EXTERNAL QUALITY REVIEW: PROTOCOL 1 COMPLIANCE CROSSWALK

#	State Reg. Sources	SFY 2019 Contract Language	Comments/Findings from Applicable Documents	Reviewer Determination
438.100(b)(2)(i) - Enrollee right to receive information				
1	The language(s) that the State has determined are prevalent in the MCO's geographic service area.	These materials must be drafted using the State developed enrollee notices and Agency model enrollee handbook format and be made available in Spanish, the prevalent non-English language in Wyoming... The Contractor shall ensure that all written materials are provided in an easily understood language and format... Written materials must include taglines in the prevalent non-English language in Wyoming, be available in large print (a font size no smaller than 18 point), and provide an explanation of the availability of written translation, American Sign Language (ASL), or oral interpretation to understand the information provided [SOW pg. 16-17].	12.12.19: **POLICY_Medicaid Enrollee Rights and Responsibilities** publishes that all written materials to be distributed to enrollees are provided using easily understandable language and format [p. 4]. The written materials must include taglines in the prevalent non-English language and are available in large print (in font no smaller than 18 pt. font) [p. 4]. Enrollees also have the right to receive interpretation and translation services in a language the enrollee can understand and at no cost to the enrollee. This includes oral interpretation and auxiliary aids, such as Teletypewriter (TTY) & Telecommunications Device for the Deaf (TDD) and American Sign Language [p. 4-5]. The **MEMBER_HANDBOOK_SFY2018** provided to enrollees describes ways for individuals to receive written information in their preferred language (e.g. Spanish) or format (e.g. Braille) by calling a toll free number or accessing the state website [p. 4]. (JH) 2.6.20: Per onsite discussion, Magellan has found enrollees tend to speak English, Spanish, and Kurdish most frequently. Magellan notes that they take a look at provider data elements (stored in their provider portal) and match with the enrollee need. Furthermore, Magellan notes that when the program started in 2015, Magellan used the materials the state had for the 1915c waiver. For outside of the 1915c waiver, Magellan developed similar notices that were then approved by WDH. (JH)	Fully Met
2	Any requirements the State has issued to the MCO specifying a standard for the reading level of written materials prepared for enrollees.	The Contractor shall ensure that all written materials are provided in an easily understood language and format… Written materials must include taglines in the prevalent non-English language in Wyoming, be available in large print (a font size no smaller than 18 point), and provide an explanation of the availability of written translation, American Sign Language (ASL), or oral interpretation to understand the information provided... Interpreter services are available for the hearing impaired and for non-English speakers. Calls may range from non-urgent requests for referral to behavioral health crises [SOW pg. 17].	12.12.19: WDH has not issued specific reading level requirements for enrollee materials; however the SOW does specify several requirements regarding enrollee materials. POLICY_Medicaid Enrollee Rights and Responsibilities publishes that all written materials to be distributed to enrollees are provided using easily understandable language and format [p. 4]. Enrollees also have the right to receive interpretation and translation services in a language the enrollee can understand and at no cost to the enrollee [p. 4]. Magellan further documents standards for font size, as well as print and language taglines. This includes offering written materials in alternative formats and appropriate provision of auxiliary aids and services [p. 4]. (JH)	Fully Met
3	The State's decision about whether or not the MCO is to notify all enrollees at least once a year their rights to request and obtain the information listed in paragraphs (f)(6) and (g) of §438.10.	The Contractor will have mechanisms in place to help enrollees and potential enrollees understand the requirements and benefits of their plan and provide such information in a manner and format that may be easily understood and is readily accessible. The Contractor is required to provide each enrollee notice of any significant change in the information specified in the enrollee handbook at least thirty (30) days before the intended effective date of the change. The Contractor is also required to have policies that highlight enrollee's rights, including their right to participate in decisions regarding his/her healthcare, refuse treatment, be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, and request a copy of medical records and to have these record amended or corrected, when necessary. Each enrollee is free to exercise his or her rights without the Contractor or its network providers treating the enrollee adversely [SOW pg. 15] The Contractor must provide specific information in the enrollee handbook that includes: A. Information about enrollee's rights and responsibilities (including their right to	12.13.19: **POLICY_Medicaid Enrollee Rights and Responsibilities** publishes standards for enrollees to request and obtain their rights. Rights include but are not limited to: sharing in developing plan of care; being free from any form of restraint or seclusion; requesting and receiving copies of medical records; and being free to exercise rights without adverse treatment from Magellan [p. 4-6]. Magellan will inform all enrollees and/or their legal guardians of their rights and responsibilities by first appointment. The rights and responsibilities will also be available upon request [p. 3]. However, WDH does not clearly indicate when enrollees should be informed of rights (e.g., upon enrollment, annually, etc.) and only mentions timeframes for "significant changes." Additionally, the **MEMBER_HANDBOOK_SFY2018** includes most information outlined in the SOW: enrollees' rights and responsibilities [p. 18-19], information and timeframes regarding grievances, appeals, and continuation of benefits [p. 20-22], and treatment options/services [p. 7]. However, **MEMBER_HANDBOOK_sFY2018** does not mention State fair hearings. (JH) 2.6.20: Per onsite discussion, Magellan describes multiple ways that the MCO informs enrollees of significant changes. For example, the Member Handbook is updated every year	Fully Met

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		be treated with respect and in due consideration for his or her dignity and privacy); B. Enrollee's right to file grievances, appeals, State fair hearing, and receive continuation of benefits; C. Treatment options; D. Requirements and timeframes for filing a grievance or appeal; E. Information on the availability of assistance in the filing process for grievances; F. Specifications that, when requested by the enrollee, benefits that the Contractor seeks to reduce or terminate will continue if the enrollee files an appeal or a request for state fair hearing within the timeframes specified for filing, and that the enrollee may, consistent with state rule and policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee; G. Information on the availability of assistance in the filing process for appeals; and, H. Enrollee's right to request a state fair hearing after the Contractor has made a determination on an enrollee's appeal which is adverse to the enrollee. [SOW pg. 17]	and a notification goes out so enrollees can request it or view it online. Other forms of notification include a monthly e-newsletter, quarterly printed newsletter, postcard that notifies enrollees of "significant changes", etc. (JH)	
4	The State's decision about whether the MCO is to furnish to each of its Medicaid/CHIP enrollees the information listed in paragraphs (f)(6) and (g) within a reasonable time after the MCO receives, from the State or its contracted representative, notice of the recipient's enrollment.	The Contractor must notify a youth and/or family of enrollment within two (2) working days of the final eligibility determination [1915(b) waiver] or date of the notification email from the State [1915(c) waiver] data showing compliance with this requirement shall be included in the quarterly data report [SOW pg. 5]. The Contractor will have mechanisms in place to help enrollees and potential enrollees understand the requirements and benefits of their plan and provide such information in a manner and format that may be easily understood and is readily accessible. The Contractor is required to provide each enrollee notice of any significant change in the information specified in the enrollee handbook at least thirty (30) days before the intended effective date of the change [SOW pg. 15].	12.20.19: The **MEMBER_HANDBOOK_SFY2018** publishes standards that the care team will set up the first meeting to explain the process within 72 hours of enrollment [p.13]. **POLICY_Medicaid Enrollee Rights and Responsibilities** affirms that Magellan will inform all enrollees and/or their legal guardians of their rights and responsibilities. Magellan is expected to make available the enrollee rights and responsibilities to all enrollees, authorized representatives, customer organizations, and the general public. Enrollees have the right to ask and receive further information about providers, clinical guidelines, benefits, etc. [p. 3-6]. **SFY19 Q4 Report** demonstrates that >95% of enrollment notification letters are sent within 2 business days of determination, which aligns with SOW [p. 5]. (JH)	Fully Met
5	Information on how the State has defined a "significant change" in the information MCOs are required to give enrollees pursuant to §438.10(f) and (g).	The Contractor shall submit documentation to the Agency demonstrating that the Contractor offers an appropriate range of services that is adequate for the anticipated number of enrollees and maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the enrollees in the service area at the time it enters in to a Contract with the Agency and any time there is a significant change (as defined by the Agency) in the Contractor's operations that impacts services [SOW pg. 19].	2.6.20: WDH and Magellan have not created a formal definition for "significant change." Per onsite discussion, Magellan and WDH informally recognize program changes related to eligibility criteria would be considered a "significant change". (JH)	Not Met
6	Whether or not the MCO is part of a State managed care initiative that employs mandatory enrollment of beneficiaries in the MCO under section 1932(a)(1)(A) of the Act. If the MCO is part of such an initiative, obtain information from the State on the State's decision about whether the State or the MCO is to provide potential enrollees with the information contained in §438.10(h).	N/A - The MCO is not part of a mandatory managed care initiative and there are not multiple MCOs available for comparative information.	Not Applicable. The MCO is not part of a mandatory managed care initiative and there are not multiple MCOs available for comparative information.	Not Applicable

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7	If the MCO is part of a mandatory managed care initiative AND IF the State has directed the MCO to provide comparative information on disenrollment as part of a chart-like comparison of MCOs obtain the State agency's definition of "disenrollment rate".	N/A - The MCO is not part of a mandatory managed care initiative and there are not multiple MCOs available for comparative information.	Not Applicable. The MCO is not part of a mandatory managed care initiative and there are not multiple MCOs available for comparative information.	Not Applicable
8	Whether or not the State agency has chosen to give providers the right to challenge the failure of an MCO to cover a contracted service.	None	1.13.20: **POLICY_Benefit Certification Appeal General Guidelines** outlines the appeal process of adverse benefit determination or claim for benefit payment, which also applies when providers act as an authorized representative of the individual. An individual may begin the appeal process if there are any disagreements with the adverse benefit determination, or claim payment denial [p. 3]. (JH) 2.20.20: Per discussions with WDH on 12-20-19, providers do not have the right to challenge failure to cover contracted services themselves and can only submit appeals on behalf of enrollees. However, this was not formalized in the SOW.	Partially Met
9	Any applicable State laws on enrollee rights.	The Contractor will have mechanisms in place to help enrollees and potential enrollees understand the requirements and benefits of their plan and provide such information in a manner and format that may be easily understood and is readily accessible... The Contractor is also required to have policies that highlight enrollee's rights, including their right to participate in decisions regarding his/her healthcare, refuse treatment, be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, and request a copy of medical records and to have these record amended or corrected, when necessary. Each enrollee is free to exercise his or her rights without the Contractor or its network providers treating the enrollee adversely [SOW pg. 15].	1.13.20: WDH provided state laws - Wyoming Administrative Rules Chapter 47 (Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules); however, the rules do not specify laws on enrollee rights and instead provide information on eligibility and provider certification. Wyoming Administrative Rules Chapter 4 (Administrative Hearings) describe Medicaid enrollees' rights to administrative hearings if applications are denied or eligibility is reduced, terminated, etc.(VR)	Fully Met
438.100(b)(2)(iii) Enrollee right to receive information on available treatment options and alternatives . . . including requirements of §438.102: Provider-enrollee communications				
10	*Information on whether or not:* The MCO has documented to the State any moral or religious objection to providing, reimbursing for, or providing coverage of, a counseling or referral service for a particular Medicaid/CHIP service or services.	The Contractor must provide specific information in the enrollee handbook that includes ... Treatment options … [SOW pg. 16].	12.12.19: **POLICY_Medicaid Enrollee Rights and Responsibilities** indicates that for a counseling or referral service that Magellan does not cover because of moral or religious objections, Magellan must inform enrollees that the service is not covered and how to obtain information from the State about how to access the service [p. 6]. **MEMBER_HANDBOOK_SFY2018** indicates all services that the CME program covers [p. 7]. However, this does not describe moral or religious objections communicated to the State. To confirm with CME whether there are any objections. (VR) 2.6.20: Per onsite discussion, Magellan confirmed no moral or religious objections apply to this program; however, there is no formal documentation to support this. (JH)	Partially Met
438.100(b)(2)(iv) and (v): Enrollee right to: - participate in decisions regarding his or her care, including the right to refuse treatment; Be free from any form of restraint . . . as specified in other Federal regulations. And rel				

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11	A written description of any State law(s) concerning advance directives. The written description may include information from State statutes on advance directives, regulations that implement the statutory provisions, opinions rendered by State courts and other States administrative directives. [Note to reviewers: Each State Medicaid/CHIP agency is required under Federal regulations at 42 CFR 431.20 to develop such a description of State laws and to distribute it to all MCOs. Revisions to this description as a result of changes in State law are to be sent to MCOs no later than 60 days from the effective date of the change in State law.]	The Contractor is also required to have policies that highlight enrollee's rights, including their right to participate in decisions regarding his/her healthcare, refuse treatment, be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, and request a copy of medical records and to have these record amended or corrected, when necessary. [SOW pg. 15].	Not Applicable. CME program delivers care coordination services to youth, does not deliver medical services. Advance directives do not apply to this program.	Not Applicable
12	*Information on whether or not:* The MCO has documented to the State any moral or religious objection to fulfilling the regulatory provisions pertaining to advance directives.	None	Not Applicable. CME program delivers care coordination services to youth, does not deliver medical services. Advance directives do not apply to this program.	Not Applicable
438.100(d): Compliance with other Federal and State laws				
13	Obtain from the State Medicaid/CHIP agency the identification of all State laws that pertain to enrollee rights and with which the State Medicaid/CHIP Agency requires its MCOs to comply.	None	1.9.20: Wyoming does not have laws that are specific to MCOs; however it does have general laws regarding basic rights of Medicaid clients: https://wyoleg.gov/statutes/compress/title42.pdf. Title 42, Welfare, includes information on Medicaid eligibility, confidentiality of records, contracts for waiver services, etc. **MEMBER_HANDBOOK_SFY2018** includes members' rights and responsibilities, including to "get healthcare services that obey Wyoming and federal laws about your rights" [p. 18-19]. (VR)	Fully Met
Subpart D: Quality Assessment and Performance Improvement				
438.206: Availability of services				
14	*Information on whether or not:* The State agency has required the MCO to adhere to any explicit standards for provider network adequacy, such as prescribed primary physician/enrollee ratios or specialist/enrollee ratios.	The Agency does not require the Contractor to contract with more providers than necessary to meet the needs of its enrollees and in consideration of the number of enrollees and expected utilization of services, and the number of providers that have met ratio requirements [SOW pg. 18].	12.16.19: The **SOW** indicates provider: beneficiary ratio requirements - FCCs 1:10, FSPs 1:10, YSP 1:25 [p.6]. **EXPECTATIONS_Network Development & Scalability Report** includes the number of providers available in SFY2019 by region and quarter and includes county maps with provider and member counts [p. 1-8]. **HANDBOOK_PROVIDER_FY2018** aligns with the SOW by indicating the required ratios for each provider type - FCCs 1:10, FSPs 1:10, YSP 1:25 [p.15-16]. SFY19 Q4 Report includes data for provider ratios, which indicate >95% compliance with the FCC ratio and 100% compliance with the FSY/YSP ratios throughout SFY19. (VR)	Fully Met
15	*Information on whether or not:* The State agency has in place any time or distance standards for beneficiary travel to access covered services in Medicaid/CHIP fee-for-service.	The Contractor will also demonstrate that they have complied with availability and accessibility of services requirements, including adequacy of the provider network through OP-18 [SOW pg. 18].	Not applicable. Time and distance standards do not apply based on the nature of the CME program. In the community-based nature of the HFWA model, providers travel to the members in this program, rather than members traveling to a clinic or facility, for example. The member's team decides where to have meetings - and all meetings are scheduled at a time and place that works best for members, per the **MEMBER_HANDBOOK_SFY2018** [p. 13]. Refer to the "Network Adequacy Tool" for more information on provider availability and access.	Not Applicable

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16	*Information on whether or not:* There are any State laws requiring MCOs to make specific types of providers available for the provision of certain services.	None	1.8.20: Per discussions with WDH on 12/20/19, WDH indicates there are no state laws regarding certain provider types for this type of intensive care coordination program. However, the CME program is limited to four provider types per the waiver agreement with CMS and Magellan only utilizes the four provider types - Family Care Coordinator (FCC), Family Support Partner (FSP), Youth Support Partner (YSP), Respite. **HANDBOOK_PROVIDER_FY2018** indicates the Magellan's use of the four provider types for the provision of a variety of services depending on the role. For example, the FCC works with a team to implement all activities of the HFWA process, delegate responsibilities, and lead the family care coordination of the child and family team process until transition can occur. The YSP is a young adult with personal experience participating in the system of care and works with "the youth on building confidence and skills around self efficacy." [p. 15-16]. (VR)	Fully Met
438.206(c)(1): Furnishing of services and timely access				
17	Obtain a copy of the State Medicaid/CHIP agency's standards for timely enrollee access to care and services required of Medicaid/CHIP and MCOs.	Geographic mapping is generated and reported on a quarterly basis and is developed by the Contractor and provided to the Agency for use in monitoring marketing, information to beneficiaries, enrollee's free choice of providers, timely access, coordination/continuity of care, coverage/authorization, quality of care, and Provider Selection. The Contractor will map referral and subsequent enrollment patterns to ensure appropriate marketing in all geographic areas [SOW pg. 18]. The measurement of any disparities by racial or ethnic groups will be used to monitor timely access and coverage and authorization of care [SOW pg. 19]. The 800 number is used to monitor the following: information to beneficiaries, grievance, timely access, coordination/continuity, fraud, waste, and abuse, and quality of care. The data is used to monitor the above topics by obtaining information from the beneficiaries, resolving issues, and identifying and addressing trends [SOW pg. 17].	12.17.19: The **POLICY_Medicaid Enrollee Rights and Responsibilities** describes standards that each enrollee has the right to easily access care in a timely fashion [p. 4]. Magellan further describes in **HANDBOOK_PROVIDER_FY2018** that it will include seamless service delivery for enrolled children, youth and families, enhanced communication and collaboration among system partners in the system of care and provision of timely and effective community-based services and supports that promote resiliency and family wellness [p. 4]. **HANDBOOK_PROVIDER_FY2018** indicates providers will provide safe, effective, patient-centered, timely, efficient and equitable care in a culturally sensitive manner [p. 38]. Additionally, the **SOW** includes a performance measure that requires providers to contact new members timely, within three working days of provider selection [p. 5]. CME demonstrates level of compliance with this measure via quarterly reports. (JH)	Fully Met
438.206(c)(2): Furnishing of services and cultural considerations.				
18	Descriptive information on the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.	The Contractor is required to participate in the Agency's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity [SOW pg. 19].	1.8.20: Magellan repeatedly demonstrates delivery of services in a culturally competent manner. For instance, **HANDBOOK_MemberHandbook** indicates "Culturally Competent" as a core principle of the program and indicates that "the plan respects and builds on the values, preferences, beliefs and culture of the child/youth and family" [p. 4]. **HANDBOOK_MemberHandbook** also explains that members can receive information in other languages [p. 18] and formats [p. 28]. **HANDBOOK_Provider_National** indicates that "Magellan is committed to embracing the rich diversity of the people we serve. We believe in providing high-quality care to culturally, linguistically and ethnically diverse populations, as well as to those who live with disabilities such as visual and hearing impairment" [p.49]. Magellan staff and providers receive cultural diversity and sensitivity training [p. 49]. **PLAN_CulturalCompetency** includes a list of relevant trainings and provider communications. Additionally, per discussions with WDH on 12/20/19, Wyoming has an "Office of Health Equity" which works to "ensure Wyoming's racial and ethnic minority residents receive the same quality healthcare as the general population" and was available as a resource to Magellan during SFY19. Presently, Magellan is partnering with this group to conduct training on cultural relevance and disparities, but this partnership was not established during SFY19. (VR)	Fully Met

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19	The requirements the State has communicated to the MCO with respect to how the MCO is expected to participate in the State's efforts to promote the delivery of services in a culturally competent manner.	The Contractor is required to participate in the Agency's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity [SOW pg. 19]. The Contractor must report demographic data (including racial/ethnic data), outcomes measures, utilization, and special needs population (target population) data to the Agency annually. The measurement of any disparities by racial or ethnic groups will be used to monitor timely access and coverage and authorization of care [SOW pg. 19].	12.19.19: **SOW** indicates Magellan is required to promote the delivery of services in a culturally competent manner to all enrollees, and to report demographic data annually [p. 19]. **HANDBOOK_PROVIDER_FY2018** describes that the program's purpose is to build relationships with "children, youth, families, family organizations, Tribes and their government, physical and behavioral healthcare communities, educational communities, human services systems, child welfare and judicial systems, faith-based organizations and other stakeholders to achieve a system of care" [p. 4]. Per **HANDBOOK_Provider_National**, Magellan is actively "recruiting, developing, retaining and monitoring a diverse provider network compatible with the member population" [p. 49] and develops a provider recruitment plan if gaps in services are identified [p. 50]. Per **EXPECTATIONS_Network Development & Scalability Report**, Magellan's provider network included "two Multi-Racial and 42 White/Non-Hispanic providers" and language competencies included "three Sign Language and five Spanish" [p 1]. (VR)	Fully Met
438.208: Coordination and continuity of care				
20	Definition/specifications used by State to identify individuals with special health care needs (SHCNs).	The Contractor must include mechanisms to assess the quality and appropriateness of care coordination furnished to enrollees with special health care needs. [SOW pg. 27].	Not Applicable. All members of the CME program have SHCNs because all youth have behavioral/mental health diagnoses (e.g. SED or SMI). Level of care is determined by use of several assessment tools, such as CASII, ECSII, CANs, ACEs.	Not Applicable
21	Methods used by the State to identify to the MCO new enrollees with SHCNs.	The Contractor must include mechanisms to assess the quality and appropriateness of care coordination furnished to enrollees with special health care needs. [SOW pg. 27].	Not Applicable. All members of the CME program have SHCNs because all youth have behavioral/mental health diagnoses (e.g. SED or SMI). Level of care is determined by use of several assessment tools, such as CASII, ECSII, CANs, ACEs.	Not Applicable
22	Whether the MCO is required to screen to identify and/or assess persons with SHCNs using the State's definition of SHCNs.	The Contractor must include mechanisms to assess the quality and appropriateness of care coordination furnished to enrollees with special health care needs. [SOW pg. 27].	Not Applicable. All members of the CME program have SHCNs because all youth have behavioral/mental health diagnoses (e.g. SED or SMI). Level of care is determined by use of several assessment tools, such as CASII, ECSII, CANs, ACEs.	Not Applicable
23	State requirements for MCO care coordination programs.	The goal of the program is to develop a community-based transition and diversion service as an alternative to institutionalization for youth with serious emotional disturbance (SED) or serious and persistent mental illness (SPMI). The Contractor will be responsible for coordinating the delivery of HFWA services (including targeted case management provided via a HFW A delivery model, respite, and youth and family training, and support services). This includes the provision of administrative services for the management of the program, including outreach, eligibility and enrollment determinations, provider corrective action plans, claims processing, provider training, outreach and payment, and enrollee and provider communications. The Contractor will also be responsible for conducting determinations of clinical eligibility, level of care redeterminations for all youth, and development and maintenance of the provider network [SOW pg. 2].	Not Applicable	Not Applicable

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24	If the organization to be reviewed is a MCO, whether the MCO is required to ensure each enrollee has: A) an ongoing source of primary care appropriate to his/ her needs, and B) a person/entity formally and primarily responsible for coordinating the health care services furnished to the enrollee.	The Contractor must document whether or not an enrolled youth has an identified primary care provider (PCP) [SOW pg. 6-7]. The Contractor formally designates a Family Care Coordinator (FCC) of the enrollee's choosing and provides information to the enrollee on how to contact their designated FCC. The FCC is responsible to coordinate the services the Contractor furnishes to the enrollee with the services the enrollee may receive in FFS Medicaid [SOW pg. 25].	1.13.20: The **HANDBOOK_MemberHandbook** and **POLICY_Medicaid Service Authorization Determination** describe the role of the primary care physician and the family care coordinator. Per the **Member Handbook**, the primary care physician (PCP) "works with the family in accessing the services [the] child needs... [and] Magellan will ensure that every child has a PCP, and that the PCP will perform and manage all EPSDT requirements" [p. 23]. The **Medicaid Service Authorization Policy** requires the PCP to determine the services the member needs and coordinate care to reduce unnecessary risk from receiving services separately. [p. 5]. Additionally, the **SOW** includes a performance measure (OP-11) that requires the CME to document whether enrolled youth have an identified PCP [p. 7]. CME demonstrates level of compliance with this measure via quarterly reports. (JH) As defined in the **Member Handbook**, the family care coordinator (FCC) is "trained to coordinate the HFWA process for an individual family" [p. 25]. The FCC, along with the FSP and YSP, "help the youth and family decide what they want for their future...help the youth/family understand and be prepared for the process...develop a child and family team" and "support the team's progress" [p. 6]. Per the **HANDBOOK_PROVIDER_FY2018**, FCCs must complete youths' applications to the HFWA program [p. 11], so enrollment cannot take place without an FCC. (JH)	Fully Met
25	If the organization is an MCO serving enrollees also enrolled in a Medicare Advantage plan and receiving Medicare benefits, information about the extent to which the MCO is required to implement: - for enrollees determined to have ongoing special conditions that require a course of treatment or regular care monitoring, a mechanism to ensure that: (1) the enrollee may directly access a specialist (e.g., through a standing referral or approved number of visits) as appropriate for the enrollee's condition and identified needs; and (2) a treatment plan that, if required by the MCO is developed by the specialist in consultation with the enrollee's primary care provider, and is (i) developed with enrollee	None	Not Applicable. Medicare Advantage does not apply to the member population.	Not Applicable

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	participation; (ii) approved by the MCO in a timely manner, if this approval is required; and iii) In accord with the State's quality assurance and utilization review standards. - a primary care and coordination program that meets State requirements and ensures each enrollee has: 1) an ongoing source of primary care appropriate to his/her needs; and 2) a person or entity formally and primarily responsible for coordinating health care services furnished to the enrollee.			
26	The State's quality assurance and utilization review standards.	The Contractor is required to establish and implement an ongoing Comprehensive Quality Assessment and Performance Improvement (QAPI) program for the services it furnishes to its enrollees. The QAPI program **must include Performance Improvement Projects (PIP)**, including any required by the Agency or CMS. The QAPI program **must include collection and submission of performance measurement data** as specified in the Contract and Statement of Work outcome measures and performance requirements and **report to the Agency on its performance**. Activities of the QAPI program must include **mechanisms to detect both underutilization and overutilization of service** [SOW pg. 27].	1.13.20: Multiple policies indicate that Magellan is required to capture performance / quality metrics. **The POLICY_Quality Improvement Program** describes Magellan's quality improvement program which implements "ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees..." [p.5] The policy also states that the QAPI program has "mechanisms to detect both underutilization and overutilization of services" [p. 5] but does not describes these mechanisms. **PIP_EXAMPLE_MinimumContactImprovement** provides an example of a performance improvement project Magellan undertook to improve minimum contact engagement for family care coordinators. Magellan collects data for the performance measures outlined in the SOW and submits the data via quarterly reports. (JH) 2.6.20: Per onsite discussion, Magellan confirmed that the quality program has "trilogy documents" - including a workplan, program description, and program evaluation; however these documents were not formally in use in SFY19 and undergoing approval currently. Magellan has an internal quality improvement committee that meets every month, as well as an external quality improvement committee. Magellan notes that the quality team and compliance committee work closely together; the quality team manages expectations, results, tracking, and data collection of any quality projects. Magellan has noted during onsite discussion that utilization management is not as applicable to this program. Since enrollees can opt out of services, metrics of utilization cannot be standardized across the program. (JH)	Partially Met
438.210(b-e): Coverage and authorization of services, including 438.114, emergency and post-stabilization services				
27	Obtain from the State Medicaid/CHIP agency the State-established standards for MCO processing of standard authorization decisions.	For standard authorization decisions, the Contractor must issue service authorizations and/or adverse action notifications as a result of the concurrent review no later than fourteen (14) calendar days after receipt of the plan, with a possible extension of fourteen (14) calendar days if the provider or enrollee requests an extension or the Contractor justifies the need for additional information and how the extension is in the enrollee's best interest [SOW pg. 22].	12.19.19: **POLICY_Medicaid Service Authorization Determination** requires standard reviews of service authorization requests to be completed "as quickly as the member's condition requires," but no longer than 14 calendar days after receipt of request [p. 5]. Standard processing time may be extended once for up to 14 calendar days [p. 6]. Expedited authorization decisions are completed within 72 hours of receipt, and may be extended for up to 14 calendar days [p. 6]. These timeframes align with timeframes outlined in the **SOW**. (VR)	Fully Met
438.214: Provider selection				

#	State Reg. Sources	SFY 2019 Contract Language	Comments/Findings from Applicable Documents	Reviewer Determination
28	Obtain from the State information on any credentialing, recredentialing, or other provider selection and retention requirements established by the State.	The Contractor must maintain and monitor a network of appropriate providers that is supported by written agreements and policies and procedures that document the process the Contractor requires for provider credentialing and re-credentialing [SOW pg. 18].	12.19.19: Per the **SOW**, the CME program "must maintain and monitor a network of appropriate providers that is supported by written agreements and policies and procedures that document the process the Contractor requires for provider credentialing and re-credentialing" [p. 18]. Magellan uses **PROVIDER_AGREEMENT_Transitions of WY Network Agreement (601370614)** as the Provider Agreement for network providers. Per **HANDBOOK_PROVIDER_FY2018**, providers must be certified and contracted by Magellan and approved by Wyoming Medicaid [p. 21]. Providers must complete the Provider Agreement, comply with minimum qualifications required for participation as a HFWA provider, meet education/experience requirements, complete requirements of Magellan's certification process, and follow state and federal laws as well as the Magellan's policies and procedures [p. 21]. The **Handbook** further includes qualifications for each provider type [p. 17-19]. Certification requires completion of background screenings, submission of Magellan's initial provider application, passing the training curriculum, and enrollment as a Wyoming Medicaid provider [p. 30-31]. Providers are required to re-certify on an annual basis, which includes training requirements and paperwork submission [p. 32]. Per **HANDBOOK_Provider_National,** Magellan is committed to promoting quality care for its members. In doing so, Magellan requires practitioners to meet and maintain a minimum set of credentials to be able to provide services to members [p. 10]. Magellan continually assesses network composition by actively recruiting, developing, retaining and monitoring a diverse provider network compatible with the member population. When gaps are identified, Magellan will develop a provider recruitment plan and monitor its effectiveness [p. 49-50]. (VR) 2.6.20: Per the **Provider Certification Guide 8-18**, each provider must meet qualifications for the provider type they are applying for in order to participate in Magellan's network. This includes basic requirements (age requirements, driver's license requirements, CPR/First Aid certification, etc.) and training/certification requirements (including Tier 1 and Tier 2 requirements). (JH) 2.6.20: Per onsite discussion, Magellan described the certification and recertification process. All providers are required to complete both processes to be added to the network and to start billing for services. For the initial certification process, providers must go through a two tier process prior to billing for services. During Tier 1, the provider is introduced to the program in an interactive classroom setting (foundations course) and through webinars. During Tier 2, the provider starts engaging with the family with coaching supervision. A coach is assigned a provider upon start and during recertification to identify and meet training needs. Recertification is on an annual basis and providers must pass an exam (80%) to meet the requirements to continue. During their training, providers are required to go through a detailed training on plans of care, strengths/needs assessments, crisis plans, discharge plans, and provider notes. The coach and training lead review each provider's documentation for issues or areas of improvement, during initial training and during recertification. Magellan tracks providers' status with Tier trainings using **Tier 1 Tracking Sheet** and **Tier II Tracking Sheet;** Magellan tracks providers' status with recertification using Recertification Tracking Sheets. (JH)	Fully Met
438.226: Enrollment and disenrollment, including section 438.56: Enrollment and disenrollment: Requirements and limitations				

#	State Reg. Sources	SFY 2019 Contract Language	Comments/Findings from Applicable Documents	Reviewer Determination
29	*Information on:* Whether or not the State Medicaid/CHIP agency allows the MCO to process enrollee requests for disenrollment for cause and, if so, whether or not the State requires enrollees to seek redress through the MCO's grievance system before the State makes a determination on the enrollee's request.	Disenrollment requested by the enrollee may occur for cause at any time [SOW pg. 14]. For enrollees that have filed a grievance or appeal, the Contractor must complete the review of the grievance in time to permit the disenrollment to be effective no later than the first day of the second month, following the month in which the enrollee requests disenrollment [SOW p. 14].	1.8.20: Per the **SOW**, enrollees may disenroll for cause at any time [p. 14], and there is no indication that this requires redress through the grievance system. **POLICY_HFWA Program_Enrollment_Disenrollment_Policy** clearly explains reasons youth may disenroll [p. 5] and the process of disenrolling. Examples of reasons for a youth to request disenrollment include poor quality of care, lack of access to covered services, lack of access to experienced providers, etc. [p. 6]. For youth/family that have filed a grievance, Magellan must complete the review of the grievance in time to permit the disenrollment, effective no later than the first day of the second month following the month in which the enrollee requests disenrollment [p. 6]. Magellan notifies enrollees via a Notice of Disenrollment letter and sends a copy to WDH [p. 6]. Note that Magellan did not have a clear disenrollment policy in place during the SFY18 review, but have since developed one. (VR)	Fully Met
30	*Information on:* A copy of the State-MCO contract provisions, which specify the methods by which the MCO assures the State Medicaid/CHIP agency that it does not request disenrollment for reasons other than those permitted under the contract.	The Contractor shall track disenrollment requests by enrollee and provide a copy to the Agency of each disenrollment letter sent to enrollees so that the Agency may verify that the Contractor did not request disenrollment for reasons other than those permitted under the contract [SOW pg. 15].	1.8.20: The **SOW** indicates the acceptable reasons for disenrollment [p. 15], which are contained in **POLICY_HFWA Program_Enrollment_Disenrollment_Policy** as well [p. 5]. Magellan sends a copy of the disenrollment letter to WDH so that WDH can verify that Magellan did not request disenrollment for reasons other than those permitted in the contract [p. 6]. (VR) 2.8.20: **REPORT_Disenrollment Counts by Reason FY2019** provides the numbers and types of disenrollments during SFY19. Magellan had 295 disenrollments - most common reasons for disenrollment were "Goals met: Family/participant" (99 disenrollments) and "Famly choice term:famly end wvr svcs/goals not met" (55 disenrollments). (VR)	Fully Met
438.228: Grievance systems				
31	Obtain information on whether or not the State delegates responsibility to the MCO for providing each Medicaid/CHIP enrollee (who has received an adverse decision with respect to a request for a covered service) notice that he or she has the right to a State fair hearing to reconsider their request for the covered service.	The Contractor must provide specific information in the enrollee handbook that includes... Enrollee's right to request a state fair hearing after the Contractor has made a determination on an enrollee's appeal which is adverse to the enrollee [SOW pg. 17]. In the event the Contractor makes an adverse action notification regarding an enrollee or if the action is a denial of payment, written notice of the adverse action notification must be mailed to the enrollee on the date of determination. All notices of adverse action notifications must, at a minimum, explain the determination, reasons for the determination, right to retrieve applicable and related copies of documents and records of the grievance, how and the right to appeal or request State fair hearing [SOW pg. 21].	1.8.20: The **SOW** indicates that Magellan must inform enrollees of their right to a state fair hearing [p. 17]. However, the member handbook and other outreach materials do not include this information. Per **POLICY_WY Medicaid Enrollee Grievances_AddendumAttachment**, "There is no second level review or state fair hearing right for members to appeal a Magellan grievance disposition" [p.1]. **POLICY_Benefit Certification Appeal General Guidelines** describes that members must receive written notice for all adverse benefit determinations and appeal decisions, and the notice includes information on regulatory requirements that members may request access to and copies of all documents relevant to an appeal free of charge [p.6-7]. However, it is not clear from the provided materials whether the notice to members includes "explain the determination, reasons for the determination, right to retrieve applicable and related copies of documents and records of the grievance, how and the right to appeal or request State fair hearing." (VR) 2.6.20: The **LETTER_Wyoming Grievance Resolution Letter** sent by Magellan to the enrollee outlines the resolution of the grievance. The letter also provides information on the appeals process. However, the letter does not outline if the enrollee has the right to a State fair hearing upon exhausting the appeals process with Magellan. **MEMBER_Handbook_SFY2019** provided to enrollees does include the right to State fair hearing [p. 32]; however, this version was not used within the review period. Upon onsite discussion, Magellan noted that **POLICY_WY Medicaid Enrollee Grievances_AddendumAttachment** is no longer valid**.** (JH) 2.8.20: Magellan submitted two versions of adverse action notifications. The earlier version	Partially Met

#	State Reg. Sources	SFY 2019 Contract Language	Comments/Findings from Applicable Documents	Reviewer Determination
			2.8.20: Magellan submitted two versions of adverse action notifications. The earlier version, **LETTER_Notice of Adverse Action_July2018_to_January2019**, does not contain as much detail; however, the more recent version which was effective January 2019 - **LETTER_Notice of Adverse Action_January2019_to_Present** includes: the determination and the reason for the determination; informs members that "a copy of your Plan of Care will be provided at no cost to you" [p. 4]; informs members of appeal rights [p. 6] and informs members of the right to a hearing with the Wyoming Department of Health and method for requesting a hearing [p. 7]. (VR)	
438.230: Sub contractual relationships and delegation				
32	Obtain from the State the "periodic schedule" established by the State according to which the MCO is to monitor and formally review on an ongoing basis all subcontractors' performance of any delegated activities.	The Contractor shall: evaluate any prospective subcontractor's ability to perform the activities to be delegated; have a written agreement that specifies the activities and reports responsibilities delegated to the subcontractor, and Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate; monitor the subcontractor's performance on an ongoing basis and subject it to formal reviews according to a periodic schedule established by the Agency, consistent with industry standards; and, look for deficiencies or areas of improvement in subcontractor's performance and take corrective action when necessary. [Contract pg. 7].	Not applicable. The program does not utilize subcontractors.	Not Applicable
438.240: Quality assessment and performance improvement program: (a) General rules, (b) Basic elements of MCO quality assessment and performance improvement programs, (c) Performance improvement projects				
33	*Obtain from the State Medicaid/CHIP agency:* Information on whether or not the State Medicaid/CHIP agency has required the MCO's performance improvement projects to address a specific topic(s), or address a specific topic(s) and also use specific quality indicators identified by the State Medicaid/CHIP agency.	See *Performance Measure Reporting* [SOW pg. 27-30].	1.8.20: WDH requires Magellan to have performance improvement projects [SOW p. 27]; however, WDH does not specify topics. **PIP_EXAMPLE_MinimumContactImprovement** describes an informal quality improvement activity Magellan undertook to improve provider minimum contact requirements by establishing a "Minimum Contacts workgroup" [p. 1-5]. (VR)	Fully Met

#	State Reg. Sources	SFY 2019 Contract Language	Comments/Findings from Applicable Documents	Reviewer Determination
34	*Obtain from the State Medicaid/CHIP agency:* The State's requirements with respect to MCO reporting of the status and results of each performance improvement project to the State Medicaid/CHIP agency.	The Contractor's PIP status and results will be reported to the Agency no less than once a year and include at least the following elements: A. Demonstration of significant improvement, sustained over time, in health outcomes and enrollee satisfaction; B. Measurement of performance using objective quality indicators; C. Implementation of interventions to achieve improvement in the access to and quality of care; D. Evaluation of the effectiveness of the interventions based on the performance measures; and, E. Planning and initiation of activities for increasing or sustaining improvement [SOW pg. 27].	1.8.20: WDH requires Magellan to report on PIP status and results annually [SOW pg. 27]. **PIP_EXAMPLE_MinimumContactImprovement** includes the following information regarding a PIP on "minimum contact requirements": Activity; Driver/cause; Intended outcome; Measures; Barriers; Interventions; Qualitative Analysis; Graphical Display. **POLICY_Quality Improvement Program** indicates that the quality assessment and performance improvement program includes "performance improvement projects in accordance with State requirements." [p. 5] Note that Magellan did not have formal methods of communicating PIPs during the SFY18 review, but has since adopted methods to communicate PIP status. (VR) 2.6.20: Per onsite discussion, Magellan noted that the SOW requires annual submission of PIP status and results (p. 27). On a quarterly basis, Magellan is also required to report dashboards for the provider scorecard PIP. Magellan and WDH also meet weekly to discuss progress on the PIPs. (JH)	Fully Met
35	*Obtain from the State Medicaid/CHIP agency:* Any reports on the status and results of the performance improvement projects submitted by the MCO in response to State requirements for reporting the status and results of each performance improvement project to the State Medicaid/CHIP agency.	None	1.8.20: WDH requires the CME to report on PIP status and results annually [SOW pg. 27]. **PIP_EXAMPLE_MinimumContactImprovement** includes the following information regarding a PIP on "minimum contact requirements": Activity; Driver/cause; Intended outcome; Measures; Barriers; Interventions; Qualitative Analysis; Graphical Display. (VR)	Fully Met
438.240(c): Performance measurement and improvement				
36	*Obtain from the State Medicaid/CHIP agency:* A list of all performance measures required of the MCO by the State for the year or years for which the review is being conducted.	See *Performance Measure Reporting* [SOW pg. 27-30].	1.8.20: The **SOW** contains the performance measures required of the CME program [p. 27-30]. Magellan submitted data for all measures during SFY19 via quarterly "Program Status Reports." (VR)	Fully Met
37	*Obtain from the State Medicaid/CHIP agency:* The actual performance measures submitted by the MCO to the State for the year or years for which the review is being conducted.	See *Performance Measure Reporting* [SOW pg. 27-30].	1.8.20: The **SOW** contains the performance measures required of the CME program [p. 27-30]. Magellan submitted data for all measures during SFY19 via quarterly "Program Status Reports." (VR)	Fully Met
38	*Obtain from the State Medicaid/CHIP agency:* Instructions from the State on whether or not the State wishes the EQRO to validate the MCO's submitted performance measures.	None	1.8.20: WDH selected the following six operational requirements for the EQRO to review in depth: •OP01 – Provider Network Certification •OP03 – SNCD Compliance •OP04 – FCC Family Engagement Timelines •OP10 – FCC Ongoing Contact •OP12 – CFT Meetings •OP14 – Evaluations and Re-assessments (VR)	Fully Met
438.240(e): Program review by the State.				

#	State Reg. Sources	SFY 2019 Contract Language	Comments/Findings from Applicable Documents	Reviewer Determination
39	Determine from the State Medicaid/CHIP agency whether or not the State has required the MCO to have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement (QAPI) program and, if so, how frequently the MCO is to make such an evaluation.	The Contractor's PIP status and results will be reported to the Agency no less than once a year and include at least the following elements: A. Demonstration of significant improvement, sustained over time, in health outcomes and enrollee satisfaction; B. Measurement of performance using objective quality indicators; C. Implementation of interventions to achieve improvement in the access to and quality of care; D. Evaluation of the effectiveness of the interventions based on the performance measures; and, E. Planning and initiation of activities for increasing or sustaining improvement [SOW pg. 27].	1.8.20: The SOW does not require Magellan to evaluate its own QAPI program. However, **POLICY_Quality Improvement Program** indicates that Magellan develops an annual quality work plan, which is based on review of the previous year's QI program and results [p. 3] Although there are not clear, formal processes for evaluating the QAPI, WDH does not require this level of evaluation. (VR)	Fully Met
438.242: Health information systems				
40	*Information on whether or not:* The State has required the MCO to undergo, or has otherwise received, a recent assessment of the MCO's health information system. If the State has required or received such an assessment, obtain a copy of the information system Assessment from the State or the MCO. Also obtain contact information about the person or entity that conducted the assessment and to whom follow-up questions may be addressed.	The Contractor is required to maintain a health information system that collects, analyzes, integrates and reports data. The Contractor's health information system shall provide information on areas including, but not limited to: denials of referrals, requests; utilization; claims; enrollee and provider grievances, complaints, and appeals data; and, disenrollment for reasons other than loss of Medicaid eligibility including disenrollment requests made by an enrollee [SOW pg. 13-14].	1.8.20: The **SOW** requires Magellan to maintain a health information system with certain components [p. 13-14]; however, WDH does not require assessments of Magellan's system. Need to confirm the IT system includes all components required in the SOW. (VR) 2.16.20: As per onsite discussion, enrolled providers are required to submit service information for members. This may come via telephone, email, and/or web portal entry. The claims and encounters go through a series of MMIS edits including data validation, eligibility, utilization review, duplicate check, etc. to determine if each should pay, suspend, deny, etc. for validation. The clinical process includes a review of all of the documentation that is submitted, claims edits, authorizations, and timely filings. Provider training and validation of the provider agreement are all necessary to move to the next 90-day authorization. To validate the numbers, a Magellan staff member runs internal error reports, along with an SIU. To obtain data from all components of the network, Magellan institutes the following processes: In terms of **referral data**, there are 3 entry points: 1) Provider may enter using the www.magellanofwyoming.com website 2) Provider may email information to wyclinical@magellan.com, and the staff will manually enter into the web reporting database 3) Provider may call to report referral, and the staff will manually enter using the www.magellanofwyoming.com website In terms of **assessment data**, the provider uses the Progress Notes feature on mp.com to report events such as phone contact, face-to-face meetings, meeting attendance, meeting	Fully Met

#	State Reg. Sources	SFY 2019 Contract Language	Comments/Findings from Applicable Documents	Reviewer Determination
			invitations, etc. **Training data** is maintained manually in a spreadsheet that the Training & Provider Certification staff uses as she provides the classes for eligible providers. Magellan also generates a standard 837 transaction (claim) to request WDH payment of the per member per month (PMPM) fee. The state also utilizes 837 files for provider claims and 835 files for remittance advice (notice of payment). In order to keep the data more current and reflective in the claims and billing processes, Magellan has instituted an improvement in the 270/271 process for eligbility. The claims department also goes through regular audits. Note, none of these processes are confirmed in documentation. (JH)	
41	State specifications for data on enrollee and provider characteristics that must be collected by the MCO.	The performance measures provide information on ... health plan/provider characteristics, and beneficiary characteristics [SOW pg. 14].	1.8.20: **SOW** requires Magellan to report demographic data [p. 19]. **SFY19 Q4 report** includes an appendix on Race and Ethnicity which reports the races/ethnicities of enrolled youth vs the races/ethnicities of non-enrolled Wyoming youth to highlight possible disparities [p. 285-288]. **SFY19 Q4 report** also includes a report on Network Development/Scalability which includes brief demographic data on the provider network [p. 281]. **POLICY_Network Provider Data Maintenance and Data Integrity** states the provider directory includes providers' name, gender, discipline, degree, license type, affiliations, languages spoken, office information, and whether they are accepting new patients, among other information [p. 3-4]. (VR)	Fully Met
42	State specifications for how MCOs are to collect data on services furnished to enrollees (i.e., whether or not the MCO must collect encounter data or may use other methods). If the State allows the MCO to use other methods, what are the State's requirements with respect to these "other methods?" If the State requires MCOs to collect encounter data and report it to the State, does the State validate this data or require it to be validated? If the data is validated, obtain a copy of the most recent validation report.	None	1.8.20: **SFY19 Q4 Report** includes data on several measures related to encounters/claims [p. 7]: -Total number of paid encounters processed by Magellan (date of adjudication) -Total number of encounters sent to the State during the reporting period (date of submission) -Total number of paid encounter units processed by Magellan (date of adjudication) -Total number of encounter units sent to the State during the reporting period (date of submission) -Number of claim encounters submitted by providers -Number of claim encounters submitted by providers within 90 days of service end date Need to confirm whether/how WDH validates this data. (VR) 2.16.20: Per onsite discussion, the claims and encounters go through a series of MMIS edits including data validation, eligibility, utilization review, duplicate check, etc. to determine if each should pay, suspend, deny, etc. for validation. Magellan and WDH noted adjustments to the RFP for a new EHR system to better collect enrollee data and better serve their clients. The updates for EHR will be included for SOW 2020. (JH)	Fully Met
Subpart F: Grievance System				
438.402: General requirements				

#	State Reg. Sources	SFY 2019 Contract Language	Comments/Findings from Applicable Documents	Reviewer Determination
43	*Obtain from the State information on:* The time frame during which enrollees and providers are allowed to file an appeal.	Appeals can be filed orally or in writing by the enrollee or an authorized representative, including the provider, within sixty (60) calendar days from the date on the adverse action notice [SOW pg. 21].	2.7.20: Per the **MEMBER_Handbook_SFY2018**, enrollees are notified of the process of filing an appeal for grievances and complaints. To file an appeal, the enrollee or their representative "must send a written appeal [or complete an Appeal Request Form or call a toll-free number] request to the Wyoming Department of Health within 30 days from the date on the letter" that Magellan sent about the grievance resolution [p. 21]. Similarly, the **POLICY_Medicaid Enrollee Grievances** documents that the enrollee has thirty (30) days within receipt of the grievance outcome to file an appeal [p. 6]. Note, a grievance is defined as "an expression of dissatisfaction about any matter other than an adverse benefit determination" [p. 2]. There appears to be conflicting timeframes for appeals regarding adverse benefit determinations. According to **POLICY_Medicaid Adverse Benefit Determination Appeal**, "following receipt of a notification of an Adverse Benefit Determination by an MCO, an enrollee has sixty (60) calendar days from the date on the Adverse Benefit Determination notice". Appeals for adverse benefit determinations are not explicitly called out in **MEMBER_HANDBOOK_SFY2018; however,** per the **MEMBER_Handbook_SFY2019**, Magellan informs enrollees that they have 30 days from the receipt of the letter to file an appeal for an adverse benefit determination [p. 31] (however this document was not in use during the review period). (JH) 2.17.20: Both WDH and Magellan do not describe if providers are allowed to file an appeal. (JH)	Partially Met
44	*Obtain from the State information on:* Whether or not the State requires enrollees to exhaust MCO level appeals prior to requesting a State fair hearing.	The Contractor must provide specific information in the enrollee handbook that includes... Enrollee's right to request a state fair hearing after the Contractor has made a determination on an enrollee's appeal which is adverse to the enrollee [SOW pg. 16-17].	1.13.20: **POLICY_Medicaid Adverse Benefit Determination Appeal** indicates that, in order to initiate a State fair hearing, the enrollee must have exhausted Magellan's appeals process for adverse benefit determinations, if Magellan fails to adhere to the notice and timing requirements in this policy [p. 3]. However, the **MEMBER_HANDBOOK_SFY2018** does not appear to mention state fair hearings and **POLICY_WY Medicaid Enrollee Grievances_AddendumAttachment** indicates, "There is no second level review or state fair hearing right for members to appeal a Magellan grievance disposition" [p.1].(JH) 2.6.20: Per onsite discussion, Magellan confirmed that enrollees have the right to initiate a state fair hearing. The option is available to enrollees, though Magellan has never had one. Magellan also confirmed the above language has since been updated for SFY2020. Magellan does not include a policy or process for exhausting MCO level appeals prior to requesting a State fair hearing for grievances. (JH)	Partially Met
45	*Obtain from the State information on:* Whether enrollees are required or permitted to file a grievance with either the State or the MCO or both.	None	1.13.20: The **POLICY_Medicaid Adverse Benefit Determination Appeal** indicates that the enrollee has the authority to file and that the "enrollee may file a grievance and request an appeal with the MCO" [pg. 3]. The **POLICY_Medicaid Enrollee Rights and Responsibilities** indicates that each enrollee "has the right to file a complaint/grievance about Magellan, a provider or the care received" [p. 5]. (JH) 2.8.20: Per previous discussions with WDH, enrollees exhaust the grievance process with Magellan first, but if they have an issue with Magellan the grievance can arise to State level review; however, this is not communicated in enrollee-facing materials. (VR)	Partially Met
438.404: Notice of Action				

#	State Reg. Sources	SFY 2019 Contract Language	Comments/Findings from Applicable Documents	Reviewer Determination
46	Obtain from the State Medicaid/CHIP Agency information on the time frames within which it requires MCOs to make standard (initial) coverage and authorization decisions and provide written notice to requesting enrollees. These time frames will be the required period within which MCOs must provide Medicaid/CHIP enrollees written notice of any intent to deny or limit a service (for which previous authorization has not been given by the MCO) and the enrollee's right to file an MCO appeal (or request a State fair hearing if the State does not require the enrollee to exhaust MCO level appeals prior to requesting a State fair hearing).	For standard authorization decisions, the Contractor must issue service authorizations and/or adverse action notifications as a result of the concurrent review no later than fourteen (14) calendar days after receipt of the plan, with a possible extension of fourteen (14) calendar days if the provider or enrollee requests an extension or the Contractor justifies the need for additional information and how the extension is in the enrollee's best interest. If the timeframe was extended for standard authorization decisions that deny or limit services, the Contractor must issue and carry out its determination expeditiously and no later than the date the extension expires. If the Contractor extends the fourteen (14) calendar day service authorization notice timeframe, it must give the enrollee written notice of the reason for the extension and inform the enrollee of the right to file a grievance if he or she disagrees with the decision [SOW pg. 22].	1.10.20: **POLICY_Medicaid Service Authorization Determination** requires standard reviews of service authorization requests to be completed as quickly as the member's condition requires, no longer than 14 calendar days after receipt of request [pg. 5-6]. There is an allowable extension for up to 14 calendar days [p. 5-6]. Under certain circumstances, an expedited authorization may occur. a) Magellan identifies the review as an expedited clinical situation; or b) The provider, or Magellan, determines that the application of the standard time frame could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. [p. 6-7]. Expedited authorization decisions should be completed within 72 hours of receipt, and may be extended for up to 14 calendar days [p. 7]. An adverse benefit determination notice must include notification of the right to file an appeal [p. 6-7]. [JH]	Fully Met
438.408: Resolution and notification: Grievances and appeals				
47	*Obtain from the State Medicaid/CHIP Agency:* The State-established standard time frames during which the State requires MCOs to: - dispose of a grievance and notify the affected parties of the result; - resolve appeals and notify affected parties of the decision; and - expedite and resolve appeals and notify affected parties of the decision.	The Contractor must resolve grievances and provide notice according to the enrollee's health condition, no more than ninety (90) calendar days from grievance receipt. The Contractor can choose to extend the grievance timeline by up to fourteen (14) calendar days if the enrollee requests an extension or the Contractor justifies a need for additional information and is able to demonstrate how the extension is in the enrollee's best interest. If delayed, the Contractor must provide reasonable efforts to give oral notification, provide written notice within two (2) calendar days, and inform of the right to file a grievance if in disagreement of the delay. Written notice must also be provided to the enrollee of grievance resolution in a reasonable format [SOW pg. 20]. The written notice must be in a format and language that meets the requirements of 42 C.F .R. 43 8.10 and include the results and date of the appeal resolution, the right to request a State fair hearing, request and receive benefits, and notice of liability of cost [SOW pg. 21]. If the provider indicates or the Contractor determines, that following the standard authorization and/or adverse action decision time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice no later than seventy-two (72) hours after receipt of the request for service. This may be extended up to fourteen (14) calendar days if the enrollee	1.10.20: The **POLICY_Medicaid Enrollee Grievances** indicates that, "where delegated, Magellan resolves grievances and provides written notice of the disposition as expeditiously as the enrollee's health condition requires within State established timeframes not to exceed ninety (90) calendar days from the receipt of the grievance request per 42 CFR §438.406(b)" [p. 4]. Through an extension request, the ninety (90) calendar day time frame may be extended up to fourteen (14) calendar days [p. 4]. If Magellan delays or extends a review, Magellan must justify the need for additional information and document how the delay is in the member's interest, make efforts to give the enrollee prompt oral notice, and give the enrollee written notice of the extension within two calendar days (and inform enrollee of right to file a grievance) [p. 4]. If an enrollee is dissatisfied with the grievance disposition, the enrollee, or their representative, may request an appeal. The outcome must be communicated to the enrollee "within thirty (30) calendar days of receipt of the grievance outcome appeal request. If the appeal is clinically urgent, it is addressed and resolved within forty-eight (48) hours of the receipt of the request, or per guidelines as established by client contract or applicable law" [p. 6]. (JH)	Fully Met

#	State Reg. Sources	SFY 2019 Contract Language	Comments/Findings from Applicable Documents	Reviewer Determination
48	*Obtain from the State Medicaid/CHIP Agency:* The methods prescribed by the State that the MCO must follow to notify an enrollee of the disposition of a grievance.	requests an extension or the Contractor justifies a need for additional information and is able to demonstrate how the extension is in the enrollee's best interest [SOW pg. 9].	1.10.20: **POLICY_Medicaid Enrollee Grievances** describes that Magellan "complies with the state established method" for notice of grievance determination; however, it is not evident that grievance and appeal notices are "in a format and language that meets the requirements of 42 C.F .R. 43 8.10 and include the results and date of the appeal resolution, the right to request a State fair hearing, request and receive benefits, and notice of liability of cost." (JH) 2.7.20: Magellan is required to send a notification letter (e.g., the **LETTER_Grievance Acknowledgement Letter**) to enrollees that acknowledges the grievance filed and the grievance disposition process. Similarly, **LETTER_Notice of Adverse Action_July2018_to_January2019** and **LETTER_Notice of Adverse Action_January2019_to_Present** inform the enrollee of its decisions on the adverse action. (JH)	Fully Met
49	*Obtain from the State Medicaid/CHIP Agency:* Information on whether or not the State requires Medicaid/CHIP enrollees to exhaust MCO level appeals before receiving a State fair hearing.		1.13.20: The **POLICY_Medicaid Adverse Benefit Determination Appeal** indicates that, in order to initiate a State fair hearing, the enrollee must have exhausted Magellan's appeals process, if Magellan fails to adhere to the notice and timing requirements in this policy [p. 3]. However, the **MEMBER_HANDBOOK_SFY2018** does not appear to mention state fair hearings and **POLICY_WY Medicaid Enrollee Grievances_AddendumAttachment** indicates, "There is no second level review or state fair hearing right for members to appeal a Magellan grievance disposition" [p.1].(JH) 2.6.20: Per onsite discussion, Magellan confirmed that enrollees have the right to initiate a state fair hearing. The option is available to enrollees, though Magellan has never had one. Magellan also confirmed the above language has since been updated for SFY2020. Magellan does not include a policy or process for exhausting MCO level appeals prior to requesting a State fair hearing for grievances. (JH)	Fully Met
438.414: Information about the grievance system to providers and subcontractors				
50	*Obtain information from the State Medicaid/CHIP Agency on:* Whether the State develops or approves the MCO's description of its grievance system that the MCO is required to provide to all Medicaid/CHIP enrollees [Note that under regulations at §438.10(g)(1) the State must either develop a description for use by the MCO or approve a description developed by the MCO].	The Agency shall have in effect procedures for monitoring the Contractor's operations, including at a minimum, operations related to: ... processing grievance and appeals [SOW pg. 33].	1.13.20: **MEMBER_HANDBOOK_sFY2018** describes complaints and grievances process to enrollees [p. 20]. Need to confirm State's approval of grievance information given to enrollees. (JH) 2.6.20: As per onsite discussion, WDH approved the definition after verifying that the CMS-required language was included. Magellan sends the materials for approval and the State's program manager reviews the documents, asking any pertinent questions and making any required edits before written approval. (JH)	Fully Met

#	State Reg. Sources	SFY 2019 Contract Language	Comments/Findings from Applicable Documents	Reviewer Determination
51	*Obtain information from the State Medicaid/CHIP Agency on:* If the States approves, rather than develops, the description of the MCO's grievance system, information on whether or not the State has already approved the MCO's description.		1.13.20: **MEMBER_HANDBOOK_SFY2018** describes complaints and grievances process to enrollees [p. 20]. (JH)	Fully Met
52	*Obtain information from the State Medicaid/CHIP Agency on:* The State-specified time frames for disposition of grievances.	The Contractor must resolve grievances and provide notice according to the enrollee's health condition, no more than ninety (90) calendar days from grievance receipt. The Contractor can choose to extend the grievance timeline by up to fourteen (14) calendar days if the enrollee requests an extension or the Contractor justifies a need for additional information and is able to demonstrate how the extension is in the enrollee's best interest. If delayed, the Contractor must provide reasonable efforts to give oral notification, provide written notice within two (2) calendar days, and inform of the right to file a grievance if in disagreement of the delay. Written notice must also be provided to the enrollee of grievance resolution in a reasonable format [SOW pg. 20].	1.10.20: Per **POLICY_Medicaid Enrollee Grievances,** Magellan resolves grievances and provides written notice of the disposition as expeditiously as the enrollee's health condition requires within State established timeframes not to exceed ninety (90) calendar days from the receipt of the grievance request [p. 4]. Through an extension request, the ninety (90) calendar day time frame may be extended up to fourteen (14) calendar days [p. 4]. If Magellan delays or extends a review, Magellan must justify the need for additional information and document how the delay is in the member's interest, make efforts to give the enrollee prompt oral notice, and give the enrollee written notice of the extension within two calendar days (and inform enrollee of right to file a grievance) [p. 4]. (JH)	Fully Met
438.420: Continuation of benefits while the MCO appeal and the State Fair Hearing are pending				
53	*Obtain from the State Medicaid/CHIP Agency information on:* Any time limits specified by the State that must be met by Medicaid/CHIP enrollees who wish to file an appeal, request for expedited appeal, or State fair hearing.	Appeals can be filed orally or in writing by the enrollee or an authorized representative, including the provider, within sixty (60) calendar days from the date on the adverse action notice [SOW pg. 21]. The Contractor must continue the enrollee's benefits if the enrollee files a request for an appeal within sixty (60) calendar days from the adverse action notification, if the appeal involves termination, suspension, or reduction of a previously authorized service, if the enrollee's services were ordered by a provider, and the original authorization has not expired [SOW pg. 22-23].	2.7.20: Per the **MEMBER_Handbook_SFY2018**, enrollees are notified of the process of filing an appeal for grievances and complaints. To file an appeal, the enrollee or their representative "must send a written appeal [or complete an Appeal Request Form or call a toll-free number] request to the Wyoming Department of Health within 30 days from the date on the letter" that Magellan sent about the grievance resolution [p. 21]. For expedited review, the 2018 Member Handbook notifies the enrollee that if enrollees want their appeal expedited, they must request their provider to send a letter to tell the Wyoming Department of Health regarding the expedited review. Upon approval, WDH will alert the enrollee within three working days if they qualify for a fast appeal [p. 21]. Similarly, the **MEDICAID: ENROLLEE GRIEVANCES** documents that the enrollee has thirty (30) days within receipt of the grievance outcome to file an appeal. Note, a grievance is defined as "an expression of dissatisfaction about any matter other than an adverse benefit determination" [p. 6]. This policy does not describe timelines for expedited review. According to **MEDICAID: ADVERSE BENEFIT DETERMINATION APPEAL**, "following receipt of a notification of an Adverse Benefit Determination by an MCO, an enrollee has sixty (60) calendar days from the date on the Adverse Benefit Determination notice" [p. 7]. The timeframes for an expedited review are assessed based on the life, physical or mental health of the member; or in the opinion of an ordering and/or rendering physician [p. 8]. Per the **MEMBER_Handbook_SFY2019**, Magellan also informs enrollees that they have 30 days from the receipt of the grievance resolution letter to file an appeal for an adverse benefit determination [p. 29]. An expedited review is filed when the enrollee or their doctor believe waiting 30 days for a decision could harm enrollee health [p. 29]. The 2019 Member Handbook further lists that enrollees "must request a hearing within 30 days from Magellan's notice of resolution [p. 30].	Fully Met
438.424: Effectuation of reversed appeal resolutions				

#	State Reg. Sources	SFY 2019 Contract Language	Comments/Findings from Applicable Documents	Reviewer Determination
54	*Obtain from the State Medicaid/CHIP Agency information on:* Whether the State or the MCO is required to pay for services in situation in which the MCO, or the State fair hearing officer reversed a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending.	If the final resolution of appeal or State fair hearing upholds the adverse action, the Contractor may recover in accordance with State policies, the costs of the enrollee's continued benefits. If services were not furnished during the appeal, the Contractor must authorize or provide the services as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours from the date that the State fair hearing officer reverses a decision to deny, limit or delay services. The Contractor must pay for disputed services if the decision to deny, limit or delay services was overturned [SOW pg. 23].	1.13.20: The **POLICY_Medicaid Adverse Benefit Determination Appeal** states that if Magellan or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, Magellan or the State must pay for those services, in accordance with State policy and regulations [p. 13]. (JH)	Fully Met