

WYOMING AND *OLMSTEAD*

A PRIMER ON DEPARTMENT OF HEALTH INITIATIVES AND POLICIES



Wyoming Department of Health

Updated July, 2017

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EXECUTIVE SUMMARY

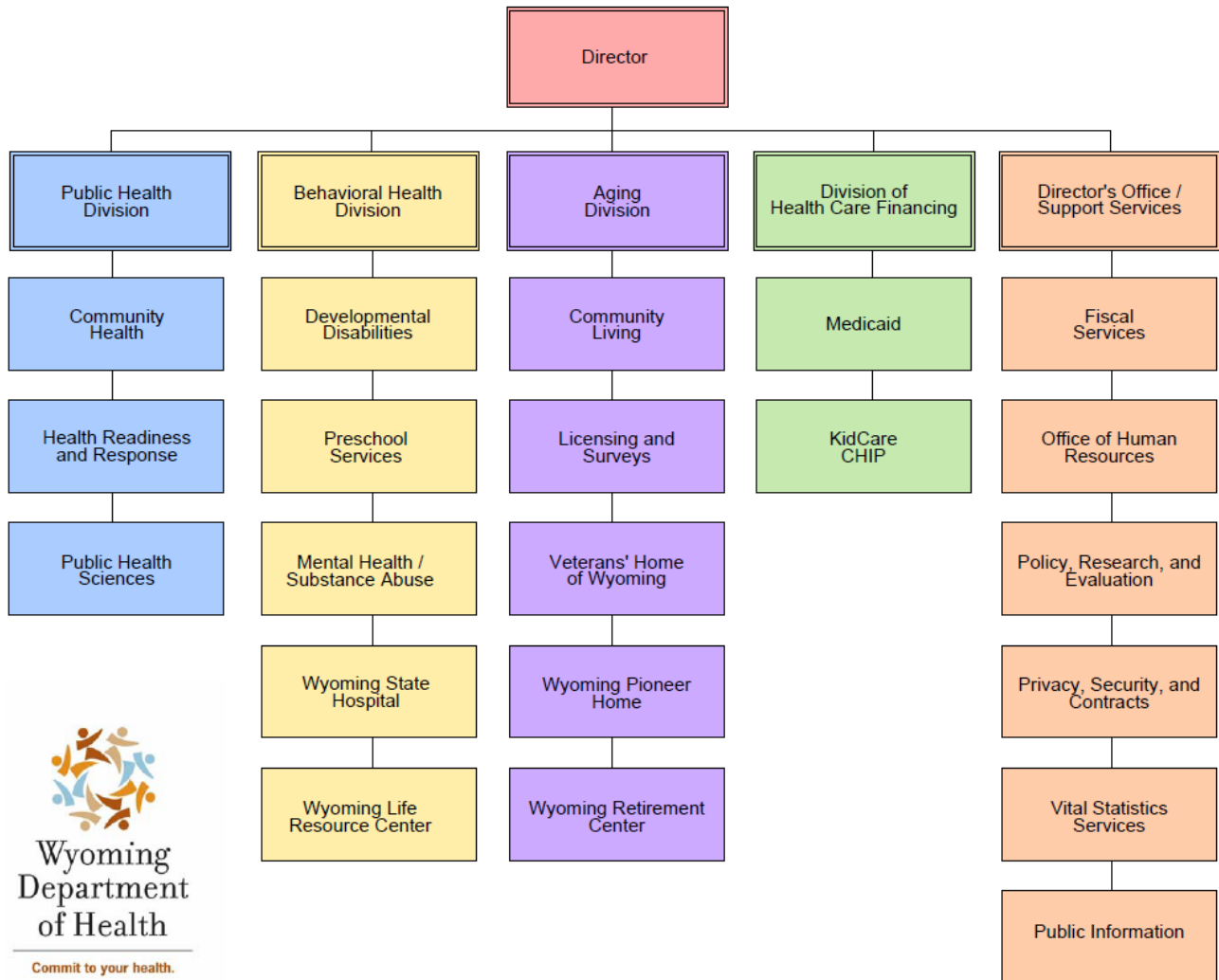
Purpose

The State of Wyoming developed its *Olmstead* plan in June, 2000 and subsequently updated the plan in 2002, and 2013. Since 2013, Wyoming has worked to improve the availability and quality of community services for those with mental illness, physical and intellectual disabilities, and aging issues to help enable those residents of our state to live productive lives in the least-restrictive, most-integrated community settings.

This document serves as a further update to Wyoming’s *Olmstead* plan. The pages that follow provide background on the Wyoming Department of Health (WDH), background on the *Olmstead* decision, as well as Wyoming’s progress toward its goals related to *Olmstead*, and the continued challenges faced by the state.

Moving forward, this plan will be reviewed and updated (as necessary) every quarter of each fiscal year.

Wyoming Department of Health Structure



BACKGROUND

The Olmstead decision

In 1995, the Atlanta Legal Aid society filed suit against the State of Georgia on behalf of two women with developmental disabilities -- Lois Curtis and Elaine Wilson -- who had been repeatedly institutionalized at Georgia Regional Hospital. Tommy Olmstead, the Commissioner of the Georgia Department of Human Resources, and the State of Georgia were named as defendants.

The plaintiffs contended that by failing to provide adequate support in the community -- despite assurances from treatment providers that that such placement was appropriate -- the State was violating Title II of the Americans with Disabilities Act, which guarantees non-discrimination based on disability for the services, programs or activities of a public entity.

In 1999, the Supreme Court released its decision in *Olmstead v. L.C.* The Court found that ‘unjustified institutional isolation’ is indeed a form of discrimination, based on two judgments:

- First, that “institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life”, and;
- Second, that “confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.”

Olmstead requirements

In its decision, the Court developed a three-part test for evaluating the qualified right of individuals with disabilities to receive funded support in the community:

- The person’s treatment professional determine that community supports are appropriate;
- The transfer from institutional care to a less-restrictive setting is not opposed by the affected individual; and,
- The provision of services in the community can be reasonably accommodated, taking into account the resources available to the State and the needs of other similarly-situated individuals with disabilities.

Further, the Court ruled that a State can meet its Olmstead responsibilities only if it has:

- A “comprehensive, effectively working plan for evaluating and placing people with disabilities in less restrictive settings”¹ and,
- A “waiting list that moves at a reasonable pace and is not controlled by the State’s endeavors to keep its institutions fully populated.”

The Court did note that institutions have their place. “We emphasize that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit

¹ U.S. Department of Justice. Civil Rights Division. “Statement of the Department of Justice on Application of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.* to State and Local Governments’ Employment Service Systems for Individuals with Disabilities.” 31 October 2016. Retrieved from: https://www.ada.gov/olmstead/olmstead_guidance_employment.htm

from community settings ... Nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it.”

However, the Court did not find -- and other courts have generally agreed -- that there is a “right” to care in an institution. States “may” keep institutions open without violating the ADA, but the decision did not rule that they “must.”²

What is an Olmstead Plan?

As previously noted, the Department of Justice requires that an Olmstead Plan be “comprehensive and effectively working” to be considered legally sufficient. An adequate plan “must reflect an analysis of the extent to which the public entity is providing services in the most integrated setting and must contain concrete and reliable commitments to expand integrated opportunities.”³ In particular, the plan must cover several basic topics:

- **Data collection, tracking and analysis.**
 - The State should specify yearly and long-term goals for increasing utilization of home- and community based services;
 - Demonstrate progress toward those goals; and
 - Closely monitor the time individuals spend waiting for these services.

- **Access to services**
 - The State must identify and address barriers to accessing community services;
 - Develop a uniform assessment for eligibility for and appropriateness of community services;
 - Establish a “No Wrong Door” policy for accessing service to maximize efficiency and minimize eligible people being denied services⁴
 - Funding cuts can violate *Olmstead* if a reduction in community-based service provision places people at risk of institutionalization.⁵

- **Community integration**
 - The State should encourage employment and economic independence;
 - Allow for education and cultural enrichment;
 - Foster family ties and social interaction; and,
 - Establish processes to transition willing individuals from more to less restrictive environments

² Deinstitutionalization Toolkit - Legal inBrief. National Council on Disability. www.ncd.gov/rawmedia_repository/Legal%20inBrief.

³ U.S. Department of Justice. Civil Rights Division. “Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*” 22 June 2011. Retrieved from: https://www.ada.gov/olmstead/q&a_olmstead.htm

⁴ Medicaid. “No Wrong Door System and Medicaid Administrative Claiming Reimbursement Guide.” Retrieved from: <https://www.medicaid.gov/medicaid/financing-and-reimbursement/admin-claiming/no-wrong-door/index.html>

⁵ U.S. Department of Justice. Civil Rights Division. “Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*” 22 June 2011. Retrieved from: https://www.ada.gov/olmstead/q&a_olmstead.htm

WYOMING'S PROGRESS ON *OLMSTEAD*

Despite the challenges of being a frontier State, Wyoming has made great strides in complying with the ADA and *Olmstead*.

Behavioral Health Division

Individuals with Developmental Disabilities (I/DD) and Acquired Brain Injuries

As with other States, Wyoming has its own institution for serving individuals with intellectual and developmental disabilities -- the Wyoming Life Resource Center (WLRC). And the evolution of both this institution and its home- and community-based alternatives traces a similar path.

The WLRC was established in 1907 as “an institution for the custody, care, education, proper treatment and discipline of the feeble-minded and epileptic persons.”⁶ The facility opened its doors to three children in June of 1912.⁷ By the end of that year, 23 individuals were enrolled and the facility had been named the “Wyoming State School for Defectives.” In 1921, the name was changed to the “Wyoming State Training School,” by which it was known until 2008 when the Legislature changed the name to the current “Wyoming Life Resource Center” (WLRC).

At its peak in the 1960s, the WLRC served more than 700 clients. In the 1960s and 1970s, following the revelation of appalling conditions and poor treatment of patients in many public institutions around the country, de-institutionalization became a national movement, and home- and community-based settings began to grow.

In 1989, the WLRC first began participating in Medicaid after receiving “Intermediate Care Facility for the Mentally Retarded” (ICF-MR) designation. All units at the WLRC were certified by 1993. In addition to the federal oversight demanded by this licensure standard, significant changes were also made due to a lawsuit -- *Weston et al. v. Wyoming State Training School, et al.*, Civil Action no. C90-0004 -- filed with an intent to “...improve services to people with intellectual disabilities”⁸ both at the facility and across the State.

Specifically, the Weston lawsuit, filed in January 1990, sought “improvement of conditions at [the Wyoming Life Resource Center], expansion of community resources and support services and transfer of class members to community programs.”⁹ As a result of the lawsuit, approximately 200 clients transitioned out of the WLRC into community settings, and attention greatly increased to the services provided to persons with intellectual disabilities in Wyoming.

The lawsuit was settled by the parties. The Settlement Agreement formally recognized ongoing obligations of the State with respect to services and supports for people with developmental disabilities.¹⁰ The Settlement Agreement is no longer in effect; it terminated December 31, 1996.¹¹ However, the State remains committed to upholding the spirit of the obligations set out by Weston. Since the Weston Settlement, additional protections have come about with regard to the institutionalization of individuals with intellectual disabilities.

⁶ Session Laws of Wyoming, 1907, Chapter 104.

⁷ A Century of Empowerment, Past, Present and Future, a handbook

⁸ A Century of Empowerment, Past, Present and Future, a handbook

⁹ *Weston et al. v. Wyoming State Training School, et al.*, Civil Action No. C90-0004, Consent Decree, Stipulated Agreement, March 13, 1991.

¹⁰ *Weston et al. v. Wyoming State Training School, et al.* Civil Action No. C90-0004, Annotated Settlement Agreement including the Order Approving Settlement Agreement and Dismissing Action, signed December 5, 1994.

¹¹ *Weston et al. v. Wyoming State Training School et al.*, Civil Action No. C90-0004, Annotated Settlement Agreement at pg. 16.

The State, as well as the WLRC, must comply with many federal and state codes, statutes and regulations, as well as the interpretations of these laws by U.S. courts.

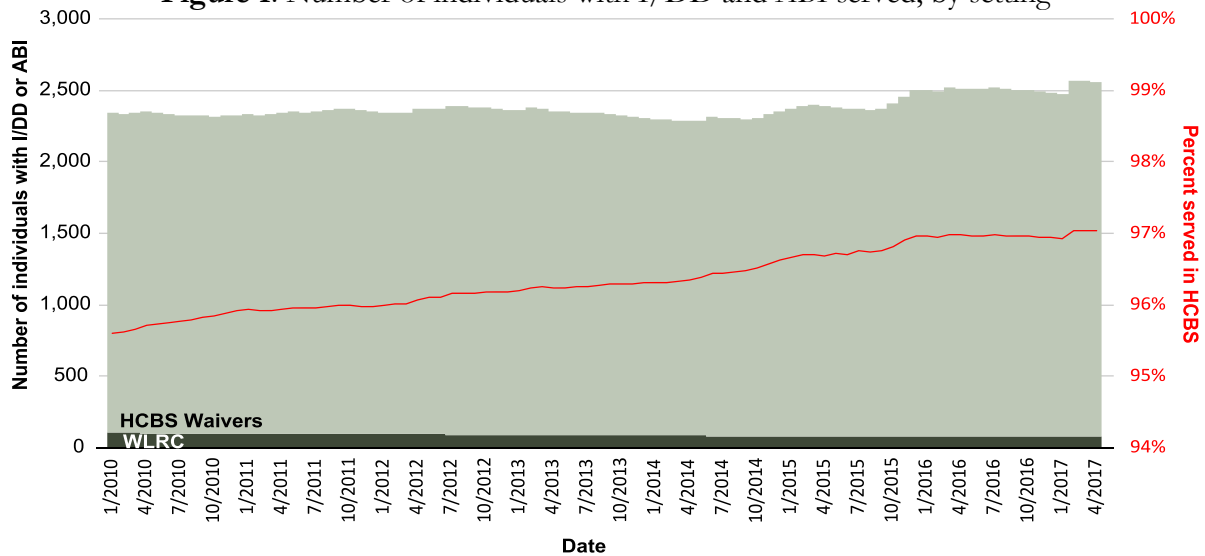
In the same time period, the census at the WLRC has dropped significantly, as home- and community-based setting options grew. Note, in Table 1, below, that the WLRC currently serves approximately half as many people as it did in the late 1990s.

Table 1: WLRC Census and cost since SFY 1999

SFY	Avg. Census	Total Cost
1999	132	\$17,886,885
2000	119	\$17,910,225
2001	118	\$18,554,833
2002	113	\$19,083,418
2003	106	\$20,558,372
2004	107	\$20,343,767
2005	98	\$21,136,896
2006	101	\$21,379,873
2007	124	\$22,711,431
2008	109	\$25,566,162
2009	101	\$26,264,407
2010	103	\$25,039,562
2011	95	\$26,722,068
2012	94	\$28,757,686
2013	90	\$27,547,048
2014	85	\$25,927,457
2015	79	\$23,902,690
2016	76	\$22,811,745

When compared with the significantly higher number of people served in home- and community-based settings, the fraction of individuals with I/DD or ABI in an institution has declined as well. This is illustrated in Figure 1, below. Note that the percent served in HCBS has increased from approximately 95.5% to 97% since 2010.

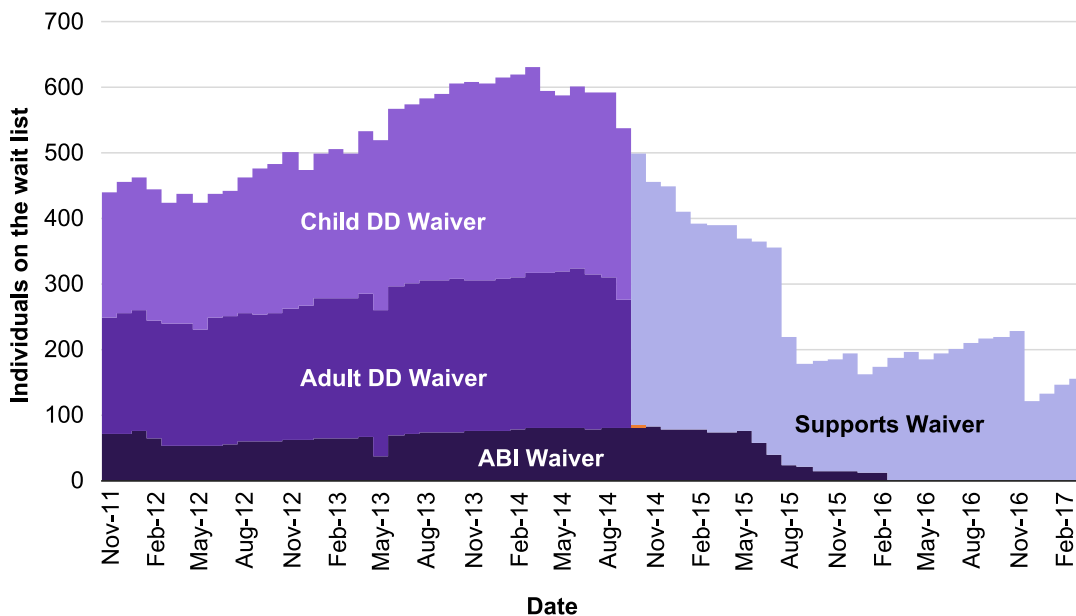
Figure 1: Number of individuals with I/DD and ABI served, by setting



In addition to a gradually shrinking percentage of individuals served in an institutional setting, the wait list for the I/DD and ABI waivers has been significantly cut since the waiver redesign of 2013 (mandated by Senate Enrolled Act 82).

Figure 2, below, illustrates the wait list since November of 2011. The wait list in April of 2017 was 167 people, with no one on the wait list more than 18 months. By contrast, the national wait time average for HCBS services was 43 months in 2013.¹²

Figure 2: DD/ABI Waiver wait list



Despite this progress, however, significant challenges remain in better integrating individuals with I/DD and ABI into community settings.

The United Cerebral Palsy (UCP) organization, for example, has produced the “Case for Inclusion” report annually since 2006. The most recent report (2016) ranks Wyoming #43 based on 2014 data. In the first report ever produced by UCP in 2006, Wyoming ranked #10. Wyoming has fallen from 10th place to 43rd place between 2006 and 2016, according to the UCP metrics.

The rubric used by the UCP to rank States has changed over the years, but important criteria in the rankings have stayed relatively consistent. These criteria include:

- The percent of expenditures going to individuals on waivers vs. ICF (institutional) settings,
- The percent of recipients in small-group (6 or fewer) settings, and the percent living with family,
- The amount of self-directed services,
- Quality metrics from the National Core Indicators (NCI),
- The percent in competitive employment, and
- The length of the waiver waiting list.

¹² Ng, T., Harrington, C., et al. *Medicaid Home and Community Based Services Programs: 2013 Data Update*. Kasier Family Foundation. 18 October 2016. Retrieved from: <http://kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2013-data-update/>

There are three primary reasons behind the drop in Wyoming’s rankings between the 2006 report and the 2016 report, which rely on data from 2004 and 2014, respectively. In order of likely importance, they are:

- The percent of Adult DD recipients with competitive and integrated employment in Wyoming has fallen from 25% in 2004 to 9% in 2014, though it has recently been increasing per State efforts (e.g. the “Employment First” initiative).
- The waitlist for DD waivers grew from 0 to 597 people between 2004 and 2014. While the waitlist decreased to fewer than 200 people in 2016, this improvement will not show up until the next two UCP reports.
- Wyoming has only recently begun participating in the National Core Indicators (NCI) survey. The 2016 UCP methodology automatically penalizes the State by 14 points (out of 100 total) for this lack of data.

Table 2, below, summarizes the UCP rankings since 2006, and compares the rankings and scores with relevant metrics from Department of Health data.

Table 2: The United Cerebral Palsy (UCP) organization “Case for Inclusion” ranking data

UCP Data				Wyoming Department of Health Data					
Report	Data from	Rank	Score	Waiver wait list	Clients		Annual per-person cost		Competitive Employment ¹³
					Waiver	WLRC	Waiver	WLRC	
2006	2004	10	"B"	n/a	n/a	n/a	n/a	n/a	25%
2007	2005	17	70.9	0	1,943	98	\$40,201*	\$215,682	22%
2008	2006	25	68.3	0	2,173	101	\$36,646*	\$211,681	21%
2009	2007	28	68.7	113	2,277	124	\$41,680*	\$183,156	19%
2010	2008	29	68.9	234	2,306	109	\$52,319	\$234,551	19%
2011	2009	21	71.6	284	2,305	101	\$52,417	\$260,043	18%
2012	2010	35	67.3	316	2,368	103	\$51,503	\$243,102	22%
2013	2011	34	66.3	383	2,398	95	\$53,542	\$281,284	13%
2014	2012	41	57.8	462	2,338	94	\$54,426	\$305,932	13%
2015	2013	45	58.9	498	2,342	90	\$54,010	\$303,071	12%
2016	2014	43	59.3	597	2,115	85	\$53,189	\$289,304	9%
2017	2015			219	2,211	79	\$53,495	\$288,599	17%

¹³ Reported by the DD Section of the Behavioral Health Division to the Department of Health Strategic Plan.

Division of Healthcare Financing (Medicaid)

Elderly and Physically-Disabled

Wyoming has also shown positive trends towards home- and community-based settings when it comes to serving the elderly and physically disabled. Wyoming Medicaid serves elderly and disabled members in need of nursing-facility level of care in four programs. These include the:

- Long Term Care (LTC) Waiver¹⁴;
- Assisted Living Facility (ALF) Waiver⁶;
- Program of All-Inclusive Care of the Elderly (PACE); and
- Skilled Nursing Facilities (SNFs) throughout the State.

Generally speaking, the first three programs are considered home- and community-based services (HCBS), while SNF services are considered institutional settings. Trends in expenditures and enrollments for the largest HCBS programs (LTC and ALF waivers) vs. SNF services are shown in Tables 3 and 4, below.

Table 3: Long-term Care and Assisted Living Facility Waivers⁶

SFY	Expenditures	Member Months	Avg. Enrollment	PMPM
2011	\$31,663,825	19,203	1,600	\$1,649
2012	\$33,821,599	18,812	1,568	\$1,798
2013	\$30,383,671	18,152	1,513	\$1,674
2014	\$30,236,004	18,369	1,531	\$1,646
2015	\$32,719,341	19,776	1,648	\$1,654
2016	\$37,126,339	21,642	1,804	\$1,715

Table 4: Nursing Facility

SFY	Expenditures	Member Months	Avg. Enrollment	PMPM
2011	\$79,967,179	20,307	1,692	\$3,938
2012	\$79,243,110	20,569	1,714	\$3,853
2013	\$77,134,902	20,232	1,686	\$3,813
2014	\$75,382,096	20,092	1,674	\$3,752
2015	\$74,242,244	19,667	1,639	\$3,775
2016	\$88,192,883	20,250	1,688	\$4,355

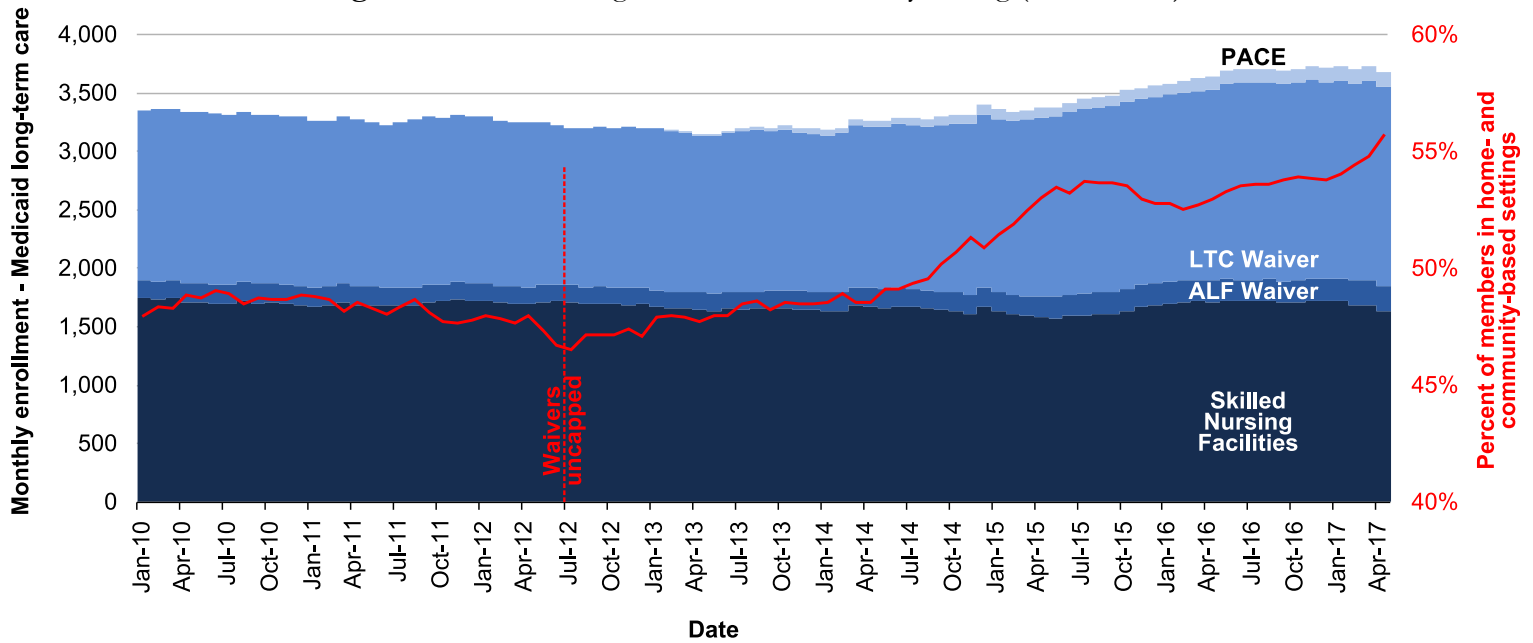
Of note in the tables:

- Per-member per-month costs for HCBS settings are approximately 40% of SNF settings.
- Enrollment growth in long-term care has largely been in HCBS settings. There are actually fewer Medicaid members in nursing homes today than there were in 2010.

Figure 3, on the next page, shows how the use of home- and community-based alternatives to institutional care has increased by almost 10 percentage points since those waivers were uncapped in 2013.

¹⁴ Note that, due to similarities in member costs and acuity, the LTC and ALF Waivers will soon be combined into the “Community Choices” Waiver.

Figure 3: Medicaid long-term care members, by setting (2010 - 2017)

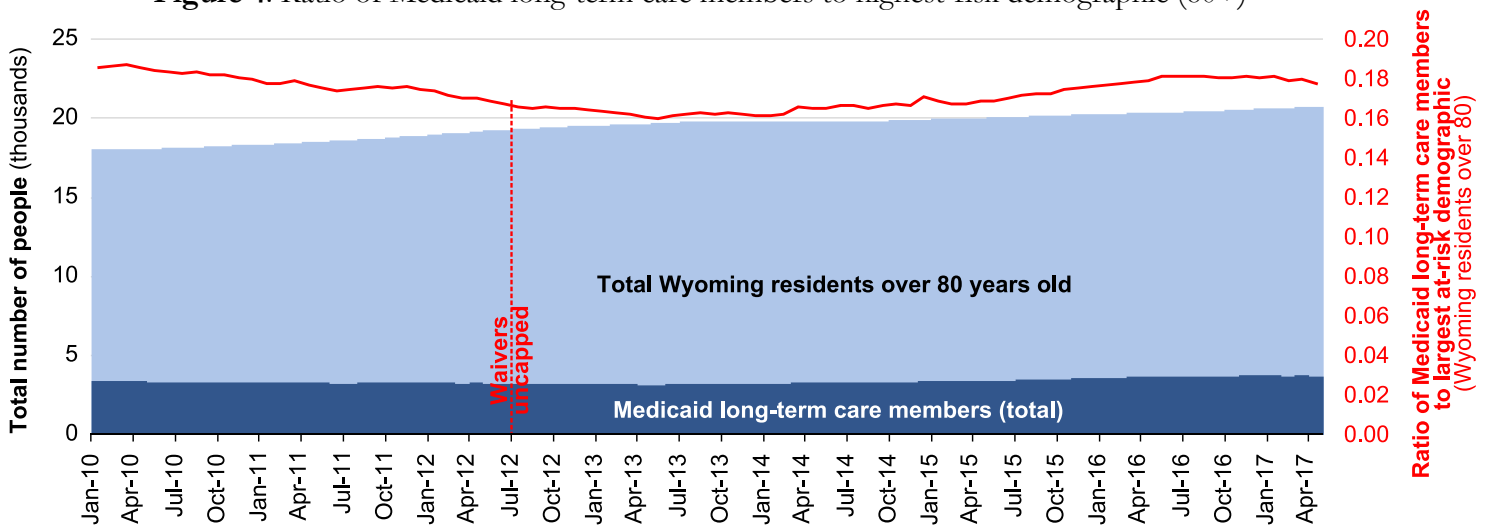


Note on Figure 3, above, the legislative decision to “uncap” the LTC and ALF waivers in SFY 2013. This has led to a gradual increase in the percentage of individuals served in HCBS settings, from approximately 47% to over 56% today. This trend is beneficial both to members (who would much prefer to remain in their own home) and to the State (since the PMPM costs are less than half of institutional care).

Note further that the total number of individuals on Medicaid long-term care has grown slowly, from approximately 3,300 people in 2010 to approximately 3,700 today, while the number of individuals served in SNF settings has declined (see Table 4).

Figure 4, below, illustrates that the growth in long-term care enrollment is largely consistent with increasing demographics. The chart shows total long-term care enrollment compared against the highest-risk demographic (all individuals over 80), in terms of both absolute numbers (blue) and a ratio (red).

Figure 4: Ratio of Medicaid long-term care members to highest-risk demographic (80+)¹⁵



¹⁵ Medicaid enrollment data from MMIS. Population data from US Census estimates, A&I Economic Analysis Division.

Because the ratio of Medicaid long-term care members to the highest-risk demographic has remained relatively stable since 2010 (at 0.18 enrollees per individual over 80), it appears that HCBS services are **generally substituting** for institutional care, rather than contributing to overall growth.

This is further substantiated by the stable, if not increasing, average acuity level of the LTC and ALF waivers, as measured by the total number of points on the LT-101 assessment, as shown in Table 5, below.

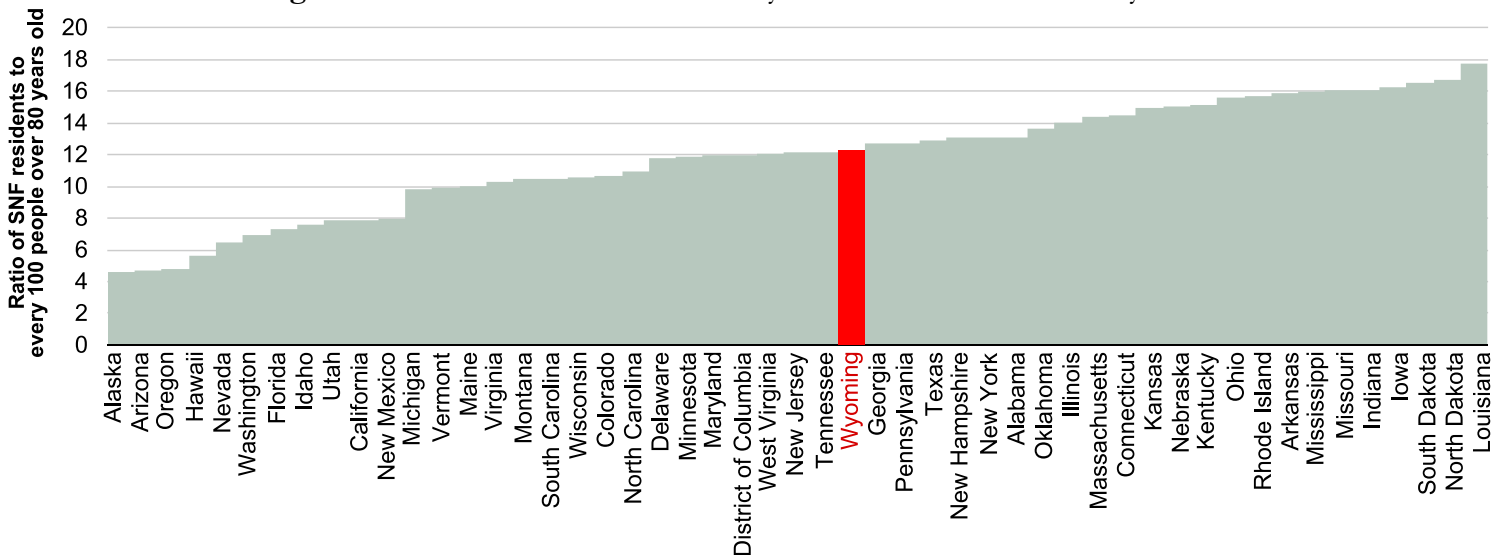
Table 5: ALF/LTC vs. SNF average number of points¹⁶

CY	LTC/ALF		SNF	
	Mean	Median	Mean	Median
2010	16.42	15	20.77	20
2011	16.53	15	20.83	21
2012	16.76	16	20.64	21
2013	16.95	16	20.75	21
2014	16.99	16	21.05	21
2015	17.11	16	21.44	21
2016	17.49	16	21.57	21

If HCBS services were entirely substituting for lower-acuity nursing home care, the relative cost savings of serving the approximately 200 additional people in HCBS in SFY 2016 would total approximately \$6.3 million per year (PMPM difference of \$2,640 * 200 individuals * 12 months).

Despite this progress, there are more challenges ahead. In terms of measuring ‘institutionalization’ among the elderly and disabled as the ratio of SNF residents to every 100 State residents who are over 80 years old (the highest-risk demographic), Wyoming ranks 28th in the nation today, as shown in Figure 5, below.

Figure 5: Ratio of SNF residents to every 100 State residents over 80 years old

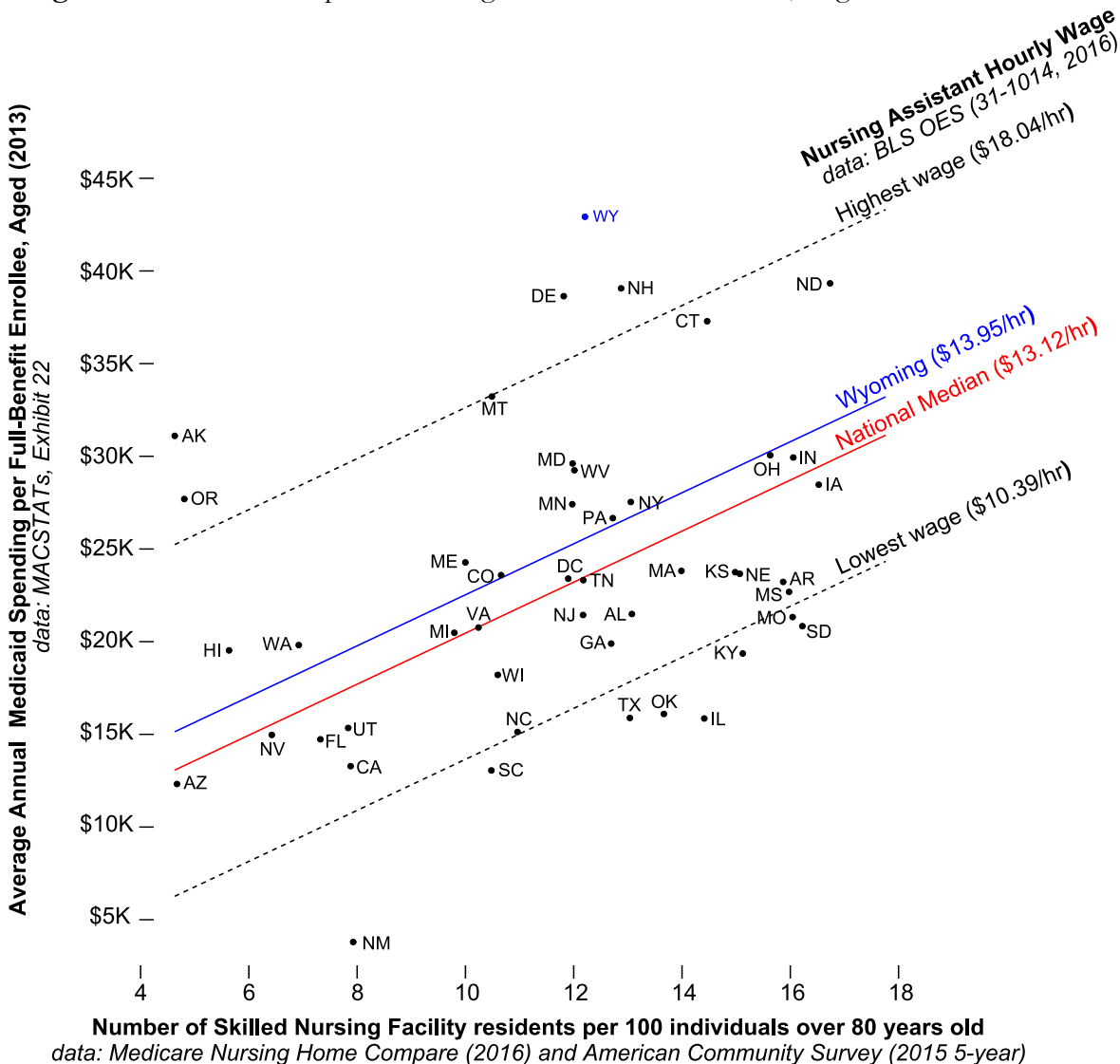


Because SNF settings are so expensive, this degree of institutionalization is partly responsible for the fact that Wyoming has the highest Medicaid cost per aged full-year equivalent enrollee. The scatterplot in Figure 6,

¹⁶ Measured for member-months with an LT-101 conducted within 400 days. Due to more frequent LT assessment requirements for LTC and ALF waivers, the average sample was 1,500 individuals for LTC/ALF and 700 for SNF.

below, shows the correlation between these two variables, controlling for labor costs, as measured by the average hourly wage for nursing assistants. These two variables are statistically-significant predictors of over 34% of the variation in Medicaid spending on the aged.

Figure 4: The relationship between degree of institutionalization, wages and Medicaid costs



OLMSTEAD PRIORITIES, 2017-2021

Behavioral Health Division

In addition to priority areas mentioned in Wyoming's 2002 *Olmstead* plan, and the subsequent 2013 update, the Behavioral Health Division will be focusing on the following areas over the next four years in relation to *Olmstead*, with the intent of serving Wyoming's neediest populations in the least-restrictive, most-integrated, and therapeutic environments.

Facilities: Wyoming Life Resource Center and Wyoming State Hospital

Facilities Redesign Project

In 2012, the Department of Health requested the commissioning of the development of a Facility Master Plan for the five (5) Department facilities. As a result, the Legislature authorized the creation of the Facilities Task Force in 2014. It includes members from the Legislature, executive branch employees and private providers. The task force was charged with reviewing the Facilities Master Plan and make any recommendations needed to address short and long-term goals and operating practices of each facility. The task force examined statutory obligations, conducted site evaluations and help public meetings at each facility. It made recommendations, which included a new vision for both the State Hospital and Life Resource Center. The Legislature and the Governor adopted the task force's findings, which are now being implemented by the Department.

The Task Force determined the role of the State should be as a "safety net" provider. The "safety net" was defined as the State's obligation to ensure access as a provider of facility-level services as a last resort for those individuals who would otherwise be critically endangered or a threat to public health and safety.

Additionally, in 2014, the Task Force set a vision for "One Campus, Long Streets". The goal is to integrate services between the State Hospital and the Life Resource Center. To do this, services were categorized into three (3) broad types of care:



- **Acute**, short-term crisis stabilization;
- **Immediate**, post-acute rehabilitation; and,
- **Long-term**, extended services to maintain functional levels.

The "One Campus, Long Streets" concept is operationalized by having the State Hospital focus on acute crisis stabilization and the Life Resource Center focus on intermediate and long-term care. The goal of acute and intermediate services is to provide care and then transition clients to the community. While long-term care means the provision of extended services, the goal includes the transition to a less-restrictive placement in the community, when possible.

The directive of the Task Force is that the State should not play a role in providing direct facility-based services to ABI, DD or dually-diagnosed individuals who do not manifest "exceptionally difficult behaviors". The State should also not provide direct facility-based services to individuals with mental illness who have not been involuntarily committed under Title 25, Title 7 or a court order. All of these populations are better served by providers in the community.

The final result of the work of the Task Force and Legislature is a realignment of the populations served and types of care provided at the State Hospital and Life Resource Center, illustrated in the figure below.

	Type of Care		
	Acute	Intermediate	Long-term
ABI/DD with exceptionally difficult behaviors	WSH	WLRC	
Title 25-Civil Commitments	WSH		
Title 7-Forensic Psych	WSH	WSH	WSH
Gero-psych	WSH	WLRC	WLRC
High Medical		WLRC	WLRC
"Hard to Place"			WLRC
"Emergency Placements"	WLRC	WLRC	WLRC

	WSH
	WLRC

Wyoming statutes were codified to reflect the new missions of the State Hospital and Life Resource Center:

“Exceptionally difficult behaviors” means a high level of assaultive or self-injurious behavior in a person with an intellectual disability or organic brain syndrome. These behaviors may include aggression and violent behavior, wandering, sexually inappropriate behavior, self-endangering behaviors or medication noncompliance. (W.S. 25-5-102 (b)(xxxix))

“Hard to place” means a person who is eligible for skilled nursing facility care; does not meet the criteria for “exceptionally difficult behaviors”, “high medical need”, or “organic brain syndrome”; and for whom no community skilled nursing facility has been identified. (W.S. 25-5-102 (b)(xxxii))

“High medical needs” means a person who is eligible for skilled nursing facility services; does not meet the criteria for “exceptionally difficult behaviors”, or “organic brain syndrome”; and would qualify for the extraordinary care nursing facility reimbursement rate. (W.S. 25-5-102 (b)(xxxiii))

“Organic brain syndrome” means a decrease in mental function due to a medical disease, other than mental illness, as defined by the department. Organic brain syndrome may be the result of an acquired brain injury or the result of dementia caused by trauma, hypoxia, cardiovascular conditions including thrombotic and embolic events or degenerative, infectious, alcohol and drug related or metabolic disorders. (W.S. 25-5-102 (b)(xxxiv)).

In addition to being an Intermediate Care Facility, the Life Resource Center was authorized to provide skilled nursing services to persons with organic brain syndrome who manifest exceptionally difficult behaviors (gero-psych); persons with high medical needs; and persons who are hard to place (W.S. 25-5-103).

Wyoming State Hospital: People Empowering People (PEP) Program

People Encouraging People (PEP) is a community integration program for patients for which finding appropriate discharge options presents a challenge because of recent or historic behavioral issues or a variety of skill deficits. Individual programming emphasizes independent living skills, social interaction, personal and collaborative problem-solving and active participation in a variety of community activities. The focus is on meaningful activities aimed at decreasing isolation, helplessness, and boredom and increasing personal growth. Day programming focuses on developing and strengthening interpersonal and independent living skills required for admission into a lower level of care.

The target population for PEP are those clients whose treatment issues impair their ability to communicate and interact; who have limited experience in independent life skills; who are otherwise ready for discharge, are awaiting placement in group homes or other transitional facilities, and will benefit from additional coaching, practice and community integration opportunities.

PEP participants are discharged when conditions warranting involuntary hospitalization no longer exist and supportive services are secured in the community. Some participants who are not quite ready for community transition are served at the WLRC in the Pathways Program. They then transition into the community from Pathways.

The program philosophy encompasses the following:

- Each person arrives with an expectation of treatment, and the program assists with meeting that expectation.
- Each person has a multitude of strengths which can be used to overcome difficulties that have resulted in delayed discharge from institutional settings.
- Each person will be provided the opportunity to progress according to her capacity.
- A multidisciplinary staff supports and encourages each patient to design and participate in treatment according to individual needs and preferences. Each participant is actively engaged in planning supports needed to return successfully to the community.

Program goals include:

- Each participating individual will display an increase in independent living skills indicating readiness for discharge to a less restrictive level of care.
- Each participant will experience a better quality of life upon returning to the community.

Wyoming State Hospital: Priority Metrics and Utilization Review/Management

In recent years, Wyoming has seen growth in volume and expenditures in “Title 25,” the legal system for emergently detaining and involuntarily hospitalizing individuals who are dangerous to themselves or others. While entry into the Title 25 system is not controlled by the WDH, it is in the interest of all stakeholders to limit the use of involuntary Title 25 commitments and services to only those cases that truly require hospitalization. The WDH continues to work with local, county-based, regional, and statewide stakeholders on initiatives to improve the continuum of care for individuals with behavioral health challenges, and ensure that, to the extent possible, services are provided in the least-restrictive, most-integrated, and therapeutic environment.

Accordingly, the WSH prioritizes and tracks the following metrics, in order to improve its service delivery and facilitate appropriate discharges and community transitions for its clients:

- Average Length of Stay
- Level of care (LOCUS)
- Barriers to discharge

The Wyoming State Hospital has partnered with Optum/WYhealth to perform utilization review and utilization management for individuals committed to the WSH under Title 25 (which includes commitments in private

“designated hospitals” throughout the state). As part of that effort, the Director’s Unit for Policy, Research, and Evaluation created a management tool and database to facilitate better data collection, facility management, and discharge planning for the Title 25 system. The database will allow the following to occur, through availability of real-time data:

- Patient tracking, facility management, and improved discharge planning for the Wyoming State Hospital;
- Ease of performing utilization review (admission reviews, continued stay reviews, medical necessity, etc.) for Optum/WYhealth; and,
- Improved data analysis, analytics, and reporting for the Director’s Office with respect to Title 25.

Wyoming Life Resource Center: Pathways Program

The Pathways Program (Pathways) is a non-forensic dual diagnosis program that supports people with intellectual disabilities and mental illness. It is a safety net for people coming from the State Hospital and the community. The program is a comprehensive ICF/IID program of assessment, stabilization, treatment and transition services back to the community. It includes integrated medical, psychiatric, behavioral, and diagnostic and assessment components.

Program goals include:

- Provide a dual diagnosis program based on integrity and best practices.
- Provide outcome driven services that successfully place people back into the community.
- Develop an infrastructure and foster referral relationships to assist transition into the community.
- Provide extensive outreach and education to both intellectual disability and mental health providers throughout the state.

Person-centered planning is the foundation of Pathways. The focus is on identifying and maximizing an individual’s strengths and preferences. It is a process that focuses on the person’s preferences, talents, dreams and goals. It is a collaborative and helps people get the supports and services they need to live a quality life based on their own preferences and values. The person served drives the planning process and those who know the person best are important participants.

The principles of Person Centered Planning include:

- Identifying and incorporating what is important to, as well as what is important for, the person into all supportive interventions.
- Using information to identify outcomes the person desires.
- Respecting each person’s life journey, dignity, and cultural background.
- Supporting the person’s self-determination.
- Providing the most integrated setting and inclusive service deliveries that support, promote and allow for inclusion and self-sufficiency.

Intellectual and Developmental Disabilities (DD) Waivers

Rate Rebasing

At the direction of the Wyoming State Legislature, WDH is undertaking a rate analysis and setting project for the Comprehensive and Supports waiver programs. The purpose of this initiative is to provide the State of Wyoming with an accurate and objective portrait of the cost to deliver Medicaid waiver services. This study will inform the State's ability to maintain and expand an adequate provider network for community based services.

Individualized Budget Amounts (IBA) and Service Cap Reviews

In conjunction with the above-mentioned rate rebasing project, WDH will re-examine the current methodology for individualized budget amounts, including the use of caps on specific waiver services. Eliminating or easing service caps will allow for greater individual choice for the services and the ability to increase or decrease specific services through the course of the individual's plan of care. Any changes resulting from this project would be intended to maximize individual control and autonomy over the services that can best serve the person in their community setting and, in times of crisis, keep services in place in the community rather than a more restrictive setting.

Waitlist Policy

It is the policy of the WDH that no individual shall wait longer than 18 months for DD waiver services. This policy will continue as long as funding and program enrollment trends allow. Reducing wait times for services is a key objective of the DD Section and the WDH. Continuing to reduce waitlists will provide needed community services and reduce the possibility of services being delivered to the same population in a more restrictive setting.

Community Mental Health and Substance Use Disorder Treatment Services

Ombudsman

The Behavioral Health Division contracts with Wyoming Guardianship Corporation to provide the Substance Abuse and Mental Health Ombudsman program (SAMHOP). Ombudsman services are delivered in Wyoming, without interference from the WDH, as part of the *Chris S. Stipulated Agreement*. Ombudsman services entail advocacy and support to help individuals resolve issues related to accessing mental health and substance use treatment and recovery. More than half (52%) of individuals that seek Ombudsman services in Wyoming live in a restrictive, but non-jail, environment. Financial need and lack of appropriate housing have been identified through the Ombudsman program as systemic barriers to community integration.

The contract requires SAMHOP to provide Ombudsman services to at least eighty (80) individuals served per quarter. In recent years, the number of persons served has exceeded those expectations

Assisted Outpatient Treatment (AOT) Grant

The Assisted Outpatient Treatment (AOT) Grant was awarded by SAMHSA to the Wyoming Department of Health in October 2016. The purpose of the AOT grant is to implement and evaluate programs which aim to reduce the incidence and/or duration of psychiatric hospitalization, homelessness, unemployment, incarceration, and interactions with the criminal justice system, while also improving the overall health and social outcomes for individuals living with serious mental illness (SMI). The AOT grant was first implemented at Central Wyoming Counseling Center in Natrona County. Emphasis in the first year of the grant was placed

on developing treatment infrastructure to support the utilization of directed outpatient commitment, as per Wyo. Stat. Ann. § 25-10-110.1, in lieu of state hospital commitment for at-risk individuals. The Wyoming Department of Health plans to expand the AOT Grant to other areas of the state in the second year of the grant. AOT Expansion sites will be selected in Summer 2017 on the basis of demonstrable regional need and a competitive grant application process. As part of the AOT grant, the Department will contract with the GAINS Center, a SAMHSA contractor, to provide training to current and potential AOT providers in Wyoming.

Title 25 “Gatekeeper” Designations

The Wyoming State Legislature amended Title 25 during the 2016 budget session to allow the Wyoming Department of Health, in consultation with local County Commissioners, to designate county gatekeepers. Designated gatekeepers serve as the single point of responsibility for the Title 25 emergency detention and involuntary hospitalization process. Designated gatekeepers are expected to provide guidance to courts, healthcare providers, and other stakeholders on the detention and hospitalization process, and to provide intensive care coordination for individuals before, during, and after the involuntary hospitalization process. The Wyoming Department of Health has received requests for gatekeeper designation from 12 community mental health providers representing 20 counties since the legislation took effect. The Wyoming Department of Health has received support from local boards of county commissions thus far in designating 8 community mental health providers representing 13 counties as official Title 25 gatekeepers. The Wyoming Department of Health continues to strive toward its goal of achieving gatekeeper designation in all 23 counties of the state.

The Department offered one-time funding in Fiscal Year 2017 to community entities interested in designating a gatekeeper for their county and establishing infrastructure to increase the effectiveness of the community response to Title 25, lower costs associated with emergency detentions and involuntary hospitalizations, and improve the continuity of care for individuals living with mental illness. The Wyoming Department of Health awarded 10 grants totaling \$623,925.

PATH Grant

The Behavioral Health Division uses federal Projects for Assistance in Transition from Homelessness (PATH) funds to provide outreach and case management services for people with serious mental illness (SMI) experiencing homelessness. Wyoming receives approximately \$300,000 each year, the majority of which goes to non-profit providers in Wyoming’s four largest counties. The focus is on helping PATH participants gain permanent sources of funding for their housing expenses. Up to 20% of PATH funds are limited to rental deposits, necessary move in costs and other necessary expenses (i.e. birth certificates, clothes for a job interview, beds) and, on occasion, for one-time rent payments when there is a risk of eviction and no other way to pay. An emphasis is placed on helping community partners increase their contributions to reducing homelessness.

Division of Health Care Financing (Medicaid)

Community Choice Waiver

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

CCW serves people who are 19 years old and older who meet the functional and financial criteria for Medicaid nursing home care. Services include case management, personal care attendant, respite care, skilled nursing, adult day care, home delivered meals, non-medical transportation, assisted living facility (ALF), and personal emergency response system. Participant directed service delivery option services include Direct Service Worker (which replaces the personal care attendant), and fiscal management. The goal of the waiver is to provide access to safe and appropriate services for Medicaid-eligible, functionally impaired elderly and physically disabled residents of Wyoming.

The objectives of the CCW program include:

1. Minimizing admissions to long-term care institutions for people who can be safely served at home or in an assisted living facility in the community;
2. Providing a transition option for eligible nursing facility residents to move from a nursing facility to a residential home or an assisted living facility;
3. Providing this population with access to appropriate health and social services to help them maintain independent living;
4. Providing for the most efficient and effective use of public funds in the provision of needed services which promote and maintain the health and welfare of waiver participants;
5. Allowing communities flexibility in development of those services; and
6. Assuring service quality is maintained for participants receiving services through this waiver.

The Waiver is housed in and administered by the Division of Healthcare Financing. Services are provided by entities within the communities that meet established provider qualification for each service they provide and have executed a Medicaid Provider Agreement. Participants are offered a choice of settings to receive their services identified on their individual Plans of Care (POC). In addition the CCW does not have a waitlist. Participants who are eligible and meet all of the program criteria are able to join the waiver program and receive services in the community in a timely manner. It is our goal to maintain a zero waitlist policy.

In addition to the CCW Program, Wyoming also provides services to the elderly and disabled population through two other programs: Program of All-Inclusive Care for the Elderly (PACE) and Project Out, described further below.

PACE

The Program of All-Inclusive Care for the Elderly (PACE) is a program which provides an option for individuals who need nursing home level of care but wish to remain in their home. The mission of the Wyoming PACE is to enable the aging population to live with dignity within their communities.

Through the PACE Center, older adults and people over the age of 55 living with disabilities can receive medical care and supportive services. Not only does PACE allow participants to stay within their own homes, but it

also provides family members and care givers with needed professional guidance, physical relief, and emotional support. Services provided through PACE include:

- On-site physician access with personalized care tailored to participant needs;
- Primary and specialty medical care including dental, audiology, optometry and podiatry;
- Nursing and social work;
- Physical, occupational and speech therapy;
- Hospital and emergency care;
- Prescription drug coverage and management;
- Lab tests and diagnostic procedures;
- Meals and nutritional counseling;
- Personal care;
- Home care;
- Adult day care; and,
- Transportation services.

PACE is currently only available in Laramie County.

Project Out

Project Out is a temporary short-term program that is designed to assist individuals who are currently residing in a nursing facility and wish to return to independent living safely within the community. This program also assists individuals – who are at imminent risk of going to a nursing facility – remain in their community and out of an institution. Project Out ensures that services and supports are provided to maintain the highest quality of life for individuals returning to the community, or individuals who wish to remain in the community.

The Division of Healthcare Financing currently partners with two provider agencies to administer this program. Transition Specialists within these agencies work with the individuals to assess eligibility and safely transition them out of, or keep them living independently, in the community. Some of the services provided through Project Out include: application assistance, first and last month's rent payments, utility deposits, transportation assistance, acquiring furniture, and accessibility and adaptive equipment.

Project Out is a key component within the Olmstead plan to safely transition and keep the elderly and disabled population out of institutions and remain in the communities they prefer.

Wyoming Super-utilizer Program (WySUP)

The Wyoming Super-Utilizer Program (WySUP) is one component of a group of initiatives within the WDH intended to improve the health outcomes of adults with complex care needs while decreasing State costs. The WDH plans to have the WySUP fully implemented by December of 2018.

This program will focus on adults with multiple comorbidities. In many cases, these individuals will have co-occurring behavioral health conditions, so the program must be tightly integrated with the mental health and substance abuse system in Wyoming.

- Adults with complex healthcare conditions are the focus of this initiative. Large coordination efforts already exist for children, to include:
 - The Care Management Entity (CME) for high-risk (SED) youth;
 - The Children's Mental Health Waiver;
 - Department of Family Services and Wyoming Department of Education services; and,
 - Medicaid coverage of Psychiatric Residential Treatment Facilities (PRTFs) and Early Prevention, Screening, Detection and Treatment (EPSDT).

- Those targeted in this project do not include individuals that are high cost simply based on their long-term care costs (e.g., nursing home residents, ID/DD waiver clients, and Long-Term Care waiver clients). Program and care management reforms are already underway to improve care and lower costs for these populations.
- Instead, the program will be targeted towards the top 5% of the remaining Medicaid population (largely SSI and Family Care Adults), using an open-source, prospective, additive risk scoring algorithm calibrated with Wyoming Medicaid claims data.

In its current phase, this project relies on a contract with a health management vendor to provide in-person care coordination for Wyoming Medicaid members selected as potential participants in the program. As mentioned above, members in this program often have co-occurring behavioral health challenges in addition to their medical conditions. The state hopes that, through more targeted care coordination, health outcomes for these clients will improve, including reduced reliance on higher levels of care (e.g., inpatient and/or involuntary hospitalization).

Upon assessment of success of the early phases of the WySUP, the state hopes to potentially expand the program to non-Medicaid populations, including those going through the Title 25 (emergency detention and involuntary hospitalization) system.

Additionally, a primary focus of this program is facilitating enrollment in, and use of, Patient-centered Medical Homes (PCMHs) for high-need, high-cost clients. As part of the project, the state will assess the feasibility of program expansion through regional or local care coordination entities, and potentially implement “Health Homes” in certain areas, under Section 2703 of the Affordable Care Act.

Aging Division

State Plan on Aging Summary

As part of its State Plan on Aging, the Community Living Section within the Aging Division of the WDH has set forth the following goals for the 2017-2021 time period:

1. Strengthen and expand programs that delay or prevent the need for long-term care services.
2. Improve awareness of and access to services.
3. Ensure the rights and safety of older adults.
4. Enhance the quality of existing programs.

These goals are rooted in the Community Living Section's primary mission to help in preventing premature institutionalization for older adults in Wyoming. Further, the goals are based on the following four components:

- Anticipating increased needs and financial restraints, improving the health of older adults in order to delay the need for services must be a priority. Improved health also increases the likelihood of aging in place, which is the preference of most older adults and a priority for the State of Wyoming.
- Without awareness and access, quality services offer little benefit to older adults. Wyoming is rural in nature, and lacks robust public transportation services; thus, access to services is a primary barrier for people who cannot drive, do not own a car, or live long distances from available services.
- Preventing abuse and exploitation of older adults is important. Increased awareness of elder abuse and exploitation helps maintain the mental and physical safety of older adults in the full range of living arrangements. The safety of older adults also needs to be considered more broadly in the context of the community. For example, older adults living alone could face additional challenges in the event of an emergency, such as a natural disaster.
- Increased access to services is less meaningful if those services are not of a high quality; thus, quality improvement and performance improvement are an important part of our mission.

Preventing Premature Institutionalization

The Aging Division is implementing three objectives within its current State Plan on Aging aimed at preventing premature institutionalization for older adults and severely disabled individuals in Wyoming. They are outlined below.

- **Objective:** Using the Ombudsman Program as an avenue to identify inappropriate institutional placements.
 - **Strategy:** The State Ombudsman will educate the regional ombudsmen to promote an *Olmstead* informed program in addressing resident rights.
 - **Performance measure:** Number of P128 (Request for less-restrictive placement) complaints to those with dispositions of "Resolved to the satisfaction of the resident or complainant."
- **Objective:** Promoting services offered through the Wyoming Home Services program.
 - **Strategy:** Improve coordination of care and other services to older adults in community-based settings.
 - **Performance measure:** Increase enrollment in the Wyoming Home Services program.

- **Objective:** Improve awareness of and access to Title III and VII services.
 - **Strategy:** Partner with providers to reach more eligible older adults, not yet enrolled.
 - **Performance measure:** Increase Title III and VII enrollment.

CHALLENGES

Statewide Coordination on *Olmstead* Plan and Initiatives

The *Olmstead* plan outlined in this document is specific only to the Wyoming Department of Health. While collaboration within various initiatives (some related to *Olmstead*) exists between state agencies and external stakeholders, there is currently no single entity (e.g. state agency, commission, or task force) that would be responsible for ensuring elements of a statewide *Olmstead* plan are executed in a comprehensive manner. The Department will continue to make progress on its *Olmstead* goals and initiatives, but the lack of statewide coordination may present a challenge going forward.

Housing

Housing availability and affordability – especially for high-need individuals at risk of institutionalization – is a challenge for all states, including Wyoming. Regular reviews of patients committed to the Wyoming State Hospital through the Title 25 system indicate that housing is a primary barrier to discharge for patients no longer meeting medical necessity for inpatient psychiatric care. While the Department has programs dedicated to assisting high-need individuals with access to housing (e.g., emergency funds or quality of life funds for first/last months rent), the supply of affordable housing in Wyoming communities is often limited.

Compounding this problem is the fact that the State of Wyoming does not have a dedicated housing authority, or state agency responsible for housing and development.

Provider Availability

Wyoming is a rural and frontier state, and has Health Provider Shortage Areas (HPSAs) in every county, for every provider type. Accordingly, access – namely the availability of some providers and services – is a continuing struggle for the state’s fragile healthcare system. Appropriate healthcare services, levels of care, and infrastructure are not available in every Wyoming community, resulting in higher demand in more populous areas and thus increasing challenges in physical access to care (travel times, limited supply, etc.).

Economic Fluctuation and Budget Reductions

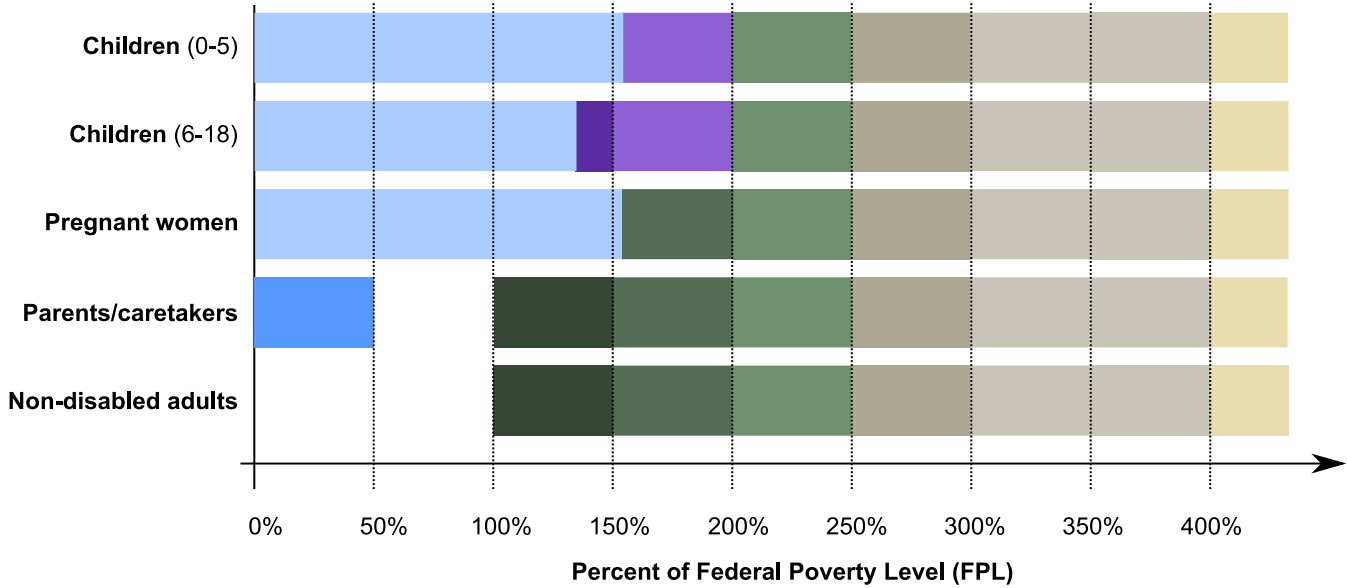
Wyoming's economy depends heavily on mineral extraction and tourism. Low prices for oil and gas, along with decreasing demand for coal have depressed output, increased unemployment, and reduced State government revenues by an estimated 23 percent for 2017-18. The Governor and Legislature have, accordingly, required state agencies to do more with less. For example, the Wyoming Department of Health operating budget was reduced by over \$150 million for the 2017-18 biennium.

Healthcare Coverage

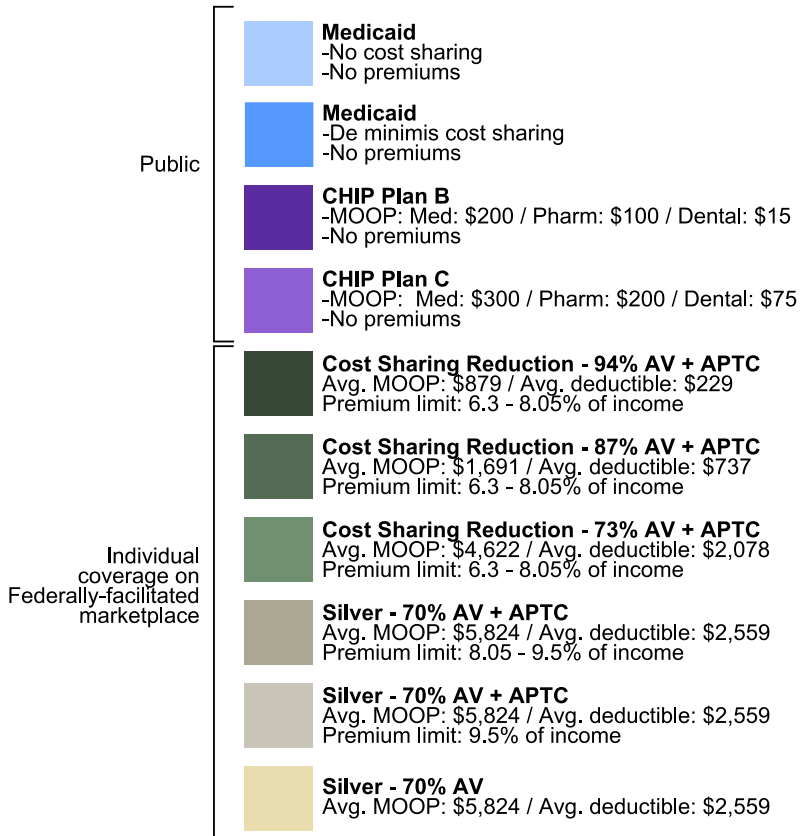
Wyoming did not elect to expand Medicaid to all low-income adults, per the Affordable Care Act. Accordingly, Wyoming has a higher rate of uninsured individuals than some of our neighboring states, primarily around low-income adults who do not currently qualify for health insurance subsidies on the Marketplace. Access to healthcare coverage is often determined to be a primary barrier to discharge for some patients at the Wyoming State Hospital and other designated hospitals in Wyoming.

Figure 5, on the next page, shows what kind of health insurance coverage is available for various categories of people and income ranges. The color key below the figure describes the premiums and member cost sharing for that particular coverage option.

Figure 5: Health insurance availability by population and income level



Insurance Coverage



Notes:

(1) Maximum out-of-pocket (MOOP) and deductible data are national averages from the Kaiser Family Foundation (2014), but are similar to WY BCBS offerings.

(2) Actuarial value (AV) refers to the expected average percent of medical costs borne by the insurer (vs. the insured)

(3) Advance Premium Tax Credits (APTC) are refundable tax credits that lower the cost of an individual's premium. The amount is based on:

- The individual's income
- The cost of the second-lowest Silver-level plan
- The sliding percent of income schedule noted to the left.

WYOMING *OLMSTEAD* GOALS, 2017-2021

The Wyoming Department of Health sets forth the following *Olmstead*-informed goals for the 2017-2021 period:

1. Complete the redesign of the Behavioral Health Division facilities, and implement and operationalize the new missions.
2. Continue to implement, and expand, the PEP and Pathways programs at the Wyoming State Hospital and Wyoming Life Resource Center.
3. Reduce volume and demand in Wyoming's "Title 25" system for involuntary commitments.
4. Decrease the average length of stay at the Wyoming State Hospital and Title 25 "designated hospitals."
5. Continue to manage the wait list for Wyoming's Comprehensive and Supports (DD/ID) waivers, and reduce the percent of individuals waiting 18 months or more (currently 1.2%).
6. Continue to increase the percentage of Medicaid long-term care recipients served in home and community-based settings, as opposed to institutional settings.
7. Continue to maintain a "zero waitlist" policy for Medicaid Long-term Care Waivers (Community Choice Waiver).
8. Expand healthcare coverage options for Wyoming's uninsured population experiencing, or at-risk of institutionalization.