Wyoming CME - EQR Network Adequacy Tool

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2019 Contract Language	Findings from CME Documentation	Compliance Status
§ 438.358 Activities related to external quality review.					
0	**(b)(1)(iv)**	Validation of MCO, PIHP, or PAHP network adequacy during the preceding 12 months to comply with requirements set forth in § 438.68 and, if the State enrolls Indians in the MCO, PIHP, or PAHP, § 438.14(b)(1).	The Contractor must maintain and monitor a network of appropriate providers that is supported by written agreements and policies and procedures that document the process the Contractor requires for provider credentialing and re-credentialing. The Contractor is prohibited from restricting network providers from acting within the lawful scope of practice and/or advising or advocating on behalf of their enrollees regarding health status, treatment options, medical care, risks and benefits of non-treatment, and enrollee's right to participate in present and future healthcare decisions [SOW pg. 18].		Not applicable.
§ 438.68 Network adequacy standards.					
(a) General Rule					
1	**(a)**	A State that contracts with an MCO, PIHP or PAHP to deliver Medicaid services must develop and enforce network adequacy standards consistent with this section.	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. Documentation is submitted quarterly [SOW pg. 19].	1.24.20: Both Magellan and WDH provided listings of providers in SFY19. Magellan's listing appears to indicate 175 providers who were active any time during SFY19. WDH's listing included 94 active providers and 145 providers with status "terminated - inactive 1 years." When comparing the providers with "active" status only, Magellan has 85 providers who were not present on WDH's active list (note: they were not on WDH's active list, but they were on WDH's "terminated" list); WDH had 4 providers who were not present on Magellan's list. When comparing all providers regardless of status, WDH listed 239 providers and Magellan listed 175; 64 of the WDH providers were not on Magellan's listing. WDH indicated that discrepancies between the provider listings is to be expected, and that Magellan's provider listing is more accurate and up to date in real time. (VR)	2. Incomplete
(b) Provider-specific network adequacy standards					
2	**(b)(1)**	At a minimum, a State must develop time and distance standards for the following provider types, if covered under the contract:			
2a	(i)	Primary care, adult and pediatric.	Not applicable.	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]. Time and distance standards do not impact member access. Rather, CME measures capacity and network adequacy through provider: beneficiary ratios.	Not applicable.

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2b	(ii)	OB/GYN.	Not applicable.	Not applicable.	Not applicable.
2c	(iii)	Behavioral health (mental health and substance use disorder), adult and pediatric.	Not applicable.	Not applicable.	Not applicable.
2d	(iv)	Specialist, adult and pediatric.	Not applicable.	Not applicable.	Not applicable.
2e	(v)	Hospital.	Not applicable.	Not applicable.	Not applicable.
2f	(vi)	Pharmacy.	Not applicable.	Not applicable.	Not applicable.
2g	(vii)	Pediatric dental.	Not applicable.	Not applicable.	Not applicable.
2h	(viii)	Additional provider types when it promotes the objectives of the Medicaid program, as determined by CMS, for the provider type to be subject to time and distance access standards.	Not applicable.	Not applicable.	Not applicable.
3	**(b)(2)**	*LTSS.* States with MCO, PIHP or PAHP contracts which cover LTSS must develop:			
3a	(i)	Time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services; and	Not applicable.	Not applicable. This program not does include LTSS.	Not applicable.
3b	(ii)	Network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services.	Not applicable.	Not applicable. This program not does include LTSS.	Not applicable.

Appendix H. Network Adequacy Review Tool

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2019 Contract Language	Findings from CME Documentation	Compliance Status
4	**(b)(3)**	*Scope of network adequacy standards* . Network standards established in accordance with paragraphs (b)(1) and (2) of this section must include all geographic areas covered by the managed care program or, if applicable, the contract between the State and the MCO, PIHP or PAHP. States are permitted to have varying standards for the same provider type based on geographic areas.	The Contractor **must serve all geographic areas and target populations within the State**. Contractor will **have staff physically available throughout the regions of the State as indicated by the growth and needs of the Contract**. Additional populations may be added or modified as appropriate and agreed upon by both parties in writing. [SOW pg. 8] 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 [SOW pg.18]. 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, highlighted in the Timelines and Deliverables Section above. The Contractor **provides supporting documentation demonstrating that it has the capacity to serve the expected statewide enrollment.** Through **geographic mapping**, distribution of provider types across the State is identified. A full listing is included in the Service Report and on the Contractor's website. **Geographic mapping is generated and reported on a quarterly basis** and is developed by the Contractor and provided to the Agency for use in monitoring marketing, information to beneficiaries, enrollee's free choice of providers, timely access, coordination/continuity of care, coverage/authorization, quality of care, and Provider Selection. The Contractor **will map referral and subsequent enrollment patterns to ensure appropriate marketing in all geographic areas** [SOW pg. 18].	1.22.20: **SFY19 Q4 report** indicates Magellan maintained 100% compliance with "rate of regions with staff member present" (OP-18) throughout the fiscal year [p.6]. Additionally, Magellan maintained high compliance with provider: member ratios for FCCs and FSP/YSP throughout the fiscal year (FCCs had >95% compliance; FSP/YSP 100% compliance) [p.5]. The report also includes geographic mapping of providers and members [p. 68-72]. (VR) 2.6.20: Per onsite discussions, the geographic mapping indicates where providers have committed to serve and providers commit to an area they are *physically* in. It is completely up to the providers regarding how much distance they will cover. Additionally, members may use telehealth; telehealth is not reserved for specific occasions and can be used at any time. FCCs and FSPs work together and these pairings help distribute the load - if an FCC is not available, an FSP may step in. Per the **MEMBER_HANDBOOK_SFY2018** [p. 13], the member's team decides where to have meetings - and all meetings are scheduled at a time and place that works best for members. Although time and distance standards may not apply, it is not clear if Magellan ensures that meetings are being scheduled at times and places that work best for members. Magellan indicated that if this were an issue, it would come up in the members' WFI-EZ survey responses. Regarding how Magellan documents "demonstrating that it has the capacity to serve the expected statewide enrollment," Magellan reports to the state who is enrolled and the state does not dictate who is enrolled. WDH provides a listing of ~1100 potential SED eligible children in the state but this does not represent true expected statewide enrollment. Magellan's providers sign a "provider agreement" (**PROVIDER_AGREEMENT_Transitions of WY Network Agreement (601370614)**) which describes the nature of the program, providers' duties, liability and confidentiality information, service descriptions, etc. Additionally, regarding mapping referral and enrollment patterns, Magellan indicated it can see referrals and how they are spread out by county and can also see where enrollments occur. However, not all referrals translate into enrollment.	1. Complete
(c) Development of network adequacy standards.					
5	**(c)(1)**	States developing network adequacy standards consistent with paragraph (b)(1) of this section must consider, at a minimum, the following elements:			

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2019 Contract Language	Findings from CME Documentation	Compliance Status
5a	(i)	The anticipated Medicaid enrollment.	The Contractor will be required to **submit an updated list of eligible youths to the Agency as deemed necessary to effectively manage the eligibility process** [SOW pg. 4]. 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, highlighted in OP- 18 in the above Timelines and Deliverable Section [SOW pg. 18]. 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].	1.22.20: Documentation does not address these elements. (VR) 2.6.20: Per onsite discussions, Magellan is aware of where there may be potential enrollees and conducts outreach via existing providers, organizations, or other community resources. Regarding provider recruitment practices, Magellan uses a social media page and works with Wyoming workforce services. Regarding waitlists, Magellan has not needed to use waitlists. However, sometimes a potential member may select a provider who is at capacity. The enrollee has the option to select another provider or wait until the desired provider is available. Magellan indicates it is not sure how long an enrollee may usually wait for their desired provider and are unsure of how many enrollees choose to wait and still join or choose not to join the program. Navigant compared Magellan's provider listing in SFY18 to SFY19 to assess provider retention and amount of change between years. In SFY18, Magellan had 107 active providers (excludes agencies). In SFY19, Magellan had 175 providers. Most (90%) of the SFY18 providers were active during SFY19 as well, based on comparison of Medicaid ID numbers. (VR) 2.12.20: Per discussions with WDH on 2-11-20, Magellan sends a roster of eligible youth to WDH on a weekly basis; this also includes disenrollments. WDH validates the eligibility of the members on the roster and makes updates to the Medicaid system as needed. (VR)	1. Complete
5b	(ii)	The expected utilization of services.	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, highlighted in OP- 18 in the above Timelines and Deliverable Section [SOW pg. 18]. The Contractor shall **perform ongoing monitoring of utilization management** (UM) data, on site review results, and claims data. The Agency will monitor the Contractor's utilization review process. Utilization reviews occur at intervals, first within the initial treatment period and then regularly thereafter. Data related to the utilization review are reported to the Agency and reviewed annually at minimum [SOW pg. 20].	1.22.20: Documentation does not address these elements. (VR) 2.6.20: Per onsite discussions, YSPs and respite are underutilized, but it is not clear whether those services are underutilized due to lack of providers or because members do not need this service. Providers enroll with Magellan voluntary. To retain providers, Magellan offers provider support groups and twice monthly learning opportunities, and Magellan staff try to build relationships with providers and be available to them. When providers leave the network, Magellan staff may informally be aware of reasons for leaving; however, there is no formal exit interview process. (VR)	1. Complete

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5c	(iii)	The characteristics and health care needs of specific Medicaid populations covered in the MCO, PIHP, and PAHP contract.	The Contractor must continue to **establish the HFWA provider network as needed to meet the needs and required service capacity for enrolled youth**. HFWA training and other internal staff training must be conducted as appropriate [SOW pg. 4]. 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]. The Contract must **ensure that all plans of care address enrollee's assessed needs (including health and safety risk factors)** and personal goals, either by the provision of services or through other means and that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which services are furnished [SOW pg. 24].	1.22.20: Per **Provider Handbook**, FCCs, FSPs, and YSPs must complete "CME and state training and certification processes for HFWA family care coordinators" and "demonstration of fidelity to NWI standards through ongoing participation in wraparound fidelity monitoring, using the WFI-EZ [p. 17-18]. Providers are expected to complete two "Tiers" of trainings within 30 and 60 days of hire [p.30]; however per discussions with Magellan, these timeframes are goals and not mandated. Providers may even pause trainings and return at a later date. (VR) 2.6.20: Per onsite discussions, Magellan ensure providers are equipped to work with the CME youth by requiring that providers fulfill trainings - providers give input regarding the topics with which they need more support (e.g., ADHD, addiction, etc.). Providers also complete Tier 1 and 2 trainings - Tier 1 is classroom-based learning whereas Tier 2 is when providers begin working with families and coordinating care. Tier 1 also covers working with the juvenile justice system among other topics. Magellan tracks providers' status with Tier trainings using "Tier Tracking Sheets" (**Tier 1 Tracking Sheet**; **Tier II Tracking Sheet**). Providers may also discuss any issues during the monthly 1:1 provider meetings (where providers meet with Magellan staff) and the clinical team provides education during case reviews. Generally, Magellan attempts to find the "right people" on the front end. (VR)	1. Complete
5d	(iv)	The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services.	The provider network must be sufficient to provide adequate access to **all services** covered under the contractual agreement for all enrollees, including those with **limited English proficiency or physical or mental disabilities** [SOW pg. 18]. The Contractor must ensure the **FCC/FSP to youth ratio is no more than one (1) FCC/FSP for a total of ten (10) youth (1:10), regardless of the youth's program or referral source. The YSP to youth ratio should be no more than one (1) YSP for a total of twenty-five (25) youth (1:25)** [SOW pg. 6]. The Contractor must **ensure contracted providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services**. The **Contractor shall review one hundred percent (100%) of provider certification and training qualifications and report this information to the Agency quarterly** [SOW pg. 24].	1.10.20: **EXPECTATIONS_Network Development & Scalability Report** indicates there were 113 certified HFWA providers at the end of SFY2019, and 19 active agencies [p. 1]. Magellan indicates that the regional distribution of providers "align with current need, as well as upcoming addition of group service delivery, enhanced C-Waiver requirements and projected increase in HFWA referrals" [p. 2]. Magellan monitors provider: member ratios and provider training compliance via performance measures submitted in the quarterly reports. **SFY19 Q4 report** indicates Magellan maintained high compliance with provider: member ratios for FCCs and FSP/YSP throughout the fiscal year (FCCs had >95% compliance; FSP/YSP 100% compliance) [p.5]. The rate of providers in network meeting all requirements was 92.5% for the entire year, with high compliance in the beginning of the year and dropping over time. Magellan explains that some of the providers not meeting all requirements is due to new providers who are working on trainings but have not yet finished trainings. All providers were enrolled Medicaid providers [p. 7]. (VR)	1. Complete

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			The Contractor must **ensure all providers within its provider network are enrolled Medicaid Providers**. [p. 11-12]		
5e	(v)	The numbers of network providers who are not accepting new Medicaid patients.	No pertinent language from the SOW.	1.22.20: Documentation does not address these elements. (VR) 2.6.20: Per onsite discussions, providers are not mandated to have a minimum number of enrollees - only a maximum. Some providers may be part time, quarter time, etc. Magellan offers fluidity and flexibility for providers, which is another method of provider retention. When asked how providers' employment status is tracked, Magellan indicated they review several documents including caseload limits, geographic mapping, referral needs, member referral waitlist (developed but not utilized). When an enrollee requests a provider whose caseload is full, the enrollee has the option to select another provider or wait until the desired provider is available. Providers are notified if a member is waiting on them to become available. Providers have the ability to directly update the provider directory to indicate whether they are accepting new clients; however, this is voluntary and is not consistently utilized across all providers. (VR) Additionally, there were some cases where providers were not compliant with caseload ratios (e.g., in Nov-Dec 2018 and May 2019 FCC caseload compliance fell under 100%). Magellan indicates this may occur during transitional times and due to paperwork processing at different times. Magellan indicates this issue is typically short-lived and resolved once all paperwork is in place. (VR)	1. Complete

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5f	(vi)	The geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees.	The Contractor **must serve all geographic areas and target populations within the State.** Contractor will have **staff physically available throughout the regions of the State as indicated by the growth and needs** of the Contract. Additional populations may be added or modified as appropriate and agreed upon by both parties in writing [SOW pg. 8]. The Contractor provides **supporting documentation demonstrating that it has the capacity to serve the expected statewide enrollment**. Through geographic mapping, distribution of provider types across the State is identified... **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. [SOW pg. 18]. 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].	1.10.20: **EXPECTATIONS_Network Development & Scalability Report** provides the counts of all provider types overall and by region, as well as geographic maps (Note: geographic maps are provided on a quarterly basis). The maps indicate that members reside in 14 of Wyoming's 23 counties. Almost all counties with members also have FCCs and FSPs who have committed to serving that county; however, one county, Hot Springs, has one member but no FCCs nor FSPs have committed to serve this county. -20 of the 23 counties had an FCC, regardless of member enrollment. -Two of the 14 counties in which members reside had YSPs committed to serving that county. -Twelve of the 14 counties in which members reside had Respite providers committed to serve that county. Per the SOW, CME must serve all geographic areas. CME did not meet this requirement in SFY2019 since three counties did not have FCCs and one of those three counties had members. (VR) 2.6.20: Per onsite discussions, the FCC is the only mandated role, which is described in the 1915 b/c waivers. The 1915(c) waiver describes several responsibilities specific to the FCC (e.g., delivery of certain waiver services, maintaining evaluation and other documents, etc.) Per onsite discussions regarding the county of Hot Springs having one member but no FCCs or FSPs, Magellan indicates that a provider in a different county took the case and provided telehealth (per Magellan, telehealth counts as face to face contact). However, this action was not clearly documented. If a member has a preference to in person meetings but only telehealth is available, the member would need to wait until another option became available. (VR)	2. Incomplete

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5g	(vii)	The ability of network providers to communicate with limited English proficient enrollees in their preferred language.	The provider network must be sufficient to provide adequate access to all services covered under the contractual agreement for all enrollees, **including those with limited English proficiency** or physical or mental disabilities. The Contractor will also demonstrate that they have complied with availability and accessibility of services requirements, including adequacy of the provider network through OP-18, highlighted in the Timelines and Deliverables Section above [SOW pg. 18].	1.23.20: It is evident that interpreters and translation are available for Magellan communications and resources are available for individuals with disabilities [**Member Handbook** p. 28], and some providers are proficient in other languages (e.g., Spanish, sign language) [**Network Development & Scalability Report** p.1]. However, it is not clear how the providers themselves are sufficient for providing access to enrollees with limited English proficiency or disabilities. (VR) 2.6.20: Per onsite discussions, providers would contact a member of the clinical team to request translation over the phone. Intake includes information about disability and languages spoken, so providers would be aware of any need for translation at intake. (VR)	1. Complete
5h	(viii)	The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities.	The provider network must be sufficient to **provide adequate access to all services covered under the contractual agreement for all enrollees, including those with limited English proficiency or physical or mental disabilities** [SOW pg. 18]. 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. The disparity analysis provides information regarding the effectiveness of the program [SOW pg. 19].	1.23.20: Access for physical and mental disabilities is addressed in 5g above. HANDBOOK_PROVIDER_FY2018 indicates that providers must "be familiar with our guidelines and standards and apply them in HFWA work with members in order to provide safe, effective, patient-centered, timely, efficient and equitable care in a culturally sensitive manner" [p.38]. Providers factor cultural considerations into the Strengths, Needs, and Cultural Discovery document [Member Handbook p.8]. 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]. (VR)	1. Complete
5j	(ix)	The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.	Provide access to Agency's existing infrastructure to serve youth, including the Wyoming **Telemedicine** infrastructure and Psychiatric Consultation (Seattle Children's Hospital Contract) services [SOW pg. 32]. The Contractor shall **have staff available using an 800 number twenty-four (24) hours a day/three hundred sixty-five (365) days a year to respond to enrollee calls**. Interpreter services are available for the hearing impaired and for non-English speakers [SOW pg. 17].	1.23.20: **Member Handbook** provides a toll free 855 number and indicates to "contact Magellan any time, day or night" [p.3]. Additionally, Magellan offers optional telehealth services [p.26].	1. Complete

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6	**(c)(2)**	States developing standards consistent with paragraph (b)(2) of this section must consider the following:			
6a	(i)	All elements in paragraphs (c)(1)(i) through (ix) of this section.	Not applicable.	Not applicable. This program does not include LTSS.	Not applicable.
6b	(ii)	Elements that would support an enrollee's choice of provider.	Not applicable.	Not applicable. This program does not include LTSS.	Not applicable.
6c	(iii)	Strategies that would ensure the health and welfare of the enrollee and support community integration of the enrollee.	Not applicable.	Not applicable. This program does not include LTSS.	Not applicable.
6d	(iv)	Other considerations that are in the best interest of the enrollees that need LTSS.	Not applicable.	Not applicable. This program does not include LTSS.	Not applicable.
(d) Exceptions process.					
7	**(d)(1)**	To the extent the State permits an exception to any of the provider-specific network standards developed under this section, the standard by which the exception will be evaluated and approved must be:			
7a	(i)	Specified in the MCO, PIHP or PAHP contract.	No pertinent language from the SOW.	Not applicable. The provider-specific network standards do not apply to this program, and therefore there are not exemptions to the provider-specific network standards.	Not applicable.
7b	(ii)	Based, at a minimum, on the number of providers in that specialty practicing in the MCO, PIHP, or PAHP service area.	No pertinent language from the SOW.	Not applicable. The provider-specific network standards do not apply to this program, and therefore there are not exemptions to the provider-specific network standards.	Not applicable.
8	**(d)(2)**	States that grant an exception in accordance with paragraph (d)(1) of this section to a MCO, PIHP or PAHP must monitor enrollee access to that provider type on an ongoing basis and include the findings to CMS in the managed care program assessment report required under § 438.66.	Not applicable.	Not applicable. The provider-specific network standards do not apply to this program, and therefore there are not exemptions to the provider-specific network standards.	Not applicable.
(e) Publication of network adequacy standards.					

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9	**(e)**	States must publish the standards developed in accordance with paragraphs (b)(1) and (2) of this section on the Web site required by § 438.10. Upon request, network adequacy standards must also be made available at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services.	A **provider directory must also be made available on the Contractor's website in a machine readable file and format** as specified by the Secretary and in 42 CFR 438.10(h)(4). The Contractor's electronic provider directory **must be updated no later than thirty (30) calendar days after the Contractor receives updated provider information** [SOW pg. 19]. These materials must be drafted using the State developed enrollee notices and Agency model enrollee handbook format and be made available in Spanish, the prevalent non-English language in Wyoming. The Contractor's enrollee handbook must include regarding the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled and the procedures for obtaining such benefits, including requirements for service authorizations. The Contractor must: A. Mail a printed copy of the information to the enrollee's mailing address; B. Provide the information by email after obtaining the enrollee's agreement to receive the information by email; C. **Post the information on its website** and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and service upon request at no cost; or, D. Provide the information by any other method that can reasonably be expected to result in the enrollee receiving that information [SOW pg. 16].	1.22.20: **POLICY_Network Provider Data Maintenance and Data Integrity** describes the provider directory, which is updated within 30 calendar days of receiving new information from providers [p. 6]. The directory is available on Magellan's website: https://www.magellanofwyoming.com/youth-families/find-a-provider/. Magellan's website also provides the member handbook in English and Spanish: https://www.magellanofwyoming.com/youth-families/why-wraparound/family-youth-guide/. CME program does not have any standards in accordance with b(1) and b(2) (time and distance standards). However, Magellan is still subject to posting other network adequacy information - per the SOW, that would be the provider directory. (VR) 2.6.20: Per onsite discussions, members receive the Member Handbook via postal mail initially, then when the Handbook is updated, members receive a postcard which describes what has changed and how to access the Handbook online. (VR) The requirement to publish network adequacy standards online applies to States who dictate time and distance standards for specific providers LTSS providers, neither of which apply to the CME program.	Not applicable.
§ 438.14 Requirements that apply to MCO, PIHP, PAHP, PCCM, and PCCM entity contracts involving Indians, Indian health care providers (IHCPs), and Indian managed care entities (IMCEs).					
(b) Network and coverage requirements. All contracts between a State and a MCO, PIHP, PAHP, and PCCM entity, to the extent that the PCCM entity has a provider network, which enroll Indians					

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10	**(b)(1)**	Require the MCO, PIHP, PAHP, or PCCM entity to demonstrate that there are sufficient IHCPs participating in the provider network of the MCO, PIHP, PAHP, or PCCM entity to ensure timely access to services available under the contract from such providers for Indian enrollees who are eligible to receive services.	No pertinent language from the SOW.	Not applicable. Although Magellan serves Indians and tribal members, IHCPs are not involved because the program does not offer clinical services.	Not applicable.