waiver amendments proposed pursuant to organization change and the error regarding service frequency.

There were no attendees at the calls and no questions submitted to the Division. The notice was sent to the state's designated tribal entities for tribal consultation, posted online on the Medicaid website [<https://health.wyo.gov/healthcarefin/medicaid/> ("Provider Information-Updates" section)], and available at the agency for public viewing. The public notice advises that hard and electronic copies of the waiver amendment are available by contacting the state program manager by phone, email, or in-person at the agency's address. There were no questions or comments received during the public notice period.

The Department intends to continue with appropriate and periodic consultation with the Tribal Health Directors, Tribal Health System and Public Health Authority and Business Council members as the program continues to move forward.

Rate Increases:

The increase in the proposed rate for Youth and Family Training and Support will also be applied to the program's peer support provider rate to remain consistent with provisions of §1902(a)(30)(A) to pay peer support providers a similar rate under either concurrent waiver authority.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The PAHP contractor's network providers submit proposed plans of care to the PAHP contractor for review and service authorization. The PAHP contractor is required to screen the authorization request data received from network providers for completeness, logic, and consistency with the goals identified in plan of care and waiver requirements. The PAHP contractor responds to the network provider's authorization request with a prior authorization number that the network provider will place on the professional service claims submitted to the State's MMIS claims system. The PAHP contractor transmits service authorization data to the state's fiscal agent/MMIS to be applied to post-service waiver claims submitted. PAHP network providers submit post-service claims to the MMIS for payment. Once the PAHP network provider submits a claim, the claim enters the MMIS and is processed through the claims adjudication cycle, which includes all edits and audits. The claim reimbursement is made directly to the PAHP network provider.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All service requests are reviewed and authorized by the PAHP contractor's clinical staff, who review the services requested, plan of care objectives developed, the requested service amount, and the duration and frequency of each service proposed. The PAHP contractor clinical staff specialist verifies the provider is certified for the requested service and that the services requested do not exceed the specified methodology. All services must receive authorization (via the plan of care approval). All billing for waiver services will be done by the PAHP contractor and submitted electronically through MMIS. All payments will be rendered through the same system. There are many edits built into the MMIS that do not allow payment for restricted services and amounts above those included in the contractual agreement between the State and the PAHP contractor. System edits include service codes with set rates, limits on number of days that can be billed in a month, number of hours that can be billed in a day, and other time specific rules which limit the amount of services that can be billed. Since all claims are submitted electronically the MMIS utilizes edits to assure that payments never exceed authorized/contracted amounts. An individual must be an active Medicaid recipient enrolled in the CMH Waiver program in order for services to be processed and paid for. This assurance is an integral component managed by the Wyoming Medicaid Management Information System (MMIS). The MMIS requires an individual to be:

- Enrolled in Medicaid
- Enrolled in a Waiver program (in this case, the CMH Waiver program).

Additional checks regarding services rendered, including appropriate provider type, no duplicate claims submitted, etc. are also performed. The Wyoming Claims Processing Subsystem uses a Recipient Master File to verify recipient eligibility for services billed by a provider. Once an individual becomes eligible for services, the participant's eligibility information is updated in the MMIS. Only services in the client's plan will be covered based on limits established. The MMIS posts exceptions if a recipient is not eligible on the service date or is restricted from the service (as indicated in the service restrictions on the Recipient Master File). Service restrictions may include restricting the recipient to a particular provider for treatment or placing the recipient on review. The MMIS checks other service limitations by referencing recipient Medicaid eligibility and by various benefit plan specific limits established by the Utilization Review (UR) Criteria File. Each claim processed by the Wyoming Claims Processing cycle (regardless of the entry method) has to pass the provider eligibility edit module. The Provider Master File verifies that the provider is actively enrolled and licensed according to the benefit plan for the category of service and dates of service. It also verifies any special restrictions for the provider for the service date on the claim. For each test that fails, the MMIS posts an exception code. The claim is adjudicated according to the exception disposition codes maintained on the Exception Control File. The Claims Processing Subsystem also uses several edits to verify the reasonableness of provider charges. First the system performs internal balancing of claim charges. Second, the system edits and checks each service charge against pricing information on the reference files. Medicaid determines the disposition of the exception codes posting to claims and the system maintains this information on line in the Exception Code File. The Claims Processing Subsystem has the capability of allowing the force payment of services on an exceptional basis, as directed in writing by Medicaid. Through the life of a claim, the system retains in the claim record all exception codes posting to the claim, the adjudication ID of the person who forced or denied any exceptions to the claim, and the date and adjudication ID of the last person who worked on the claim. These features provide an audit trail to support the claim's payment process.

In addition, the state ensured services were actually rendered by:

- EOB review process;
- CME review of documentation submitted to their system before passing the claim to the state's fiscal agent for processing; and,
- State staff performs a sample review of claims and their supporting documentation.

Any payments made that are deemed incorrect are recouped through claim adjustments on either an individual or mass scale. Per the current PAHP contract, the PAHP has 60 days to identify needed adjustments and return the funds to the state through a credit balance process or payment to the state for the identified over-payment.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements

under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly

expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the

waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	843.07	7743.78	8586.85	42030.28	41136.00	83166.28	74579.43
2	843.07	7743.78	8586.85	42030.28	41959.00	83989.28	75402.43
3	843.07	7743.78	8586.85	42030.28	42798.00	84828.28	76241.43
4	843.07	7743.78	8586.85	42030.28	43654.00	85684.28	77097.43
5	843.07	7743.78	8586.85	42030.28	44527.00	86557.28	77970.43

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Hospital	
Year 1	135		135
Year 2	135		135
Year 3	135		135
Year 4	135		135
Year 5	135		135

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The state used SFY23 LOS utilization to calculate the average length of stay. The average length of stay estimate is calculated by taking the total number of days waiver recipients received waiver coverage during the waiver year divided by the number of unduplicated recipient count. Total days of waiver coverage = last-date-of-service - first-date-of-service + 1. If a recipient becomes institutionalized during the time of waiver coverage, those days are excluded from the calculation. Based on SFY2023 claims, the number of participants that received reimbursable services was 114. The average length of stay reported in the SFY 2024 claims, based upon reports generated from the Medicaid Management Information System (MMIS), which is the report used to complete the CMS-372 is 199 days [22,630 total days of waiver coverage/114 participants=198.51]. The SFY-2023 MMIS data will be used for each year of the waiver.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D is calculated using:

1) Estimated number of users:

The estimated number of unduplicated users in the waiver is 135 for all waiver years. This estimate reflects the maximum number of unduplicated participants for each waiver year, and it is a historical number used in this waiver.

2) Estimated number of units per user:

For the original Waiver Year 1 estimated number of units of services (taking into account ALOS)- SFY23 MMIS claims data report ALOS-199 days/365 days=0.55; 0.55×57 service units=31 service units per waiver user/per year. This calculation assumes that the length of stay continues to be 199 days per participant. Based on the projected service utilization above, if a participant utilized Youth and Family Training and Support services for 365 days, the average number of units per waiver user/per year would be 57 units. The estimate of 57 units of service is based on a historical derivation of the number of units utilized for this service, and it mirrors the assumption used in the previous waiver amendment (WY.0451.R03.05).

3) Estimated cost per unit:

Waiver Year One Youth and Family Training and Support services were paid at \$14.68 per fifteen-minute unit. This cost per unit was increased by 5% from the previous waiver amendment (WY.0451.R03.05) informed by the results of a comprehensive rate study conducted in 2023. The change in unit cost in turn impacts increases in Factor D estimates from the previous waiver amendment. Factor D is estimated to remain constant across all waiver years, and the State will continue to monitor the rate and implementation of the rate over the waiver renewal period to respond to warranted changes.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' is estimated using:

1) SFY23 MMIS Claims Data was used to estimate Factor D', annual average per capita expenditures for all other services (state plan and services required under EPSDT) provided to waiver participants is \$7,743.78. This calculation includes institutional costs when a youth leaves the waiver for the institution and returns to the waiver in the same waiver year. Estimating Factor D' using the same average per capita expenditure amount from the SFY23 report and applying the estimated increase in waiver participants, it is projected that Factor D' would remain the same between waiver years.

Factor D' is lower than Factor G' due to the population served which is young and medically stable and traditionally have had lower utilization of state plan services than other Medicaid HCBS waiver populations served (IDD, long term care, etc.). The main cost driver for this waiver's population come from utilization of inpatient psychiatric stabilization and PRTF service vs. other special health care conditions that require high utilization of state plan medical services.

The prescribed drugs furnished to Medicare/Medicaid dual eligible participants under the provisions of Part D are not processed through the State's MMIS and are therefore excluded from the MMIS reporting and from Factor D'.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Factor G value must reflect the average per capita cost for the level(s) of institutional care that would otherwise be furnished to waiver participants.

Factor G expenditures reported in the SFY 2023 claims data are: \$42,030.28.

Expenditures for institutional care for the level of care served by the waivers had been steadily decreasing but more recent PRTF utilization data indicates a recent slight upward trend and the state's utilization management contractor is actively working an improvement process that is anticipated to level the slight upward trend. Given these variables, the state will use the same estimated cost from SFY23 with no estimated increase.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' includes the average per capita cost of all other Medicaid services furnished while the individual is institutionalized (including State plan and expanded EPSDT services) and the cost of short term hospitalization (furnished with the expectation that the person would return to the institution).

Factor G' expenditures reported in the SFY 2023 claims are: \$ 41136. Expenditures for Factor G' are trending up 2% each year, based off the trend identified in the claims data, Factor G' is anticipated to continue this trend.

The prescribed drugs furnished to Medicare/Medicaid dual eligible participants under the provisions of Part D are not processed through the State's MMIS and are therefore excluded from the MMIS reporting and from Factor G'.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.

Waiver Services	
Youth and Family Training and Support	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Youth and Family Training and Support Total:							113814.77
Youth and Family Training and		15 minute unit	135	57.43	14.68	113814.77	
GRAND TOTAL:							113814.77
Total: Services included in capitation:							
Total: Services not included in capitation:							113814.77
Total Estimated Unduplicated Participants:							135
Factor D (Divide total by number of participants):							843.07
Services included in capitation:							
Services not included in capitation:							843.07
Average Length of Stay on the Waiver:							199

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support							
GRAND TOTAL:							113814.77
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							113814.77
<i>Total Estimated Unduplicated Participants:</i>							135
<i>Factor D (Divide total by number of participants):</i>							843.07
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							843.07
<i>Average Length of Stay on the Waiver:</i>							199

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Youth and Family Training and Support Total:							113814.77
Youth and Family Training and Support		15 minute unit	135	57.43	14.68	113814.77	
GRAND TOTAL:							113814.77
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							113814.77
<i>Total Estimated Unduplicated Participants:</i>							135
<i>Factor D (Divide total by number of participants):</i>							843.07
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							843.07
<i>Average Length of Stay on the Waiver:</i>							199

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Youth and Family Training and Support Total:							113814.77
Youth and Family Training and Support		15 minute unit	135	57.43	14.68	113814.77	
GRAND TOTAL:							113814.77
Total: Services included in capitation:							
Total: Services not included in capitation:							113814.77
Total Estimated Unduplicated Participants:							135
Factor D (Divide total by number of participants):							843.07
Services included in capitation:							
Services not included in capitation:							843.07
Average Length of Stay on the Waiver:							199

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Youth and Family Training and Support Total:							113814.77
Youth and Family Training and Support		15 minute unit	135	57.43	14.68	113814.77	
GRAND TOTAL:							113814.77
Total: Services included in capitation:							
Total: Services not included in capitation:							113814.77
Total Estimated Unduplicated Participants:							135
Factor D (Divide total by number of participants):							843.07
Services included in capitation:							
Services not included in capitation:							843.07
Average Length of Stay on the Waiver:							199

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Youth and Family Training and Support Total:							113814.77
Youth and Family Training and Support	<input type="checkbox"/>	15 minute unit	135	57.43	14.68	113814.77	
GRAND TOTAL:							113814.77
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							113814.77
<i>Total Estimated Unduplicated Participants:</i>							135
<i>Factor D (Divide total by number of participants):</i>							843.07
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							843.07
<i>Average Length of Stay on the Waiver:</i>							199