Appendix A: Abbreviations and Acronyms

ANE	Abuse, Neglect, and Exploitation
ASL	American Sign Language
CANS	Child and Adolescent Needs and Strengths
CAP	Corrective Action Plan
CAPS	Claims Adjudication Payment System
CASII	Child and Adolescent Service Intensity Instrument
CFR	Code of Federal Regulations
CFT	Child and Family Team
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMHW	Wyoming's 1915(c) Children's Mental Health Waiver
CME	Care Management Entity
CMS	Centers for Medicare & Medicaid Services
DHCF	Division of Healthcare Financing
EDW	Enterprise Data Warehouse
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ESCII	Early Childhood Service Intensity Instrument
FCC	Family Care Coordinator
FFS	Fee-For-Service
FSP	Family Support Partner
HFWA	High Fidelity Wraparound
HIPAA	Health Insurance Portability and Accountability Act
HLOC	Higher Level of Care
IHCP	Indian Health Care Provider
IHI	Institute for Healthcare Improvement
ISCA	Information System Capabilities Assessment
IT	Information Technology
LOC	Level of Care
LOS	Length of Stay
LTSS	Long-Term Services and Supports
OOH	Out-of-Home
OP	Operational Requirement
QAPI	Quality Assessment and Performance Improvement
QIA	Quality Improvement Activity
QIC	Quality Improvement Committee
PAHP	Prepaid Ambulatory Health Plan
PCCM	Primary Care Case Management
PDSA	Plan Do Study Act
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
PMPM	Per-Member Per-Month
POC	Plan of Care
PRTF	Psychiatric Residential Treatment Facility
SBU	Strategic Business Unit
SCH	Seattle Children's Hospital
SED	Serious Emotional Disturbance
SFY	State Fiscal Year
SNCD	Strength, Needs, and Culture Discovery
SOC	System of Care
SOP	Standard Operating Procedure

SOW	Statement of Work
SPMI	Serious and Persistent Mental Illness
SQL	Structured Query Language
SSIS	SQL Server Integration Services
TMTMTY	Too Much, Too Many, Too Young (Medication Standards)
WDH	Wyoming Department of Health
WFI-EZ	Wraparound Fidelity Index-Short Form
YSP	Youth Support Partner

Appendix B: Status of SFY 2019 Recommendations

Table 1. Status of SFY 2019 Recommendations

#	SFY 2019 Recommendation	Responsibility	Findings	Comments
Protocol 1. Validation of Performance Improvement Projects				
1.	**Recommendation:** Develop a data analysis plan for internal tracking and external communication. It is important to create a roadmap for organizing and analyzing the data. For sustainability of the PIPs, Magellan should consider recording these processes in a clear plan of action. The data analysis plan should clearly define: • Goals for data analysis and tracking • Roles and responsibilities for staff members, including data quality control • Data collection instruments will be used • Data sources • How and when data will be consistently and accurately collected A data analysis plan is helpful for Magellan to confirm that the data analysis method follows the prescribed procedures and ensures reliability and consistency in the data. Furthermore, a clearly defined roadmap facilitates future replication of the data and clarifies processes for external validation. If there is clear documentation about the data analysis method, others may be able to replicate the results reliably using the same data. Clear documentation may also reveal any flaws in the approach, and therefore prevent inaccurate results in the future.	Magellan	Partially Addressed	Magellan used formal Quality Improvement Activity (QIA) templates to describe the activity selection and methodology, data and results, and analysis cycle. However, documentation was still lacking complete data analysis elements (e.g., did not fully describe qualitative and quantitative data analysis processes; did not include relevant performance measures for all PIPs).
2.	**Recommendation:** Formally document barriers and related interventions for all PIPs.	Magellan	Fully Addressed	Magellan conducted multiple cycles of barrier identification and intervention development for

#	SFY 2019 Recommendation	Responsibility	Findings	Comments
	Magellan should identify and document barriers to provider performance by considering stakeholder engagement and data analysis. This will allow Magellan to identify strategies to address the major barriers found during the research phase. Magellan should consider interventions that address system changes, which are likely to induce permanent change. Additionally, Magellan may standardize and continuously monitor successful interventions and incorporate revisions if the original interventions are not successful.			each PIP. Magellan linked each intervention with specific barriers, tracked performance across each remeasurement, and updated interventions based on measured performance.
Protocol 2. Validation of Performance Measures				
3.	**Recommendation:** Ensure cross-training and development / maintenance of measure-level execution documents. Magellan should consider: • Developing technical specifications for creating each measure, and • Cross-training at least one additional staff member for each step of the process. While the current team has the institutional knowledge and technical skills to create the various reports each week, month, quarter, and year, it is critical that Magellan can continue this level of service in the event of employee emergency or departure. The technical specification should include systems accessed, data sources, location and names of each program / file (e.g., SQL source, Excel workbook), timing for both run and delivery, test scenarios, manual adjustments to data, approval requirements, common errors and other technical details. The documents may also include any notes that would help a substitute staff member execute the measure, as well as any common errors or anomalies along with research or other steps required to resolve.	Magellan	Fully Addressed	Magellan has shown commitment to improving measure documentation and cross-training. Magellan analytics and measure result creation staff have significantly enhanced both the quantity and quality of the documentation supporting acquisition of input data, calculation of numerator, denominator, and rate for the measures generated via SQL. For each measure reviewed, the creation staff noted the person(s) provided with documentation describing the measure result creation and/or job shadowing to observe the primary staff creating the measure. This will result in fewer issues in the event of an emergency or staffing changes.

#	SFY 2019 Recommendation	Responsibility	Findings	Comments
4.	**Recommendation:** Clarify intentions for reporting requirements by developing documentation to capture non-technical business requirements. A national measure steward does not exist for many of the quality measures for the CME program. Consequently, WDH and Magellan need to document measure details comparable to national measure documentation. Magellan and WDH would benefit from creating business requirements which should include enough detail for the staff coding and testing the measures. WDH may work with Magellan to create a "business requirements" document, or "statement of understanding" to specify Magellan's understanding and approach to each measure (e.g., clarifying numerators and denominators). This would allow both parties to avoid making assumptions on the intent of each measure, query, definition, or report. Several times during Guidehouse's assessment, Magellan or WDH staff discussed "what the measure meant to them." These lower level details have not been previously documented. Documenting these low-level details will remove the ambiguity of each measure. Furthermore, it would allow both parties to specify the desired data sources, code values, date spans, etc. This document would not require detailed technical specifications.	WDH and Magellan	Fully Addressed	Per discussions with WDH and Magellan, WDH and Magellan worked collaboratively to review and update reporting requirements to ensure shared understanding between all parties. The updated reporting requirements were included within the most recent SOW, effective January 2021. WDH and Magellan continue to collaborate on clarifying reporting requirements and making updates to the SOW when appropriate.
Protocol 3. Compliance with Medicaid Managed Care Regulations				
5.	**Recommendation:** Clarify certain terminology used in the SOW. WDH can clarify its intentions and assure that it receives the expected outcomes by defining the following terms: • Easily understandable: While WDH clearly indicates expectations around language availability, font sizes, and formats, WDH may strengthen requirements around this terminology	WDH	Fully Addressed	Although not in place during the SFY 2020 review period, WDH has since made SOW amendments, effective January 2021, which include clarified terminology.

#	SFY 2019 Recommendation	Responsibility	Findings	Comments
	by requiring materials to meet certain reading level thresholds (e.g., Flesch-Kincaid Grade Level). • Significant change: WDH may define this term in the SOW rather than operate under a mutual / informal assumption with Magellan on when changes are "significant," as is current practice.			
6.	**Recommendation:** Add language to the SOW to reflect a provider's right to an appeal and clarify moral and religious objections. There is an opportunity to add and clarify language in the SOW regarding the following: • Provider's right to appeal: WDH may formally define in its SOW whether the provider has the right to challenge a failure to cover contracted services or if providers can only submit grievances/appeals on behalf of employees. • Moral and religious objections: WDH may formally define in its SOW whether moral and religious objections apply to this program.	WDH	Fully Addressed	Although not in place during the SFY 2020 review period, WDH has since made SOW amendments, effective January 2021, which address providers' right to appeal and moral and religious objections.
7.	**Recommendation:** Update enrollee-facing materials to clarify information on the enrollee's right to a State fair hearing. Magellan can clarify the State fair hearings and grievances processes to enrollees by updating enrollee materials, such as the grievance resolution letter template, to explain State fair hearings and how an enrollee can request one.	Magellan	Fully Addressed	Magellan has updated the Member Handbook and grievance resolution letter to address State fair hearings.
8.	**Recommendation:** Update materials to clarify grievance processes and the relationship between complaints and grievances. Magellan can address the discrepancy between complaints and grievances by clarifying the differences in	Magellan	Partially Addressed	Magellan has taken steps to resolve the issue internally by clarifying terminology in an internal Complaint and Grievance Procedure document in July 2020, shortly after the review period. However, external materials (e.g.,

#	SFY 2019 Recommendation	Responsibility	Findings	Comments
	the Member Handbook and updating Magellan policies to address complaints and grievances and their associated resolution systems. This includes differentiating language and timelines for action between complaints and grievances, as well as any other similar terminology. Magellan should also update its internal policies and enrollee materials to describe what constitutes a complaint, and if there is a resolution process available.			Provider Handbook) still indicated a lack of clarity between grievances and complaints and used the terms interchangeably.
9.	**Recommendation:** Update enrollee-facing materials to clarify information on the enrollee's right to file a grievance with WDH. Magellan can clarify the grievance processes to enrollees by updating enrollee materials, such as the Member Handbook, to explain whether an enrollee can file a grievance directly with WDH and how/when the enrollee would do so.	Magellan	Not Addressed	Although Magellan updated enrollee-facing materials to clarify State fair hearings, materials were not updated to address the enrollee's right to file a grievance with WDH.
10.	**Recommendation:** Magellan should clarify the existing language and timelines in all applicable documents regarding grievances, appeals, adverse benefit determinations. For consistency and to avoid confusion, Magellan can update its existing documents regarding any discrepancies in timeframes noted above.	Magellan	Fully Addressed	Magellan's documentation reflects consistent timelines regarding grievances, appeals, adverse benefit determinations.
11.	**Recommendation:** Update the SOW to clarify timeframes for State fair hearings. The SOW references State fair hearings several times but does not indicate relevant timeframes. WDH should update the SOW to clearly indicate the timeframe in which an enrollee must request a State fair hearing, in accordance with federal regulations.	WDH	Fully Addressed	Although not in place during the SFY 2020 review period, WDH has since made SOW amendments, effective January 2021, which address State fair hearing timeframes.

#	SFY 2019 Recommendation	Responsibility	Findings	Comments
Protocol 4. Validation of Network Adequacy				
12.	**Recommendation:** Implement regular validation checks of provider enrollment data. WDH should implement regularly scheduled validation checks of the data Magellan provides to confirm it aligns with information in WDH's system, with a small margin for differences in real time. To confirm accurate recordkeeping and consistent provider enrollment reconciliation efforts, WDH should clearly document these validation efforts and acceptable margins for differences. Additionally, WDH and Magellan should work together to determine criteria for removing disenrolled providers from both WDH and Magellan's listing.	WDH	Partially Addressed	WDH has started implementing regular validation checks of provider enrollment data and is still in the process of working with Magellan to confirm shared understanding of "active" providers.
13.	**Recommendation:** Facilitate a more targeted recruitment strategy. WDH may facilitate a more targeted recruitment strategy by requiring use of the listing of potential enrollees. WDH may consider incorporating targets for outreach and develop/promote best practices for Magellan and providers for enrollee recruitment. However; this would require WDH to ensure the listing stays up to date with accurate information.	WDH	Fully Addressed	WDH continues to identify opportunities for referral sources to the CME program. WDH has begun working with other key parties in the system of care, including health management and utilization management vendors, to better collaborate and potentially increase referrals.
14.	**Recommendation:** Document strategies to expand provider geographic coverage. Although Magellan acknowledges facing challenges due to Wyoming's unique geography and climate, Magellan does not clearly indicate strategies for reaching under-served areas of the State. Magellan may be better prepared by documenting a plan of action for geographic areas that are not covered and taking into consideration alternate approaches if telehealth is not the enrollee's preference.	Magellan	Partially Addressed	Magellan respectfully disagrees with the original finding "as Magellan meets the SOW requirements of the geographic need based on regions and not counties." Magellan has developed an annual network development plan and network strategy committee to address continued needs.

#	SFY 2019 Recommendation	Responsibility	Findings	Comments
15.	**Recommendation:** Track certain information about the provider network to facilitate improved provider recruitment and retention. Magellan would benefit from establishing ways to track providers' full-time employment status, potential enrollee waiting time, and reasons that providers leave the network (via exit interviews or surveys). It is important for Magellan to track this information in a formal manner so that other staff, or future staff, will be able to easily obtain this information. Exit interviews or surveys may also inform why Magellan has providers who do not finish the initial training/certification, which could provide Magellan with ways to improve the onboarding process. Additionally, being able to track information on provider turnover may benefit Magellan's recruitment and retention efforts.	Magellan	Partially Addressed	Magellan indicates progress toward this recommendation. Magellan indicated that they will conduct exit interviews in the future and review findings with the network strategy meeting. Magellan has also streamlined the onboarding process by allowing providers to complete trainings while going through the credentialing and contracting process.
16.	**Recommendation:** Incentivize providers to operate in alignment with requirements and best practices. It is important for Magellan to balance provider accountability with the realities of the CME program's network – providers are unfamiliar with documentation requirements and do not receive compensation during initial trainings. For this reason, WDH and Magellan may find it more beneficial to incentivize providers rather than impose penalties. WDH may consider adding language to the SOW to address areas where providers should be held more accountable or may choose to address performance issues in the future using the pay for performance tiered rates that are currently under development.	WDH and Magellan	Partially Addressed	Magellan indicated that the current training practices are set up to allow providers to complete their training at a pace that works for their lives and is supported and tracked by the Magellan coaches and trainer to ensure training falls within the set guidelines. Several interventions are underway to increase compliance: • Implementing a system for computer-tracked attestations • Moving the Tier 1 training to be in parallel to the provider contracting instead of the current tandem process Magellan is also exploring pay for performance models for future consideration. Magellan also utilizes the provider one-on-one meetings and newsletters to enhance provider accountability.

#	SFY 2019 Recommendation	Responsibility	Findings	Comments
				The SOW does not appear to include language addressing provider accountability and the pay for performance tiered rate initiative is currently paused.
17.	**Recommendation:** Clarify how providers can access translation services. Providers may benefit from clear instructions on how to access translation services for enrollees whose primary language is not English.	Magellan	Fully Addressed	Per discussions with Magellan, providers have access to a link/form on the website for translation services and translation information is available in weekly updates and other provider communications.

Appendix C: Protocol 1 - PIP Worksheets

ENROLLMENT INITIATIVE

Worksheet 1.1. Review the Selected PIP Topic

PIP Topic: Enrollment Initiative Quality Improvement Activity

Assess the appropriateness of the selected PIP topic by answering the following questions about the MCP and PIP. Insert comments to explain "No" and "Not applicable (NA)" responses.

Question	Yes	No	NA	Comments
1.1 Was the PIP topic selected through a comprehensive analysis of MCP enrollee needs, care, and services (e.g., consistent with demographic characteristics and health risks, prevalence of conditions, or the need for a specific service by enrollees)? (If the PIP topic was required by the state, please check "not applicable" and note in comments.)	✓	--	--	The Enrollment Initiative was selected from state and national research of residential treatment in children. In the Quality Improvement Activity (QIA) documentation, Magellan cites the U.S. Surgeon General's Report on Mental Health (1999) in stating that "there is limited evidence that supports the effectiveness of residential treatment." Additionally, Magellan cites their Health Services Children's Task Force (2008), which found that "shorter lengths of stay for residential services may be more beneficial than longer treatment episodes." These analyses of enrollee care and services led to the selection of the Enrollment Initiative, under which youth are engaged in the CME program while enrolled in a Psychiatric Residential Treatment Facilities (PRTF) and offered support post-discharge.
1.2 Did selection of the PIP topic consider performance on the CMS Child and Adult Core Set measures?	--	--	✓	N/A - The CMS Child and Adult Core Set measures focus on clinical measures and do not apply to this PIP topic.
1.3 Did the selection of the PIP topic consider input from enrollees or providers who are users of, or concerned with, specific service areas? (If the PIP topic was required by the state, please check "not applicable" and note in comments.) ○ To the extent feasible, input from enrollees who are users of, or concerned with, specific services areas should be obtained.	✓	--	--	Per virtual discussion, Magellan held informal conversation with parents of youth enrolled in PRTFs, and leveraged parent support groups to assist in the selection of this PIP topic. However, Magellan did not provide evidence of stakeholder engagement within reviewed QIA documentation.
1.4 Did the PIP topic address care of special populations or high priority services, such as: ○ Children with special health care needs	✓	--	--	The PIP topic directly pertained to services for children aged 4-20 years old who have serious and persistent mental illness (SPMI) / severe emotional disturbance (SED) and meet PRTF level

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
○ Adults with physical disabilities ○ Children or adults with behavioral health issues ○ People with intellectual and developmental disabilities ○ People with dual eligibility who use long-term services and supports (LTSS) ○ Preventive care ○ Acute and chronic care ○ High-volume or high-risk services ○ Care received from specialized centers (e.g., burn, transplant, cardiac surgery) ○ Continuity or coordination of care from multiple providers and over multiple episodes ○ Appeals and grievances ○ Access to and availability of care				of care. Encouraging enrollment is an essential strategy for ensuring access to services for youth and overall CME program success.
1.5 Did the PIP topic align with priority areas identified by HHS and/or CMS?	✓	--	--	The PIP topic directly aligned with numerous priority areas and goals identified by HHS, CMS, and the CME program. The PIP topic is based on national and state research showing limited effectiveness of treating youth with mental disorders in institutional settings. The topic seeks to connect youth enrolled in a PRTF with services to be utilized post-discharge from the residential facility to decrease average length of stay, allow for successful community re-entry, and avoid re-admissions. This aligns with numerous priorities, including HHS National Quality Strategy aims (*Healthy People / Healthy Communities*), CMS Quality Strategy priorities (*Promote Effective Communication and Coordination of Care, Work with Communities to Promote Best Practices of Healthy Living, Make Care Safer by Reducing Harm Caused in the Delivery of Care, Promote Effective Prevention and Treatment of Chronic Disease*), and numerous CME program goals. Decreasing average length of stay within residential facilities and avoiding readmissions may also reduce the overall cost of care for Medicaid enrollees, which aligns with national priorities to keep care affordable.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
1.6 Overall assessment: In the comments section, note any recommendations for improving the PIP topic.				Magellan should capture input on PIP topic selection received from youth, their families, and providers within the required QIA form. Magellan should also describe processes and methods for soliciting input for PIP topic selection.

Worksheet 1.2. Review the PIP Aim Statement

PIP Aim Statement:

1. "Do the interventions implemented as part of the Enrollment Initiative demonstrate a change in the number of readmissions to a higher level of care (HLOC)?"

2. "Do the members included within the enrollment initiative have a different initial LOS compared to those members who opt-out of the program?"

Assess the appropriateness of the selected PIP topic by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
2.1 Did the PIP aim statement clearly specify the improvement strategy, population, and time period for the PIP?	--	✓	--	While the PIP aim statements specified the improvement strategy (Enrollment Initiative), the statement did not clearly specify the population (Medicaid youth in Wyoming aged 4-20 years old who are enrolled at the PRTF level of care) or time period for measurement (baseline 10/1/2018-09/30/2019; remeasurement 10/1/2019-9/30/2020).
2.2 Did the PIP aim statement clearly specify the population for the PIP?	--	✓	--	The PIP aim statements did not clearly specify the population for the PIP. While Aim Statement #2 does explain that performance measurements are compared between members who participate in the CME Enrollment Initiative and those who opt-out of the program, neither statement specified the study population (Medicaid youth in Wyoming aged 4-20 years old who are enrolled at the PRTF level of care).
2.3 Did the PIP aim statement clearly specify the time period for the PIP?	--	✓	--	The PIP aim statements did not specify the time period for the PIP. Baseline measurements for the Enrollment Initiative occur within 10/1/2018-09/30/2019, which are compared to data from the remeasurement period of 10/1/2019-9/30/2020. These items are not specified in either PIP aim statement.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
2.4 Was the PIP aim statement concise?	✓	--	--	The PIP aim statements each consisted of a single question, aligned directly with performance measures.
2.5 Was the PIP aim statement answerable?	✓	--	--	The PIP aim statements were both closed-ended questions relating directly to the impact of interventions on performance measures. Both aim statements were answerable with "yes" or "no" responses.
2.6 Was the PIP aim statement measurable?	✓	--	--	The PIP aim statements directly related to changes in performance measures between populations for the PIP (number of readmissions to a higher level of care; initial length of stay), which were both measurable.
2.7 Overall assessment: In the comments section, note any recommendations for improving the PIP aim statement.				The PIP aim statements did not specify the change in performance measures that would constitute "improvement" (e.g., *fewer* readmissions to a higher level of care; *shorter* initial length of stay). Specifying improvement would clarify the "aim" of each statement.

Worksheet 1.3. Review the Identified PIP Population

PIP Population: All WY State Medicaid members (aged 4-20 years old) that are enrolled within the PRTF level of care for the measurement timeframe of 10/01/19 – 09/30/20.

Assess whether the study population was clearly identified by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
3.1 Was the project population clearly defined in terms of the identified study question (e.g., age, length of the study population's enrollment, diagnoses, procedures, other characteristics)? • The required length of time will vary depending on the PIP topic and performance measures	✓	--	--	Magellan specified the project population by age (4-20 years old), timeframe of enrollment (10/01/19 – 09/30/20), diagnoses (enrolled within the PRTF level of care), and other characteristics (WY State Medicaid member). Additionally, Magellan specified the comparison groups for the PIP (Medicaid members within the PRTF that are included within the Enrollment Initiative; Medicaid members within the PRTF that opt-out of the Enrollment Initiative).
3.2 Was the entire MCP population included in the PIP?	--	✓	--	Since this PIP only covers youth receiving services within a PRTF (or prospective CME members), the entire

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
				MCP population is not included within the Enrollment Initiative.
3.3 If the entire population was included in the PIP, did the data collection approach capture all enrollees to whom the PIP question applied? • If data can be collected and analyzed through an administrative data system, it may be possible to study the whole population. For more guidance on administrative data collection, see Worksheet 1.6.	✓	--	--	The data collection method used an administrative data system, in which Magellan conducted a programmed pull of all claims / encounter data.
3.4 Was a sample used? (If yes, use Worksheet 1.4 to review sampling methods). • If the data will be collected manually (such as through medical record review), sampling may be necessary	--	✓	--	In both measures, Magellan specified: "All eligible occurrences, no sampling used."
3.5 Overall assessment: In the comments section, note any recommendations for identifying the project population.				N/A

Worksheet 1.4. Review the Sampling Method

Overview of Sampling Method: No sampling was used for this PIP.

If HEDIS® sampling is used, check here, and skip the rest of this worksheet. ☐

Assess whether the sampling method was appropriate by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses. Refer to Appendix B for an overview of sampling approaches for EQR data collection activities.

Question	Yes	No	NA	Comments
4.1 Did the sampling frame contain a complete, recent, and accurate list of the target PIP population? • A sampling frame is the list from which the sample is drawn. It includes the universe of members of the target PIP population, such as individuals, caregivers, households, encounters, providers, or other population units that are eligible to be included in the PIP. The completeness, recency, and accuracy of the sampling frame are key to the representativeness of the sample	--	--	✓	N/A - No sampling was used for this PIP.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
4.2 Did the sampling method consider and specify the true or estimated frequency of the event, the confidence interval to be used, and the acceptable margin of error?	--	--	✓	N/A - No sampling was used for this PIP.
4.3 Did the sample contain a sufficient number of enrollees taking into account non-response?	--	--	✓	N/A - No sampling was used for this PIP.
4.4 Did the method assess the representativeness of the sample according to subgroups, such as those defined by age, geographic location, or health status?	--	--	✓	N/A - No sampling was used for this PIP.
4.5 Were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field.	--	--	✓	N/A - No sampling was used for this PIP.
4.6 Overall assessment: In the comments section, note any recommendations for improving the sampling method.				N/A

Worksheet 1.5. Review the Selected PIP Variables and Performance Measures

Selected PIP Variables and Performance Measures:

1. **Quantifiable Measure #1**: Mean number of readmissions to a higher level of care (HLOC) (inpatient and/or PRTF) within 30/90/180 days after discharge from PRTF for Enrollment Initiative members and opt-out youth. (1a 30 days, 1b 90 days, 1c 180 days)

2. **Quantifiable Measure #2**: Average length of stay (LOS) for members during the initial PRTF stay for members in the enrollment initiative compared to youth who opt-out of the initiative.

Assess whether the selected PIP variables were appropriate for measuring performance and tracking improvement by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Recall that CMS encourages MCPs to choose variables for PIPs that reflect health outcomes. Performance measures are then used to measure these health outcomes. When selecting variables, the MCP should consider existing performance measures.

Question	Yes	No	NA	Comments
PIP variables				
5.1 Were the variables adequate to answer the PIP question? • Did the PIP use objective, clearly defined, time-specific variables (e.g.,	✓	--	--	Magellan specified objective, clearly defined continuous variables (numerator and denominator) for each performance measure: 1. **Measure #1**:

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
an event or status that can be measured)? • Were the variables available to measure performance and track improvement over time? (CMS encourages states to select variables that can be examined on at least a semi-annual basis				[The number of unduplicated members age 4-20 who were readmitted to an inpatient psychiatric facility or PRTF within 30/90/180 days of the original discharge] / [The total number of unduplicated members age 4-20 who were discharged from a PRTF during the measurement period] 2. **Measure #2**: [Sum of days in PRTF (discharge date minus admission date) during measurement period] / [Number of discharges for participants in group] Additionally, variables were time-specific and were able to be measured over time (mean number of readmissions within 30/90/180 days after discharge; average length of stay during the initial PRTF stay).
Performance measures				
5.2 Did the performance measure assess an important aspect of care that will make a difference to enrollees' health or functional status?	✓	--	--	Magellan made clear that treatment in inpatient / PRTF settings "can be detrimental to some youth" and supports community treatment of the study population within the rationale. Since the performance measures assess mean number of readmissions and average length of stay within PRTF settings, these measures impact enrollee health and functional status.
5.3 Were the performance measures appropriate based on the availability of data and resources to collect the data (administrative data, medical records, or other sources)?	✓	--	--	Magellan analyzed administrative data (programmed pull from claims / encounter files of all eligible members). This data source is appropriate for calculating length of stay and determining readmission status. Magellan did note that leveraging claims data for this PIP creates a "lag", as providers have 12 months to submit claims. However, Magellan has accounted for this lag by extending data collection through 12/31/2020.
5.4 Were the measures based on current clinical knowledge or health services research? • Examples may include: ○ Recommended procedures	✓	--	--	Measures selected were based on appropriate utilization. Magellan utilized U.S. Dept of Health and Human Services 2012 readmission statistics to create benchmarks for quantifiable measure #1 (mean number of readmissions).

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
○ Appropriate utilization (hospital admissions, emergency department visits) ○ Adverse incidents (such as death, avoidable readmission) ○ Referral patterns ○ Authorization requests ○ Appropriate medication use				
5.5 Did the performance measures: • Monitor the performance of MCPs at a point in time? • Track MCP performance over time? • Compare performance among MCPs over time? • Inform the selection and evaluation of quality improvement activities?	✓	--	--	Both performance measures monitored performance at a point in time and over time. Measure #1 determined readmissions within 30, 90, and 180 days from discharge, and Measure #2 determined average length of stay during the initial PRTF stay. Both measures were evaluated across the measurement period (10/1/2019-9/30/2020) and will be compared to a similar baseline period previously reported (10/01/2018-9/30/2019). With only one MCP, The performance measures did not compare performance among MCPs.
5.6 Did the MCP consider existing measures, such as CMS Child and Adult Core Set, Core Quality Measure Collaborative, certified community behavioral health clinics (CCBHC) measures, HEDIS®, or AHRQ measures?	--	✓	--	Magellan did not consider or utilize existing measures for this PIP.
5.7 If there were gaps in existing measures, did the MCP consider the following when developing new measures based on current clinical practice guidelines or health services research? • Did the measure address accepted clinical guidelines relevant to the PIP question? • Did the measure address an important aspect of care or operations that was meaningful to MCP enrollees? • Did available data sources allow the MCP to reliably and accurately calculate the measure? • Were all criteria used in the measure defined clearly (such as time periods, characteristics of eligible enrollees,	--	--	✓	N/A - Magellan did not utilize existing measures for this PIP.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
services to be assessed, and exclusion criteria)?				
5.8 Did the measures capture changes in enrollee satisfaction or experience of care? • Although enrollee satisfaction/experience is an important outcome of care in clinical areas, improvement in satisfaction should not be the only measured outcome of a clinical project. Some improvement in health or functional status should also be addressed • For projects in nonclinical areas (such as addressing access or availability of services), measurement of health or functional status is preferred	--	✓	--	Measures captured mean number of readmissions and average length of stay during the initial stay in a PRTF. Measures did not address enrollee satisfaction or experiences of care.
5.9 Did the measures include a strategy to ensure inter-rater reliability (if applicable)?	--	--	✓	N/A – Magellan used an administrative data collection methodology for this PIP, which did not include medical record abstraction.
5.9 If process measures were used, is there strong clinical evidence indicating that the process being measured is meaningfully associated with outcomes? • This determination should be based on published guidelines, including citations from randomized clinical trials, case control studies, or cohort studies • At a minimum, the PIP should be able to demonstrate a consensus among relevant practitioners with expertise in the defined area who attest to the importance of a given process	--	--	✓	N/A – Magellan did not use process measures for this PIP.
5.10 Overall assessment: In the comments section, note any recommendations for improving the selected PIP variables and performance measures.				N/A

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Worksheet 1.6. Review the Data Collection Procedures

Assess whether the data collection procedures were valid and reliable by answering the following questions. This worksheet includes three sections: (1) overall data collection procedures, (2) data collection procedures for administrative data sources, and (3) data collection procedures for medical record review. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Section 1: Assessment of Overall Data Collection Procedures

Question	Yes	No	NA	Comments
6.1 Did the PIP design specify a systematic method for collecting valid and reliable data that represents the population in the PIP?	✓	--	--	Magellan specified they utilized a programmed pull from all claims / encounter files of all eligible members to collect data for this PIP. Magellan used SQL to pull data for this PIP from the iSeries database.
6.2 Did the PIP design specify the frequency of data collection? If yes, what was the frequency (for example, semi-annually)?	✓	--	--	Per virtual discussion, Magellan collects and reports data quarterly (included within quarterly reports sent to the State). Magellan also conducts an annual report for this PIP.
6.3 Did the PIP design clearly specify the data sources? • Data sources may include: ○ Encounter and claims systems ○ Medical records ○ Case management or electronic visit verification systems ○ Tracking logs ○ Surveys ○ Provider and/or enrollee interviews	✓	--	--	Magellan sourced data for this PIP from encounter and claims data systems.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
6.4 Did the PIP design clearly define the data elements to be collected? • Accurate measurement depends on clear and concise definitions of data elements (including numerical definitions and units of measure)	✓	--	--	While not included in "Data Collection Methodology" within the QIA form, Magellan specified individual variables within performance measures, which appear to serve as data elements. For Measure #1, data elements included: • Numerator: The number of unduplicated members age 4-20 who were readmitted to an inpatient psychiatric facility or PRTF within 30/90/180 days of the original discharge. • Denominator: The total number of unduplicated members age 4-20 who were discharged from a PRTF during the measurement period. For Measure #2, data elements included: • Numerator: Sum of days in PRTF (discharge date minus admission date) during measurement period • Denominator: Number of discharges for participants in group
6.5 Did the data collection plan link to the data analysis plan to ensure that appropriate data would be available for the PIP?	✓	--	--	Magellan linked the data collection plan with the data analysis plan within "Data Collection Process" in the QIA form. Magellan noted: "The Corporate Analytics Department will conduct the analysis by using secondary claims data on Medicaid members that is provided by the State of WY for analysis by the WY CME."
6.6 Did the data collection instruments allow for consistent and accurate data collection over the time periods studied?	--	✓	--	Magellan noted there is a lag in receipt of the full dataset for this PIP, since CME providers have 12 months to submit claims data, which may impact data consistency. Despite the lag in data, Magellan notes "the QIA will conduct the annual analysis on claims-based data through 12/31/2020."
6.7 If qualitative data collection methods were used (such as interviews or focus groups), were the methods well-defined and designed to collect meaningful and useful information from respondents?	--	--	✓	N/A - Qualitative data collection methods were not used for this PIP. Data for this PIP was collected through a programmed pull of claims / encounter data.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
6.8 Overall assessment: In the comments section, note any recommendations for improving the data collection procedures. **Note:** Include assessment of data collection procedures for administrative data sources and medical record review noted below.				Magellan should specify the frequency of data collection cycle in C.4 of the QIA form. CMS states in EQR Protocol that "more frequent access to data…supports continuous quality improvement (QI) and Plan Do Study Act (PDSA) efforts and can allow an MCP or state to correct or revise course more quickly." Specifying frequency of data collection is critical in assuring that calculated performance measures can be reliably used to gauge improvement. Magellan should also include in the QIA form additional information on the instruments used to collect data, including key data fields, and personnel collecting data for the PIP. Magellan should show proof that data systems captured all eligible admissions / discharges, and also describe the process for data submission by providers.

Section 2: Assessment of Data Collection Procedures for Administrative Data Sources

Question	Yes	No	NA	Comments
6.9 If inpatient data was used, did the data system capture all inpatient admissions/discharges?	✓	--	--	Per virtual discussion, Magellan confirmed that the systems utilized to collect data for this PIP (iSeries database; Cognos) are comprehensive and capture all PRTF discharges, assuming overnight data updates occurred successfully.
6.10 If primary care data was used, did primary care providers submit encounter or utilization data for all encounters?	--	--	✓	N/A – This PIP utilized inpatient data from PRTF stays.
6.11 If specialty care data was used, did specialty care providers submit encounter or utilization data for all encounters?	--	--	✓	N/A – This PIP utilized inpatient data from PRTF stays.
6.12 If ancillary data was used, did ancillary service providers submit encounter or utilization data for all services provided?	--	--	✓	N/A – This PIP utilized inpatient data from PRTF stays.
6.13 If LTSS data was used, were all relevant LTSS provider services included (for example, through encounter data, case management systems, or electronic visit verification (EVV) systems)?	--	--	✓	N/A – This PIP utilized inpatient data from PRTF stays.

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Question	Yes	No	NA	Comments
6.14 If EHR data was used, were patient, clinical, service, or quality metrics validated for accuracy and completeness as well as comparability across systems?	--	--	✓	N/A – This PIP utilized inpatient data from PRTF stays.

Section 3: Assessment of Data Collection Procedures for Medical Record Review

Question	Yes	No	NA	Comments
6.15 Was a list of data collection personnel and their relevant qualifications provided? • Data collection personnel require the conceptual and organizational skills to abstract data. These skills will vary depending on the nature of the data and the degree of professional judgment required. For example, trained medical assistants or medical records clerks may collect data if the abstraction involves verifying the presence of a diagnostic test report. However, experienced clinical staff (such as registered nurses) should be used to extract data to support a judgment about whether clinical criteria are met	--	--	✓	N/A - Medical record review does not apply to this PIP.
6.16 For medical record review, was inter-rater and intra-rater reliability described? • The PIP should also consider and address intra-rater reliability (i.e., reproducibility of judgments by the same abstractor at a different time)	--	--	✓	N/A - Medical record review does not apply to this PIP.
6.17 For medical record review, were guidelines for obtaining and recording the data developed? • A glossary of terms for each project should be developed before data collection begins to ensure consistent interpretation among and between data collection staff • Data collection staff should have clear, written instructions, including an overview of the PIP, how to complete each section of the form or instrument, and general guidance on how to handle situations not covered by the instructions. This is particularly important when multiple reviewers are collecting data	--	--	✓	N/A - Medical record review does not apply to this PIP.

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Worksheet 1.7. Review Data Analysis and Interpretation of PIP Results

Assess whether the data analysis and interpretation was appropriate by answering the following questions. Insert comments to explain "No" and "Not Applicable" responses.

Question	Yes	No	NA	Comments
7.1 Was the analysis conducted in accordance with the data analysis plan?	✓	--	--	According to the QIA form, Magellan planned to leverage their Corporate Analytics Department to conduct data analysis using secondary Medicaid claims data provided by the State of Wyoming. Analysis included calculating the following variables and performance measures: **1. Measure #1:** [The number of unduplicated members age 4-20 who were readmitted to an inpatient psychiatric facility or PRTF within 30/90/180 days of the original discharge] / [The total number of unduplicated members age 4-20 who were discharged from a PRTF during the measurement period] **2. Measure #2:** [Sum of days in PRTF (discharge date minus admission date) during measurement period] / [Number of discharges for participants in group] While remeasurement (data for 10/1/2019-9/30/2020) analysis was not presented in the QIA form, baseline measurements appear to follow the above process.
7.2 Did the analysis include baseline and repeat measurements of project outcomes?	--	✓	--	The analysis will include baseline measurements (data collected from 10/1/2018-09/30/2019) as well as data from the remeasurement period (10/1/2019-9/30/2020). Baseline measurements were reported within the QIA form; however, Magellan stated that full data analysis for this PIP will be available in May 2021.
7.3 Did the analysis assess the statistical significance of any differences between the initial and repeat measurements?	--	--	✓	N/A - Since the analysis did not report remeasurements, Magellan could not assess statistical significance between measurements.
7.4 Did the analysis account for factors that may influence the comparability of initial and repeat measurements?	--	✓	--	Per virtual discussion, Magellan confirmed this information will be included within the full data analysis, expected in May 2021.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
7.5 Did the analysis account for factors that may threaten the internal or external validity of the findings?	--	✓	--	Per virtual discussion, Magellan confirmed this information will be included within the full data analysis, expected in May 2021.
7.6 Did the PIP compare the results across multiple entities, such as different patient subgroups, provider sites, or MCPs? • Comparing the performance across multiple entities involves greater statistical design and analytical considerations than those required for a project assessing performance of a single entity, such as an MCP, over time	✓	--	--	While the PIP primarily deals with a single patient group (Medicaid members aged 4-20 years old who are enrolled at the PRTF level of care), the analysis compared data between youth who participate in the Enrollment Initiative and those who opt-out. Additionally, the analysis included all eligible youth in PRTFs across Wyoming.
7.7 Were PIP results and findings presented in a concise and easily understood manner?	--	--	✓	N/A - Full results were not included in the QIA form (a complete analysis will be provided by Magellan in early 2021).
7.8 To foster continuous quality improvement, did the analysis and interpretation of the PIP data include lessons learned about less-than-optimal performance? • Analysis and interpretation of the PIP data should be based on a continuous improvement philosophy and reflect on lessons learned and opportunities for improvement	✓	--	--	While the complete analysis is still pending, Magellan offered barriers for both measures in the QIA form that can be considered "lessons learned". These included: 1. "Guardians/parents refusal to accept the program/opting out" 2. "Some guardian/parents may feel overwhelmed and stressed with youth being placed in PRTF in the early stages and not feel like deciding at that time" 3. "PRTF admissions seem to be cyclical with high and low times throughout the year" 4. "Limited knowledge and understanding of the HFWA Program"
7.9 Overall assessment: In the comments section, note any recommendations for improving the analysis and interpretation of PIP results				N/A

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Worksheet 1.8. Assess the Improvement Strategies

Assess whether the selected improvement strategies were appropriate for achieving improvement by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
8.1 Was the selected improvement strategy evidence-based, that is, was there existing evidence (published or unpublished) suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes (as measured by the PIP variables)?	✓	--	--	Magellan selected six interventions for this PIP, including: 1. "Upon admission to PRTF, Magellan Family Support Specialist will reach out to the parents/ guardians within three days of auto-referral regarding the HFWA program to provide education and coordinate transfer to a network FSP" 2. "FSP will work with the family during the youth's stay at the PRTF to educate about the benefits of HFWA" 3. "FSP will begin coordinating with a network Family Care Coordinator to ensure that supports are in place upon discharge from the PRTF" 4. "Initial training for providers on the Protocol for Service Coordination-education for how to work with PRTF and the treatment team" 5. "Web-site posting about the Enrollment Initiative on the Provider Website" 6. "Provider Update sent out on the Enrollment Initiative" While Magellan did not provide published evidence for the effectiveness of these interventions, they appear to be based on the barriers identified by the workgroup for each performance measure. For example, the workgroup identified the barrier "Limited knowledge and understanding of the High Fidelity Wrap Around Program", which has driven the selection of numerous education-focused interventions ("Initial training for providers on the Protocol for Service Coordination-education for how to work with PRTF and the treatment team").
8.2 Was the strategy designed to address root causes or barriers identified through data analysis and quality improvement processes? • Interventions that might have a short-term effect, but that are unlikely to generate long-term change (such as a	✓	--	--	Aligning closely with selected interventions, the four barriers identified for performance measures included: 1. "Guardians/parents refusal to accept the program/opting out" 2. "Some guardian/parents may feel overwhelmed and stressed

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Question	Yes	No	NA	Comments
one-time reminder letter to enrollees or providers) are insufficient • It is expected that interventions associated with significant improvement will be system interventions (such as educational efforts, policy changes, or targeting of additional resources) • It is expected that interventions should be measurable on an ongoing basis (e.g., quarterly, monthly) to monitor intervention progress				with youth being placed in PRTF in the early stages and not feel like deciding at that time" 3. "PRTF admissions seem to be cyclical with high and low times throughout the year" 4. "Limited knowledge and understanding of the High Fidelity Wrap Around Program" Interventions selected by Magellan appear to address systemic issues (e.g., lack of enrollment; low awareness / lack of education on available programs; family stress), and intend to achieve long-term, programmatic improvements. However, interventions listed in the QIA form do not offer a framework for evaluating their progress, including timeframes for measurement.
8.3 Was the rapid-cycle PDSA approach used to test the selected improvement strategy? • The steps in the PDSA cycle[1] are to: ○ **Plan.** Plan the test or observation, including a plan for collecting data, and interpreting the results ○ **Do.** Try out the test on a small scale ○ **Study.** Set aside time to analyze the data and assess the results ○ **Act.** Refine the change, based on what was learned from the test. Determine how to sustain the intervention, if successful • If tests of change were not successful (i.e., did not achieve significant improvement), a process to identify possible causes and implement solutions should be identified	✓	--	--	Per virtual discussion, Magellan leverages the rapid-cycle PDSA approach for all quality improvement initiatives, although this is not mentioned in the QIA form. Magellan also consulted PIP workgroups and the QIC to develop improvement strategies for this topic.
8.4 Was the strategy culturally and linguistically appropriate?[2]	✓	--	--	Strategies were not reported in QIA documentation. However, per virtual discussion with Magellan, this PIP ensures the proper delivery of HFWA services, of which cultural competence is a critical element.

[1] Institute for Healthcare Improvement: Science of Improvement, Testing Changes. Available at http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

[2] More information on culturally and linguistically appropriate services may be found at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
8.5 Was the implementation of the strategy designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes (e.g., patient risk factors, Medicaid program changes, provider education, clinic policies or practices)?	✓	--	--	Interventions seek to encourage participation in the Enrollment Initiative / avoid families opting out of HFWA services post-discharge. Noted as a barrier within the PIP, a smaller sample of participants within the Enrollment Initiative increases the risk of performance measure results skewing toward outliers (e.g., little / no readmission data; significantly long / short average lengths of stay). Through encouraging outreach and education on HFWA services for eligible families and providers, interventions look to assure a sufficient sample size and mitigate this potential risk.
8.6 Building on the findings from the data analysis and interpretation of PIP results (Step 7), did the PIP assess the extent to which the improvement strategy was successful and identify potential follow-up activities?	--	--	✓	N/A - Full results were not included in the QIA form (a complete analysis will be provided by Magellan in early 2021).
8.7 Overall assessment: In the comments section, note any recommendations for improving the implementation strategies.				Magellan should describe leveraging the PDSA cycle to select interventions within the QIA form. Additionally, Magellan should describe strategies for assuring cultural and linguistic appropriateness of the topic within documentation.

Worksheet 1.9. Assess the Likelihood that Significant and Sustained Improvement Occurred

Assess the likelihood that significant and sustained improvement occurred by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
9.1 Was the same methodology used for baseline and repeat measurements?	--	--	✓	N/A - Full results were not included in the QIA form (a complete analysis will be provided by Magellan in May 2021).
9.2 Was there any quantitative evidence of improvement in processes or outcomes of care?	--	--	✓	N/A - Full results were not included in the QIA form (a complete analysis will be provided by Magellan in May 2021).
9.3 Was the reported improvement in performance likely to be a result of the selected intervention? • It is not necessary to demonstrate conclusively (e.g., through controlled studies) that a change is an effect of the intervention; it is sufficient to show	--	--	✓	N/A - Full results were not included in the QIA form (a complete analysis will be provided by Magellan in May 2021).

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Question	Yes	No	NA	Comments
that the change might reasonably be expected to result from the intervention • It is not necessary to undertake data analysis to correct for secular trends (e.g., changes that reflect continuing growth or decline in a measure because of external forces over an extended period). The measured improvement should reasonably be determined to have resulted from the intervention				
9.4 Is there statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention?	--	--	✓	N/A - Full results were not included in the QIA form (a complete analysis will be provided by Magellan in May 2021).
9.5 Was sustained improvement demonstrated through repeated measurements over time?	--	--	✓	N/A - Full results were not included in the QIA form (a complete analysis will be provided by Magellan in May 2021).
9.6 Overall assessment: In the comments section, note any recommendations for improving the significance and sustainability of improvement as a result of the PIP.				N/A

Worksheet 1.10. Perform Overall Validation of PIP Results

Provide an overall validation rating of the PIP results. The "validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced evidence of significant improvement. Insert comments to explain the rating.

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☐ Low confidence ☒ No confidence	Since the Enrollment Initiative PIP did not include final data analysis, EQRO reviewers are unable to determine a validation rating.

Worksheet 1.11. Framework for Summarizing Information about Performance Improvement Projects (PIPs)

1. General PIP Information

Managed Care Plan (MCP) Name: Wyoming Department of Health Care Management Entity (CME) Program
PIP Title: Enrollment Initiative Quality Improvement Activity

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

PIP Aim Statement:

1. "Do the interventions implemented as part of the Enrollment Initiative demonstrate a change in the number of readmissions to a HLOC?"
2. "Do the members included within the enrollment initiative have a different initial LOS compared to those members who opt-out of the program?"

Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)

☐ State-mandated (state required plans to conduct a PIP on this specific topic)
☐ Collaborative (plans worked together during the planning or implementation phases)
☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state)
☒ Plan choice (state allowed the plan to identify the PIP topic)

Target age group (check one):

☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children

*If PIP uses different age threshold for children, specify age range here: Children aged 4-20 years old

Target population description, such as duals, LTSS or pregnant women (please specify): All WY State Medicaid members (aged 4-20 years old) that are enrolled within the PRTF level of care for the measurement timeframe of 10/01/19 – 09/30/20.

Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)

1. "Upon admission to PRTF, Magellan Family Support Specialist will reach out to the parents/ guardians within three days of auto-referral regarding the HFWA program to provide education and coordinate transfer to a network FSP"
2. "FSP will work with the family during the youth's stay at the PRTF to educate about the benefits of HFWA"
3. "FSP will begin coordinating with a network Family Care Coordinator to ensure that supports are in place upon discharge from the PRTF"

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

1. "Initial training for providers on the Protocol for Service Coordination (education for how to work with PRTF and the treatment team)"
2. "Web-site posting about the Enrollment Initiative on the Provider Website"
3. "Provider Update sent out on the Enrollment Initiative"

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

1. "Auto-enrollment in HFWA services for youth enrolled within the PRTF level of care, with option for youth / caregiver opt-out."

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3. Performance Measures and Results (Add rows as necessary)

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Decreased number of readmissions to a higher level of care. (Mean number of readmissions to a HLOC (inpatient and/or PRTF) within 30/90/180 days after discharge from PRTF for Enrollment Initiative members and opt-out youth. (1a 30 days, 1b 90 days, 1c 180 days)	10/1/2018-09/30/2019	n=18; rate of 61%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Average length of stay (LOS) for members during the initial PRTF stay for members in the enrollment initiative compared to youth who opt-out of the initiative.	10/1/2018-09/30/2019	n=18; rate of 87.1	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☐ Yes ☒ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☒ Baseline year
☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):

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Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☒ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: Magellan should: • Document input directly obtained from enrolled youth, families, and providers to select the PIP topic within the QIA form. • Specify the change in performance measures that would constitute "improvement" (e.g., fewer readmissions to a HLOC; shorter initial length of stay) within the aim statements. • Specify the frequency of data collection within the QIA form. • Include additional information in the QIA form regarding the instruments used to collect data, including key data fields and personnel responsible for collecting data. • Directly reference the PDSA cycle within the QIA form and describe the process of developing improvement strategies using the cycle.

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MINIMUM CONTACTS

Worksheet 1.1. Review the Selected PIP Topic

PIP Topic: Improving Minimum Contact Engagement for Family Care Coordinators

Assess the appropriateness of the selected PIP topic by answering the following questions about the MCP and PIP. Insert comments to explain "No" and "Not applicable (NA)" responses.

Question	Yes	No	NA	Comments
1.1 Was the PIP topic selected through a comprehensive analysis of MCP enrollee needs, care, and services (e.g., consistent with demographic characteristics and health risks, prevalence of conditions, or the need for a specific service by enrollees)? (If the PIP topic was required by the state, please check "not applicable" and note in comments.)	✓	--	--	Magellan demonstrated a need for the PIP topic within the Rationale section of the QIA form. According to Magellan, "Minimum contact requirements support fidelity and demonstrate consistency of member and caregiver engagement." However, Magellan has observed that since contract inception in 2015, "there have been ongoing concerns regarding providers' failure to achieve minimum contact requirements." Data reported each year from 2016-2018 indicated that minimum contacts were below the 100 percent goal for both telephone and in-person contacts. This PIP topic seeks to improve on these observed issues by improving the frequency of Family Care Coordinator (FCC) contacts with members / caregivers.
1.2 Did selection of the PIP topic consider performance on the CMS Child and Adult Core Set measures?	--	--	✓	N/A - The CMS Child and Adult Core Set measures focus on clinical measures and do not apply to this PIP topic.
1.3 Did the selection of the PIP topic consider input from enrollees or providers who are users of, or concerned with, specific service areas? (If the PIP topic was required by the state, please check "not applicable" and note in comments.) • To the extent feasible, input from enrollees who are users of, or concerned with, specific services areas should be obtained.	✓	--	--	Per discussion with Magellan, Magellan conducted an informal survey of CME providers to select this PIP topic. Magellan also held meetings with providers to discuss minimum contact requirements. Magellan did not solicit input from enrollees for this PIP topic.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
1.4 Did the PIP topic address care of special populations or high priority services, such as: • Children with special health care needs • Adults with physical disabilities • Children or adults with behavioral health issues • People with intellectual and developmental disabilities • People with dual eligibility who use long-term services and supports (LTSS) • Preventive care • Acute and chronic care • High-volume or high-risk services • Care received from specialized centers (e.g., burn, transplant, cardiac surgery) • Continuity or coordination of care from multiple providers and over multiple episodes • Appeals and grievances • Access to and availability of care	✓	--	--	The PIP topic directly pertained to services for children aged 4-20 years old who have serious and persistent mental illness (SPMI) / severe emotional disturbance (SED) / and meet Psychiatric Residential Treatment Facility (PRTF) level of care. Minimum contact requirements are an essential part of ensuring that members and caregivers remain engaged and obtain full benefit from the CME program.
1.5 Did the PIP topic align with priority areas identified by HHS and/or CMS?	✓	--	--	The PIP topic directly aligned with numerous priority areas and goals identified by HHS, CMS, and the CME program. The topic seeks to enhance access to and engagement within HFWA services by improving the frequency of Family Care Coordinator (FCC) contacts with members / caregivers. This aligns with numerous priorities, including HHS National Quality Strategy aims (*Better Care - Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe*), CMS Quality Strategy priorities (*Strengthen Person and Family Engagement as Partners in Their Care, Promote Effective Communication and Coordination of Care*), and additional CME program goals.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
1.6 Overall assessment: In the comments section, note any recommendations for improving the PIP topic.				Magellan should document input received from providers to inform PIP topics selection, as well as processes for soliciting input within the QIA form. Additionally, Magellan should consider soliciting input directly from enrolled youth and families to inform the selection of the PIP topic.

Worksheet 1.2. Review the PIP Aim Statement

PIP Aim Statement: Improve the frequency in which providers are in compliance with minimum contact requirements; meet goal of 100 percent compliance with minimum contact requirement.

Assess the appropriateness of the selected PIP topic by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
2.1 Did the PIP aim statement clearly specify the improvement strategy, population, and time period for the PIP?	--	✓	--	This aim statement was confirmed verbally by Magellan via virtual discussions. The aim statement did not specify the improvement strategy, population, or time period.
2.2 Did the PIP aim statement clearly specify the population for the PIP?	--	✓	--	This aim statement was confirmed verbally by Magellan via virtual discussions. The aim statement did not clearly specify the study population of the PIP (youth discharged from a PRTF).
2.3 Did the PIP aim statement clearly specify the time period for the PIP?	--	✓	--	This aim statement was confirmed verbally by Magellan via virtual discussions. The aim statement did not specify the time period for the PIP (latest remeasurement 7/1/2019 – 6/30/2020).
2.4 Was the PIP aim statement concise?	--	✓	--	This aim statement was confirmed verbally by Magellan via virtual discussions. The aim statement was not a concise question as modeled in CMS protocol.
2.5 Was the PIP aim statement answerable?	--	✓	--	This aim statement was confirmed verbally by Magellan via virtual discussions. The aim statement was not a concise question as modeled in CMS protocol.
2.6 Was the PIP aim statement measurable?	✓	--	--	The aim statement is based around the goal of meeting 100 percent compliance with the minimum contacts requirement.

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Question	Yes	No	NA	Comments
2.7 Overall assessment: In the comments section, note any recommendations for improving the PIP aim statement.				Magellan should confirm the aim statement for the Minimum Contacts PIP. Specifically, the aim statement should be a concise, answerable question that defines the improvement strategy, study population, and time period of the topic.

Worksheet 1.3. Review the Identified PIP Population

PIP Population: Number of enrollees with a full week / month within measurement period.

Assess whether the study population was clearly identified by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
3.1 Was the project population clearly defined in terms of the identified study question (e.g., age, length of the study population's enrollment, diagnoses, procedures, other characteristics)? • The required length of time will vary depending on the PIP topic and performance measures	✓	--	--	Magellan confirmed the study population in virtual discussion, including "number of enrollees with a full week within measurement period" (Performance Measure #1) and the "number of enrollees with a full month within measurement period" (Performance Measure #2). Since the population refers to CME program enrollees, it is defined by age (4-20 years) and diagnoses (SED / SPMI diagnosis).
3.2 Was the entire MCP population included in the PIP?	--	✓	--	This PIP included the "number of enrollees with a full week within measurement period" (Performance Measure #1) and the "number of enrollees with a full month within measurement period" (Performance Measure #2) as a sample. CME members who do not fall within these categories will not be included within this PIP.
3.3 If the entire population was included in the PIP, did the data collection approach capture all enrollees to whom the PIP question applied? • If data can be collected and analyzed through an administrative data system, it may be possible to study the whole population. For more guidance on administrative data collection, see Worksheet 1.6.	✓	--	--	The data collection method used an administrative data system, in which Magellan runs a SQL query weekly. Magellan also appeared to utilize a review of provider progress notes for this PIP, stating "Data for measures 1 and 2 originate from progress notes entered by providers on MagellanProvider.com" in the QIA form.
3.4 Was a sample used? (If yes, use Worksheet 1.4 to review sampling methods).	--	--	✓	N/A - No sampling was used for this PIP.

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• If the data will be collected manually (such as through medical record review), sampling may be necessary				
3.5 Overall assessment: In the comments section, note any recommendations for identifying the project population.				Magellan should clearly define the identified PIP population within the Project Rationale section of the QIA form. The population should be defined in documentation by age, length of enrollment, diagnoses, procedures, and other characteristics as applicable. Magellan should also specify if the PIP applies to the entire CME population within the rationale.

Worksheet 1.4. Review the Sampling Method

Overview of Sampling Method: No sampling was used for this PIP.

If HEDIS® sampling is used, check here, and skip the rest of this worksheet. ☐

Assess whether the sampling method was appropriate by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses. Refer to Appendix B for an overview of sampling approaches for EQR data collection activities.

Question	Yes	No	NA	Comments
4.1 Did the sampling frame contain a complete, recent, and accurate list of the target PIP population? • A sampling frame is the list from which the sample is drawn. It includes the universe of members of the target PIP population, such as individuals, caregivers, households, encounters, providers, or other population units that are eligible to be included in the PIP. The completeness, recency, and accuracy of the sampling frame are key to the representativeness of the sample	--	--	✓	N/A - No sampling was used for this PIP.
4.2 Did the sampling method consider and specify the true or estimated frequency of the event, the confidence interval to be used, and the acceptable margin of error?	--	--	✓	N/A - No sampling was used for this PIP.
4.3 Did the sample contain a sufficient number of enrollees taking into account non-response?	--	--	✓	N/A - No sampling was used for this PIP.
4.4 Did the method assess the representativeness of the sample according to subgroups, such as those	--	--	✓	N/A - No sampling was used for this PIP.

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Question	Yes	No	NA	Comments
defined by age, geographic location, or health status?				
4.5 Were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field.	--	--	✓	N/A - No sampling was used for this PIP.
4.6 Overall assessment: In the comments section, note any recommendations for improving the sampling method.				N/A

Worksheet 1.5. Review the Selected PIP Variables and Performance Measures

Selected PIP Variables and Performance Measures:

1. **Quantifiable Measure #1**: Rate of members/caregivers contacted by telephone at least once a week.

2. **Quantifiable Measure #2**: Rate of members/caregivers contacted in person at least twice a month.

Assess whether the selected PIP variables were appropriate for measuring performance and tracking improvement by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Recall that CMS encourages MCPs to choose variables for PIPs that reflect health outcomes. Performance measures are then used to measure these health outcomes. When selecting variables, the MCP should consider existing performance measures.

Question	Yes	No	NA	Comments
PIP variables				
5.1 Were the variables adequate to answer the PIP question? • Did the PIP use objective, clearly defined, time-specific variables (e.g., an event or status that can be measured)? • Were the variables available to measure performance and track improvement over time? (CMS encourages states to select variables that can be examined on at least a semi-annual basis	✓	--	--	Magellan specified objective, clearly defined continuous variables (numerator and denominator) for each performance measure: 1. **Measure #1**: [Number of members contacted by phone at least once a week] / [Number of members enrolled with a full week within measurement period] 2. **Measure #2**: [Number of members/caregivers contacted in person at least twice a month] / [Number of members/caregivers enrolled with a full month within measurement period] Additionally, both numerators were time-specific ("at least once a week / month")

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Question	Yes	No	NA	Comments
				and were measured across each measurement period weekly.
Performance measures				
5.2 Did the performance measure assess an important aspect of care that will make a difference to enrollees' health or functional status?	✓	--	--	In the QIA form, Magellan stated that "the minimum contact requirement is an integral part of the HFWA process to ensure members and caregivers are engaged in services and able to obtain full benefit from the program." Enabling additional members to full benefit from the CME program can be expected to make a difference in enrollee health and/or functional status.
5.3 Were the performance measures appropriate based on the availability of data and resources to collect the data (administrative data, medical records, or other sources)?	✓	--	--	Magellan used an administrative data collection process (through running a SQL query to analyze progress notes) for this PIP. Magellan stated that progress notes entered by providers document contacts with members and describe the method of contact (over phone, in-person, etc.) Magellan appears to have sufficient data sources to measure performance.
5.4 Were the measures based on current clinical knowledge or health services research? • Examples may include: ○ Recommended procedures ○ Appropriate utilization (hospital admissions, emergency department visits) ○ Adverse incidents (such as death, avoidable readmission) ○ Referral patterns ○ Authorization requests ○ Appropriate medication use	✓	--	--	Magellan made clear that maintaining contact between FCCs and members is "an integral part of the HFWA process to ensure members and caregivers are engaged in services and able to obtain full benefit from the program" and that "minimum contact requirements support fidelity and demonstrate consistency of member and caregiver engagement." Measures that evaluate frequency of FCC in-person and phone contacts with members can be considered recommended procedures.
5.5 Did the performance measures: • Monitor the performance of MCPs at a point in time? • Track MCP performance over time? • Compare performance among MCPs over time? • Inform the selection and evaluation of quality improvement activities?	✓	--	--	Both performance measures monitored the performance of the MCP over time (contacted by telephone at least once a week; contacted in person at least twice a month). Additionally, performance was measured over three measurement periods (baseline; remeasurement 1, and remeasurement 2). The performance measures do not compare performance among MCPs.
5.6 Did the MCP consider existing measures, such as CMS Child and Adult	--	✓	--	Magellan did not consider or utilize existing measures for this PIP.

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Question	Yes	No	NA	Comments
Core Set, Core Quality Measure Collaborative, certified community behavioral health clinics (CCBHC) measures, HEDIS®, or AHRQ measures?				
5.7 If there were gaps in existing measures, did the MCP consider the following when developing new measures based on current clinical practice guidelines or health services research? • Did the measure address accepted clinical guidelines relevant to the PIP question? • Did the measure address an important aspect of care or operations that was meaningful to MCP enrollees? • Did available data sources allow the MCP to reliably and accurately calculate the measure? • Were all criteria used in the measure defined clearly (such as time periods, characteristics of eligible enrollees, services to be assessed, and exclusion criteria)?	--	--	✓	N/A - Magellan did not utilize existing measures for this PIP.
5.8 Did the measures capture changes in enrollee satisfaction or experience of care? • Although enrollee satisfaction/experience is an important outcome of care in clinical areas, improvement in satisfaction should not be the only measured outcome of a clinical project. Some improvement in health or functional status should also be addressed • For projects in nonclinical areas (such as addressing access or availability of services), measurement of health or functional status is preferred	--	✓	--	The performance measures for this PIP captured the frequency and method of FCC contact with members / caregivers. Measures did not address enrollee satisfaction or experiences of care.
5.9 Did the measures include a strategy to ensure inter-rater reliability (if applicable)?	--	--	✓	N/A - Magellan used an administrative data collection methodology and did not leverage medical record abstraction.
5.9 If process measures were used, is there strong clinical evidence indicating that the process being measured is meaningfully associated with outcomes? • This determination should be based on published guidelines, including	--	--	✓	N/A - Magellan did not use process measures for this PIP.

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Question	Yes	No	NA	Comments
citations from randomized clinical trials, case control studies, or cohort studies • At a minimum, the PIP should be able to demonstrate a consensus among relevant practitioners with expertise in the defined area who attest to the importance of a given process				
5.10 Overall assessment: In the comments section, note any recommendations for improving the selected PIP variables and performance measures.				N/A

Worksheet 1.6. Review the Data Collection Procedures

Assess whether the data collection procedures were valid and reliable by answering the following questions. This worksheet includes three sections: (1) overall data collection procedures, (2) data collection procedures for administrative data sources, and (3) data collection procedures for medical record review. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Section 1: Assessment of Overall Data Collection Procedures

Question	Yes	No	NA	Comments
6.1 Did the PIP design specify a systematic method for collecting valid and reliable data that represents the population in the PIP?	✓	--	--	Magellan offered the following baseline methodology for data collection: "Data for measures 1 and 2 originate from progress notes entered by providers on MagellanProvider.com. The data is then pulled using a SQL code/query for the needed time frames." To ensure further reliability, Magellan conducted provider outreach to validate collected data.
6.2 Did the PIP design specify the frequency of data collection? If yes, what was the frequency (for example, semi-annually)?	✓	--	--	Magellan specified that data is collected weekly and monthly for this PIP. For weekly data pulls, Magellan stated that results are "reviewed for follow-up with the providers as applicable."

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Question	Yes	No	NA	Comments
6.3 Did the PIP design clearly specify the data sources? • Data sources may include: ○ Encounter and claims systems ○ Medical records ○ Case management or electronic visit verification systems ○ Tracking logs ○ Surveys ○ Provider and/or enrollee interviews	✓	--	--	According to the QIA form, the data sources for this PIP were "progress notes entered by providers on Magellanprovider.com"
6.4 Did the PIP design clearly define the data elements to be collected? • Accurate measurement depends on clear and concise definitions of data elements (including numerical definitions and units of measure)	✓	--	--	Magellan defined data elements to be collected for this PIP in discussion. Magellan clarified that progress notes have distinct check-box fields for "Description of Support", which includes planned contact, CFT meeting, weekly phone contact, bi-monthly face-to-face, and other options for contacts. Magellan uses SQL to pull data elements from progress notes.
6.5 Did the data collection plan link to the data analysis plan to ensure that appropriate data would be available for the PIP?	--	✓	--	Per virtual discussion, Magellan leveraged the QIC for planning discussions related to data analysis for this PIP but did not use a formal data analysis plan.
6.6 Did the data collection instruments allow for consistent and accurate data collection over the time periods studied?	✓	--	--	Per virtual discussion with Magellan, progress notes have distinct check-box fields for "Description of Support", which includes planned contact, CFT meeting, weekly phone contact, bi-monthly face-to-face, and other options for contacts. This enables accurate, automated data collection for the PIP.
6.7 If qualitative data collection methods were used (such as interviews or focus groups), were the methods well-defined and designed to collect meaningful and useful information from respondents?	--	--	✓	N/A - Qualitative data collection methods were not used for this PIP.

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Question	Yes	No	NA	Comments
6.8 Overall assessment: In the comments section, note any recommendations for improving the data collection procedures. **Note:** Include assessment of data collection procedures for administrative data sources and medical record review noted below.				Magellan should consider developing a formal data analysis plan for the PIP. The data analysis plan should clearly define: • Goals for data analysis and tracking • Roles and responsibilities for staff members, including data quality control • Data collection instruments will be used • Data sources • How and when data will be consistently and accurately collected

Section 2: Assessment of Data Collection Procedures for Administrative Data Sources

Question	Yes	No	NA	Comments
6.9 If inpatient data was used, did the data system capture all inpatient admissions/discharges?	--	--	✓	N/A – Progress notes from encounters with members were used as a data source.
6.10 If primary care data was used, did primary care providers submit encounter or utilization data for all encounters?	--	--	✓	N/A – Progress notes from encounters with members were used as a data source.
6.11 If specialty care data was used, did specialty care providers submit encounter or utilization data for all encounters?	--	--	✓	N/A – Progress notes from encounters with members were used as a data source.
6.12 If ancillary data was used, did ancillary service providers submit encounter or utilization data for all services provided?	✓	--	--	Magellan confirmed the data source (progress notes uploaded to Magellanprovider.com) captured all member contacts with FCCs.
6.13 If LTSS data was used, were all relevant LTSS provider services included (for example, through encounter data, case management systems, or electronic visit verification (EVV) systems)?	--	--	✓	N/A – Progress notes from encounters with members were used as a data source.
6.14 If EHR data was used, were patient, clinical, service, or quality metrics validated for accuracy and completeness as well as comparability across systems?	--	--	✓	N/A – Progress notes from encounters with members were used as a data source.

Section 3: Assessment of Data Collection Procedures for Medical Record Review

Question	Yes	No	NA	Comments
6.15 Was a list of data collection personnel and their relevant qualifications provided?	--	--	✓	N/A - Medical record review does not apply to this PIP.

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Question	Yes	No	NA	Comments
• Data collection personnel require the conceptual and organizational skills to abstract data. These skills will vary depending on the nature of the data and the degree of professional judgment required. For example, trained medical assistants or medical records clerks may collect data if the abstraction involves verifying the presence of a diagnostic test report. However, experienced clinical staff (such as registered nurses) should be used to extract data to support a judgment about whether clinical criteria are met				
6.16 For medical record review, was inter-rater and intra-rater reliability described? • The PIP should also consider and address intra-rater reliability (i.e., reproducibility of judgments by the same abstractor at a different time)	--	--	✓	N/A - Medical record review does not apply to this PIP.
6.17 For medical record review, were guidelines for obtaining and recording the data developed? • A glossary of terms for each project should be developed before data collection begins to ensure consistent interpretation among and between data collection staff • Data collection staff should have clear, written instructions, including an overview of the PIP, how to complete each section of the form or instrument, and general guidance on how to handle situations not covered by the instructions. This is particularly important when multiple reviewers are collecting data	--	--	✓	N/A - Medical record review does not apply to this PIP.

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Worksheet 1.7. Review Data Analysis and Interpretation of PIP Results

Assess whether the data analysis and interpretation was appropriate by answering the following questions. Insert comments to explain "No" and "Not Applicable" responses.

Question	Yes	No	NA	Comments
7.1 Was the analysis conducted in accordance with the data analysis plan?	✓	--	--	Analysis included calculating the following variables and performance measures: 1. **Measure #1**: [Number of members contacted by phone at least once a week] / [Number of members enrolled with a full week within measurement period] 2. **Measure #2**: [Number of members/caregivers contacted in person at least twice a month] / [Number of members/caregivers enrolled with a full month within measurement period] Each measure had a goal of 100 percent compliance. Magellan compared data for the above measures across a baseline period (7/1/2017-6/30/2018), as well as two remeasurement periods (7/1/2018-6/30/2019; 7/1/2019-6/30/2020).
7.2 Did the analysis include baseline and repeat measurements of project outcomes?	✓	--	--	Magellan compared data for the performance measures across a baseline period (7/1/2017-6/30/2018), as well as two remeasurement periods (7/1/2018-6/30/2019; 7/1/2019-6/30/2020). Magellan reported the following rates for each period: **Measure #1** (Rate of members/caregivers contacted by telephone at least once a week) • Baseline: 28.42% • Remeasurement 1: 49.62% • Remeasurement 2: 71.63% **Measure #2** (Rate of members/caregivers contacted in person at least twice a month) • Baseline: 72.71% • Remeasurement 1: 84.22% • Remeasurement 2: 90.53% Both measures fell below the expected goal of 100 percent.

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Question	Yes	No	NA	Comments
7.3 Did the analysis assess the statistical significance of any differences between the initial and repeat measurements?	✓	--	--	Magellan tested for statistical significance when assessing differences between measurements (Baseline vs. R1; R1 vs. R2) in both performance measures. Using Fisher's Exact Test, Magellan found that each difference across the measurement periods had a 2-tailed p value less than 0.0001 and were statistically significant.
7.4 Did the analysis account for factors that may influence the comparability of initial and repeat measurements?	✓	--	--	Throughout the analysis, Magellan accounted for barriers and factors that might have influenced the comparability of initial and repeat measurements. These efforts included convening a work group, administering a survey as a "barrier analysis", and conducting outreach / education with providers regarding minimum contact requirements. Magellan also accounted for a substantial barrier that emerged during the second remeasurement period, the COVID-19 public health emergency. To promote data consistency, Magellan added virtual contact through Zoom / other virtual platforms as forms of in-person contact.
7.5 Did the analysis account for factors that may threaten the internal or external validity of the findings?	--	✓	--	QIA documentation for this PIP did not address any factors that may threaten the internal or external validity of findings.
7.6 Did the PIP compare the results across multiple entities, such as different patient subgroups, provider sites, or MCPs? • Comparing the performance across multiple entities involves greater statistical design and analytical considerations than those required for a project assessing performance of a single entity, such as an MCP, over time	--	--	✓	N/A -- The analysis did not include comparison across different patient groups or MCPs.
7.7 Were PIP results and findings presented in a concise and easily understood manner?	✓	--	--	Magellan included all calculations for each performance measure within Section 2 of the QIA form. Additionally, Magellan offered explanations of quantitative analysis, as well as qualitative analysis of progress on this PIP within Section 3 of the

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Question	Yes	No	NA	Comments
				documentation. Magellan divided each section by measurement period and clearly described progress on each measure.
7.8 To foster continuous quality improvement, did the analysis and interpretation of the PIP data include lessons learned about less-than-optimal performance? • Analysis and interpretation of the PIP data should be based on a continuous improvement philosophy and reflect on lessons learned and opportunities for improvement	✓	--	--	Magellan convened a work group and discussed with providers after each measurement period to interpret results and address barriers to goal achievement. Magellan also administered a survey to providers to better understand challenges associated with meeting minimum contact requirements. This continuous process led to numerous key improvements for assuring minimum contact, including the Minimum Contact Drilldown Report, conducting outreach / education, and a new internal process where Magellan's Clinical department would not process reauthorization requests from providers unless the provider was able to demonstrate that they were meeting the requirements of the minimum contacts with the member/caregiver.
7.9 Overall assessment: In the comments section, note any recommendations for improving the analysis and interpretation of PIP results				N/A

Worksheet 1.8. Assess the Improvement Strategies

Assess whether the selected improvement strategies were appropriate for achieving improvement by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
8.1 Was the selected improvement strategy evidence-based, that is, was there existing evidence (published or unpublished) suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes (as measured by the PIP variables)?	✓	--	--	Magellan implemented numerous improvement strategies / interventions throughout the course of this PIP. Per the QIA form, interventions included: 1. "Development of Minimum Contact Drilldown Report (OP10 Report) at the provider level for analysis and review with providers" 2. "Implementation of weekly Clinical Department review of OP10 Report to determine how to assist specific providers with meeting minimum contact requirements"

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Question	Yes	No	NA	Comments
				3. "Provided provider communications concerning: a. The importance of selecting checkboxes on progress notes within the Provider Portal to ensure they are obtaining credit for their contacts with members/guardians b. Process changes and the importance of meeting minimum contact requirements" 4. "Development and utilization of the Provider Scorecard and review of the OP10 drilldown report with Network and provider 1:1s (claims-based report was utilized for provider education prior to the development of the OP10 drilldown report in 12/2018)" 5. "Development and roll-out of a training to provide education concerning minimum contact requirements and how to properly complete a progress note (sent out to Program Directors and Coaches and reviewed during the External QIC held 6/20/19)" 6. "Review overall network status on minimum contacts and reiterate minimum contact requirements during the Monthly Provider Calls" 7. "Magellan of Wyoming High Fidelity Wraparound Provider Requirements & Timelines posted to provider website as a reference for understanding minimum contact requirement timelines (page 3)" 8. "Development and implementation of a Provider Education Desktop Procedure to identify providers consistently failing to meet minimum requirements and follow through the education process to the potential for escalation to a formal corrective action for failure to demonstrate improvement" 9. "Developed an internal process where the Clinical Department in the CME will not process reauthorization requests unless providers are demonstrating that they are meeting

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Question	Yes	No	NA	Comments
				the requirements of minimum contacts with the member/caregiver" 10. "Approved a back-up FCC when the primary FCC is unable to make the visits to the family" 11. (*Added for remeasurement 2*): Approved meetings between FCCs and members held via Zoom / virtual platforms as in-person contacts. While not based on published evidence, interventions were developed based on a barrier analysis informed by direct input from CME providers on challenges associated with meeting minimum contact requirements. Each intervention directly addressed at least one barrier.
8.2 Was the strategy designed to address root causes or barriers identified through data analysis and quality improvement processes? • Interventions that might have a short-term effect, but that are unlikely to generate long-term change (such as a one-time reminder letter to enrollees or providers) are insufficient • It is expected that interventions associated with significant improvement will be system interventions (such as educational efforts, policy changes, or targeting of additional resources) • It is expected that interventions should be measurable on an ongoing basis (e.g., quarterly, monthly) to monitor intervention progress	✓	--	--	Magellan conducted a barrier analysis after baseline measurements, which directly led to the development of interventions. Barriers identified based on provider feedback included: 1. "A lack of developed processes to address contact requirements if there is a planned sickness or emergency for the FCC" 2. "Lack of education on the minimum contact requirements" 3. "Providers do not have an awareness of how to resolve engagement issues they may encounter" 4. "Provider agencies do not have standard operating procedures outlining how to achieve minimum contacts with members/caregivers" 5. "Solo/individual providers do not have backup FCCs to provide services during an absence" 6. "Providers report confusion with how to properly fill out the progress note template on the Provider Portal to obtain credit for meeting requirements" 7. "Providers do not have an awareness of their overall rate of achievement of minimum contacts in relation to the Network of providers" Interventions include policy changes with substantial impact (e.g., allowing back-up FCCs, virtual contact, etc.) that will likely produce long-term change within the

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Question	Yes	No	NA	Comments
				CME program. Additionally, the impact of interventions can be evaluated with each performance remeasurement period.
8.3 Was the rapid-cycle PDSA approach used to test the selected improvement strategy? • The steps in the PDSA cycle[3] are to: ○ **Plan.** Plan the test or observation, including a plan for collecting data, and interpreting the results ○ **Do.** Try out the test on a small scale ○ **Study.** Set aside time to analyze the data and assess the results ○ **Act.** Refine the change, based on what was learned from the test. Determine how to sustain the intervention, if successful • If tests of change were not successful (i.e., did not achieve significant improvement), a process to identify possible causes and implement solutions should be identified	✓	--	--	Per virtual discussion, Magellan leverages the rapid-cycle PDSA approach for all quality improvement initiatives, although this is not mentioned in the QIA form.
8.4 Was the strategy culturally and linguistically appropriate?[4]	✓	--	--	Per virtual discussion, Magellan stated that the Minimum Contacts PIP offers universal benefit to all enrollees. The initiative ensures proper implementation of HFWA services, of which cultural competency is a critical component.
8.5 Was the implementation of the strategy designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes (e.g., patient risk factors, Medicaid program changes, provider education, clinic policies or practices)?	✓	--	--	Interventions pursued by Magellan seek to eliminate common challenges and barriers reported by providers in meeting minimum contact requirements. Barrier analysis showed many providers were unaware of minimum contact requirements and the appropriate process for documenting contacts in progress notes, which has a direct impact on the achievement of this PIP. Increasing provider education and outreach will adjust for this factor. Additionally, with the onset of COVID-19 public health emergency and related restrictions, CME providers were not permitted to hold any in-person contact. Interventions to consider Zoom / virtual

[3] Institute for Healthcare Improvement: Science of Improvement, Testing Changes. Available at http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

[4] More information on culturally and linguistically appropriate services may be found at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

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Question	Yes	No	NA	Comments
				contacts as in person contacts enabled providers to continue safely meeting in-person contact requirements.
8.6 Building on the findings from the data analysis and interpretation of PIP results (Step 7), did the PIP assess the extent to which the improvement strategy was successful and identify potential follow-up activities?	✓	--	--	Magellan followed an iterative process for barrier identification and intervention development for this PIP and will continue adjusting interventions for the next period. For example, after remeasurement 2, Magellan identified that barriers #1, #2, and #6 "no longer appeared to be an issue in preventing improvement in the measures", noting the successful impact of intervention. Magellan also identified a new barrier during this period with the onset of COVID-19 and subsequent impacts on in-person meetings, which led to additional interventions permitting virtual meetings as in person contacts.
8.7 Overall assessment: In the comments section, note any recommendations for improving the implementation strategies.				Magellan should describe leveraging the PDSA cycle to select interventions within the QIA form. Additionally, Magellan should describe strategies for assuring cultural and linguistic appropriateness of the topic within documentation.

Worksheet 1.9. Assess the Likelihood that Significant and Sustained Improvement Occurred

Assess the likelihood that significant and sustained improvement occurred by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
9.1 Was the same methodology used for baseline and repeat measurements?	✓	--	--	Magellan used the same methodology for calculating each performance measure across all measurement periods: 1. **Measure #1**: [Number of members contacted by phone at least once a week] / [Number of members enrolled with a full week within measurement period] 2. **Measure #2**: [Number of members/caregivers contacted in person at least twice a month] / [Number of members/caregivers enrolled with a full month within measurement period]

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Question	Yes	No	NA	Comments
9.2 Was there any quantitative evidence of improvement in processes or outcomes of care?	✓	--	--	While Magellan did not meet goals of achieving 100 percent compliance with minimum contact requirements, there was significant quantitative evidence of improvement in contact with members across the measurement period. Across the project, rate of weekly telephone contact increased from 28.42% baseline measurement to 71.63% for the most recent remeasurement (07/01/2019-6/30/2020). Similarly, rate of bi-monthly in person contact increased from 72.71% to 90.53% across the same period. All observed differences were statistically significant. In analysis, Magellan noted that these factors had been trending upward since initiation of the program. Rate of weekly telephone contact also increased across SFY 2016 – 2017 from 9.44% to 15.42%, and rate of bi-monthly in person contact increased from 41.06% to 53.04% across the same period. Data analysis clearly shows evidence of significant improvement across both measures.
9.3 Was the reported improvement in performance likely to be a result of the selected intervention? • It is not necessary to demonstrate conclusively (e.g., through controlled studies) that a change is an effect of the intervention; it is sufficient to show that the change might reasonably be expected to result from the intervention • It is not necessary to undertake data analysis to correct for secular trends (e.g., changes that reflect continuing growth or decline in a measure because of external forces over an extended period). The measured improvement should reasonably be determined to have resulted from the intervention	✓	--	--	Magellan stated in the QIA form that the PIP workgroup "noted the successful impact of interventions." Magellan demonstrated statistically significant improvement across each measurement period, following the implementation of interventions.
9.4 Is there statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention?	✓	--	--	Using Fisher's Exact Test, Magellan found that each difference across the measurement periods (Baseline vs. R1; R1 vs. R2) had a 2-tailed p value less than 0.0001 and were statistically significant. Since barriers and

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Question	Yes	No	NA	Comments
				interventions were adjusted within each measurement period, interventions likely contributed to improvement.
9.5 Was sustained improvement demonstrated through repeated measurements over time?	✓	--	--	Magellan showed statistically significant improvement in each performance measure across all measurement periods in the QIA form.
9.6 Overall assessment: In the comments section, note any recommendations for improving the significance and sustainability of improvement as a result of the PIP.				N/A

Worksheet 1.10. Perform Overall Validation of PIP Results

Provide an overall validation rating of the PIP results. The "validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced evidence of significant improvement. Insert comments to explain the rating.

PIP Validation Rating (check one box)	Comments
☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence	As detailed above, Magellan adhered to relevant PIP methodology and process and produced evidence of statistically significant improvement.

Worksheet 1.11. Framework for Summarizing Information about Performance Improvement Projects (PIPs)

1. General PIP Information

Managed Care Plan (MCP) Name: Wyoming Department of Health Care Management Entity (CME) Program
PIP Title: Improving Minimum Contact Engagement for Family Care Coordinators
PIP Aim Statement: Improve the frequency in which providers are in compliance with minimum contact requirements; meet goal of 100 percent compliance with minimum contact requirement.
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) ☐ State-mandated (state required plans to conduct a PIP on this specific topic) ☐ Collaborative (plans worked together during the planning or implementation phases) ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) ☒ Plan choice (state allowed the plan to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here: Children aged 4-20 years old

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Target population description, such as duals, LTSS or pregnant women (please specify):
Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)

N/A

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

1. "Development of Minimum Contact Drilldown Report (OP10 Report) at the provider level for analysis and review with providers"
2. "Implementation of weekly Clinical Department review of OP10 Report to determine how to assist specific providers with meeting minimum contact requirements"
3. "Provided provider communications concerning:
    a. The importance of selecting checkboxes on progress notes within the Provider Portal to ensure they are obtaining credit for their contacts with members/guardians
    b. Process changes and the importance of meeting minimum contact requirements"
4. "Development and utilization of the Provider Scorecard and review of the OP10 drilldown report with Network and provider 1:1s (claims-based report was utilized for provider education prior to the development of the OP10 drilldown report in 12/2018)"
5. "Development and roll-out of a training to provide education concerning minimum contact requirements and how to properly complete a progress note (sent out to Program Directors and Coaches and reviewed during the External QIC held 6/20/19)"
6. "Review overall network status on minimum contacts and reiterate minimum contact requirements during the Monthly Provider Calls"
7. "Magellan of Wyoming High Fidelity Wraparound Provider Requirements & Timelines posted to provider website as a reference for understanding minimum contact requirement timelines (page 3)"
8. "Development and implementation of a Provider Education Desktop Procedure to identify providers consistently failing to meet minimum requirements and follow through the education process to the potential for escalation to a formal corrective action for failure to demonstrate improvement"

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

1. "Developed an internal process where the Clinical Department in the CME will not process reauthorization requests unless providers are demonstrating that they are meeting the requirements of minimum contacts with the member/caregiver"
2. "Approved a back-up FCC when the primary FCC is unable to make the visits to the family"
3. (*Added for remeasurement 2*): Approved meetings between FCCs and members held via Zoom / virtual platforms as in-person contacts

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3. Performance Measures and Results (Add rows as necessary)

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Rate of members/ caregivers contacted by telephone at least once a week	07/01/2017-06/30/2018	n= 3,047; rate of 28.42%	☐ Not applicable—PIP is in planning or implementation phase, results not available	n= 2.404; rate of 71.63%.	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Rate of members/ caregivers contacted in person at least twice a month	7/1/2017-6/30/2018	n= 2,624; rate of 72.71%	☐ Not applicable—PIP is in planning or implementation phase, results not available	n= 2,029; rate of 90.53%.	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year
☐ First remeasurement ☒ Second remeasurement ☐ Other (specify):

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP:

Magellan should:

- Solicit input directly from enrolled youth and families to inform the selection of the PIP topic.
- Confirm the aim statement for the Minimum Contacts PIP. The aim statement should be a concise, answerable question that defines the improvement strategy, study population, and time period of the topic.
- Clearly define the identified PIP population within the QIA form.

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- Formalize data collection and analysis processes in a written data analysis plan.
- Deploy strategies to assure reliability and validity of findings and describe these in the QIA form.
- Directly reference the PDSA cycle within the QIA form and describe the process of developing improvement strategies using the cycle.

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ENGAGEMENT AND IMPLEMENTATION

Worksheet 1.1. Review the Selected PIP Topic

PIP Topic: Engagement and Implementation Improvement

Assess the appropriateness of the selected PIP topic by answering the following questions about the MCP and PIP. Insert comments to explain "No" and "Not applicable (NA)" responses.

Question	Yes	No	NA	Comments
1.1 Was the PIP topic selected through a comprehensive analysis of MCP enrollee needs, care, and services (e.g., consistent with demographic characteristics and health risks, prevalence of conditions, or the need for a specific service by enrollees)? (If the PIP topic was required by the state, please check "not applicable" and note in comments.)	✓	--	--	Magellan selected the PIP topic after a comprehensive analysis was conducted, including all stakeholders in the CME program. As described in the rationale, the Wyoming SFY 2017 Q4 report identified several opportunities for provider improvement in areas of face-to-face contacts, SNCD completion timeliness, POC development timeliness, and CANS severity. Additionally, the implementation rate (defined as >180 days of wraparound for state reporting) was at 65 percent during SFY 2017. The PIP topic began with meetings led by local network lead and a national Director of Quality to identify key performance indicators based on a balanced scorecard model, adapted from Harvard Business Review. Additionally, Magellan solicited feedback from members / caregivers and providers on service deficiencies and areas of improvement. Members identified relative weakness in the wraparound principles of "Outcomes Based" and "Strength and Family Driven." Magellan also gathered information from WY CME Cross Functional Leadership to inform selection of this PIP topic. According to the QIA form, each cross functional lead contributed subject matter expertise in their functional areas (network/ provider relations, coaching/ training, family support, care management, quality, reporting, analytics, communications, and administration).
1.2 Did selection of the PIP topic consider performance on the CMS Child and Adult Core Set measures?	--	--	✓	N/A - The CMS Child and Adult Core Set measures focus on clinical measures and do not apply to this PIP topic.
1.3 Did the selection of the PIP topic consider input from enrollees or	✓	--	--	Magellan conducted significant stakeholder engagement with CME

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Question	Yes	No	NA	Comments
providers who are users of, or concerned with, specific service areas? (If the PIP topic was required by the state, please check "not applicable" and note in comments.) • To the extent feasible, input from enrollees who are users of, or concerned with, specific services areas should be obtained.				members, caregivers, and providers to develop this PIP topic. As described in the rationale, Magellan obtained enrollee and caregiver feedback from the Survey for Basic Foundations of Wraparound and Satisfaction. Provider feedback was solicited at the February 28, 2018 Provider Retreat.
1.4 Did the PIP topic address care of special populations or high priority services, such as: • Children with special health care needs • Adults with physical disabilities • Children or adults with behavioral health issues • People with intellectual and developmental disabilities • People with dual eligibility who use long-term services and supports (LTSS) • Preventive care • Acute and chronic care • High-volume or high-risk services • Care received from specialized centers (e.g., burn, transplant, cardiac surgery) • Continuity or coordination of care from multiple providers and over multiple episodes • Appeals and grievances • Access to and availability of care	✓	--	--	The PIP topic directly pertained to services for the entire CME program, which serves children aged 4-20 years old who have serious and persistent mental illness (SPMI) / severe emotional disturbance (SED) / and meet Psychiatric Residential Treatment Facility (PRTF) level of care. Provider scorecards are intended to assess the quality of services offered to members, the performance of the CME program, and to identify areas for continued improvement. Additionally, engagement of youth and full implementation of care plans are critical for enabling members to receive full benefit from the program.
1.5 Did the PIP topic align with priority areas identified by HHS and/or CMS?	✓	--	--	The PIP topic directly aligned with numerous priority areas and goals identified by HHS, CMS, and the CME program. The topic seeks to increase transparency related to provider and program performance, and place additional focus on engagement and implementation within the program. This aligns with numerous priorities, including HHS National Quality Strategy aims (*Better Care - Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe*), CMS Quality Strategy

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Question	Yes	No	NA	Comments
				priorities (*Promote Effective Communication and Coordination of Care*), and additional CME program goals.
1.6 Overall assessment: In the comments section, note any recommendations for improving the PIP topic.				N/A

Worksheet 1.2. Review the PIP Aim Statement

PIP Aim Statement:

- "Does the change in authorization process improve the percent of youth and families reaching engagement threshold (>60 days)?"
- "Does the change in authorization process improve the percent of youth and families reaching implementation threshold (>180 days)?"

Assess the appropriateness of the selected PIP topic by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
2.1 Did the PIP aim statement clearly specify the improvement strategy, population, and time period for the PIP?	--	✓	--	While the PIP aim statements specified the improvement strategy (change in authorization process) and population (CME youth and families), the statements did not specify the time period for measurement (baseline May 2018 – August 2018; remeasurement 1 SFY 2019; remeasurement 2 SFY 2020).
2.2 Did the PIP aim statement clearly specify the population for the PIP?	--	✓	--	While the aim statements identified comparison groups for the PIP (youth and families reaching engagement and implementation thresholds), the aim statement did not specify the overall study population. The population was confirmed in discussion with Magellan and included Wyoming youth discharged from HFWA within each month collected on a rolling basis.
2.3 Did the PIP aim statement clearly specify the time period for the PIP?	--	✓	--	The PIP aim statements did not specify the time period for the PIP. Baseline measurements for the PIP occurred from May – August 2018, which are compared to data from the remeasurement periods of SFY 2019 (July 2018 – June 2019) and SFY 2020 (July 2019 – June 2020).

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Question	Yes	No	NA	Comments
				These items are not specified in either PIP aim statement.
2.4 Was the PIP aim statement concise?	✓	--	--	The PIP aim statements each consisted of a single question, aligned directly with performance measures.
2.5 Was the PIP aim statement answerable?	✓	--	--	The PIP aim statements were both closed-ended questions relating directly to the impact of improvement strategies on performance measures. Both aim statements were answerable with "yes" or "no" responses.
2.6 Was the PIP aim statement measurable?	✓	--	--	The PIP aim statements directly related to measuring improvement in the percentage of youth and families reaching engagement and implementation thresholds.
2.7 Overall assessment: In the comments section, note any recommendations for improving the PIP aim statement.				Magellan should include measurement timeframes, including baseline measurements and remeasurements, within aim statements for the PIP. Additionally, Magellan should specify the study population for the PIP within the aim statement.

Worksheet 1.3. Review the Identified PIP Population

PIP Population: Wyoming youth discharged from HFWA services within the review period.

Assess whether the study population was clearly identified by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
3.1 Was the project population clearly defined in terms of the identified study question (e.g., age, length of the study population's enrollment, diagnoses, procedures, other characteristics)? • The required length of time will vary depending on the PIP topic and performance measures	--	✓	--	Per virtual discussion with Magellan, the population for this PIP includes Wyoming youth discharged from HFWA services within each month, collected on a rolling basis.
3.2 Was the entire MCP population included in the PIP?	--	✓	--	The PIP focuses on youth discharged from HFWA services within each month, which may not include the entire CME population.
3.3 If the entire population was included in the PIP, did the data collection	✓	--	--	The data collection method used an administrative data system, in which

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Question	Yes	No	NA	Comments
approach capture all enrollees to whom the PIP question applied? • If data can be collected and analyzed through an administrative data system, it may be possible to study the whole population. For more guidance on administrative data collection, see Worksheet 1.6.				Magellan conducted a programmed pull of all claims / encounter data.
3.4 Was a sample used? (If yes, use Worksheet 1.4 to review sampling methods). • If the data will be collected manually (such as through medical record review), sampling may be necessary	--	--	✓	N/A - No sampling was used for this PIP.
3.5 Overall assessment: In the comments section, note any recommendations for identifying the project population.				Magellan should clearly define the identified PIP population within the Project Rationale section of the QIA form. The population should be defined in documentation by age, length of enrollment, diagnoses, procedures, and other characteristics as applicable. Magellan should also specify if the PIP applies to the entire CME population within the rationale.

Worksheet 1.4. Review the Sampling Method

Overview of Sampling Method: No sampling was used for this PIP.

If HEDIS® sampling is used, check here, and skip the rest of this worksheet. ☐

Assess whether the sampling method was appropriate by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses. Refer to Appendix B for an overview of sampling approaches for EQR data collection activities.

Question	Yes	No	NA	Comments
4.1 Did the sampling frame contain a complete, recent, and accurate list of the target PIP population? • A sampling frame is the list from which the sample is drawn. It includes the universe of members of the target PIP population, such as individuals, caregivers, households, encounters, providers, or other population units that are eligible to be included in the PIP. The completeness, recency, and accuracy of the sampling frame are	--	--	✓	N/A - No sampling was used for this PIP.

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Question	Yes	No	NA	Comments
key to the representativeness of the sample				
4.2 Did the sampling method consider and specify the true or estimated frequency of the event, the confidence interval to be used, and the acceptable margin of error?	--	--	✓	N/A - No sampling was used for this PIP.
4.3 Did the sample contain a sufficient number of enrollees taking into account non-response?	--	--	✓	N/A - No sampling was used for this PIP.
4.4 Did the method assess the representativeness of the sample according to subgroups, such as those defined by age, geographic location, or health status?	--	--	✓	N/A - No sampling was used for this PIP.
4.5 Were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field.	--	--	✓	N/A - No sampling was used for this PIP.
4.6 Overall assessment: In the comments section, note any recommendations for improving the sampling method.				N/A

Worksheet 1.5. Review the Selected PIP Variables and Performance Measures

Selected PIP Variables and Performance Measures:

3. **Quantifiable Measure #1**: Engagement: percent of youth and families not reaching engagement threshold (>60 days)

4. **Quantifiable Measure #2**: Implementation: percent of youth and families reaching implementation threshold (>180 days)

Assess whether the selected PIP variables were appropriate for measuring performance and tracking improvement by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Recall that CMS encourages MCPs to choose variables for PIPs that reflect health outcomes. Performance measures are then used to measure these health outcomes. When selecting variables, the MCP should consider existing performance measures.

Question	Yes	No	NA	Comments
PIP variables				
5.1 Were the variables adequate to answer the PIP question? • Did the PIP use objective, clearly defined, time-specific variables (e.g.,	✓	--	--	While Magellan did not specify each variable within Section 1B of the QIA form, the Executive Summary and Appendices for Q4 SFY 2020 described

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Question	Yes	No	NA	Comments
an event or status that can be measured)? • Were the variables available to measure performance and track improvement over time? (CMS encourages states to select variables that can be examined on at least a semi-annual basis				the following continuous variables for each performance measure [pg. 170]: 3. **Measure #1**: [Count of youth <60 days of HFWA ("not engaged")] / [Count of discharged youth HFWA] 4. **Measure #2**: [Count of youth >180 days of HFWA ("implemented")] / [Count of discharged youth HFWA] Both measures use objective and time-specific variables, with Magellan providing quantitative definitions of "engagement" and "implementation". Additionally, Magellan noted that measures are "rolling 12 month measures", recalculated and assessed quarterly.
Performance measures				
5.2 Did the performance measure assess an important aspect of care that will make a difference to enrollees' health or functional status?	✓	--	--	While not specified in the QIA form, Magellan explained in the Q4 SFY 2020 Report that "the percentage of youth not engaging is an important alert measure for HFWA [pg. 170]." As the beginning phase of HFWA, engagement enables youth to receive full benefit from the CME program to improve their health and/or functional status. Additionally, full implementation of program benefits and care plans is critical for youth to improve their health and/or functional status to the greatest degree possible.
5.3 Were the performance measures appropriate based on the availability of data and resources to collect the data (administrative data, medical records, or other sources)?	✓	--	--	Magellan analyzed administrative data (programmed pull from claims / encounter files of all eligible members). This data source, the FCC ALOS report, is appropriate for calculating days of HFWA services received by members.
5.4 Were the measures based on current clinical knowledge or health services research? • Examples may include: ○ Recommended procedures ○ Appropriate utilization (hospital admissions, emergency department visits) ○ Adverse incidents (such as death, avoidable readmission) ○ Referral patterns ○ Authorization requests ○ Appropriate medication use	✓	--	--	Magellan explained that lack of member engagement is an "alert" for HFWA. Promoting engagement and full implementation of CME program benefits can be considered recommended procedures.

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Question	Yes	No	NA	Comments
5.5 Did the performance measures: • Monitor the performance of MCPs at a point in time? • Track MCP performance over time? • Compare performance among MCPs over time? • Inform the selection and evaluation of quality improvement activities?	✓	--	--	Both performance measures monitored performance at a point in time and over time. Magellan recalculates each measure quarterly, rolling over a 12 month period. Additionally, both measures were evaluated first within the baseline period (May – August 2018), and compared with remeasurements (July 2018 – June 2019; July 2019 – June 2020). The performance measures do not compare performance among MCPs.
5.6 Did the MCP consider existing measures, such as CMS Child and Adult Core Set, Core Quality Measure Collaborative, certified community behavioral health clinics (CCBHC) measures, HEDIS®, or AHRQ measures?	--	✓	--	Magellan did not consider or utilize existing measures for this PIP.
5.7 If there were gaps in existing measures, did the MCP consider the following when developing new measures based on current clinical practice guidelines or health services research? • Did the measure address accepted clinical guidelines relevant to the PIP question? • Did the measure address an important aspect of care or operations that was meaningful to MCP enrollees? • Did available data sources allow the MCP to reliably and accurately calculate the measure? • Were all criteria used in the measure defined clearly (such as time periods, characteristics of eligible enrollees, services to be assessed, and exclusion criteria)?	--	--	✓	Magellan did not utilize existing measures for this PIP.
5.8 Did the measures capture changes in enrollee satisfaction or experience of care? • Although enrollee satisfaction/experience is an important outcome of care in clinical areas, improvement in satisfaction should not be the only measured outcome of a clinical project. Some improvement in health or functional status should also be addressed	--	✓	--	The performance measures for this PIP captured the rate at which youth and families met HFWA engagement and implementation thresholds. Measures did not directly address enrollee satisfaction or experiences of care.

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Question	Yes	No	NA	Comments
• For projects in nonclinical areas (such as addressing access or availability of services), measurement of health or functional status is preferred				
5.9 Did the measures include a strategy to ensure inter-rater reliability (if applicable)?	--	--	✓	N/A - Magellan used an administrative data collection methodology for this PIP, which does not include medical record abstraction.
5.9 If process measures were used, is there strong clinical evidence indicating that the process being measured is meaningfully associated with outcomes? • This determination should be based on published guidelines, including citations from randomized clinical trials, case control studies, or cohort studies • At a minimum, the PIP should be able to demonstrate a consensus among relevant practitioners with expertise in the defined area who attest to the importance of a given process	--	--	✓	N/A - Magellan did not use process measures for this PIP.
5.10 Overall assessment: In the comments section, note any recommendations for improving the selected PIP variables and performance measures.				Magellan should outline numerators and denominators used for each performance measure in Section 1B of the QIA form. Data and results can be included within Section 2 (Data/Results Table).

Worksheet 1.6. Review the Data Collection Procedures

Assess whether the data collection procedures were valid and reliable by answering the following questions. This worksheet includes three sections: (1) overall data collection procedures, (2) data collection procedures for administrative data sources, and (3) data collection procedures for medical record review. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Section 1: Assessment of Overall Data Collection Procedures

Question	Yes	No	NA	Comments
6.1 Did the PIP design specify a systematic method for collecting valid and reliable data that represents the population in the PIP?	✓	--	--	Magellan specified they utilize a programmed pull from all claims / encounter files of all eligible members to collect data for this PIP. Magellan provided the FCC ALOS Engagement report after on-site discussion. Data from claims systems is organized by discharge reason and presents quarterly totals of data.
6.2 Did the PIP design specify the frequency of data collection? If yes, what	✓	--	--	Magellan specified they collect data "once a year." However, Magellan also

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Question	Yes	No	NA	Comments
was the frequency (for example, semi-annually)?				noted that the measure encompasses "the most recent past 12 months", and measures are recalculated quarterly [pg. 170, Q4 SFY 2020 Report].
6.3 Did the PIP design clearly specify the data sources? • Data sources may include: ○ Encounter and claims systems ○ Medical records ○ Case management or electronic visit verification systems ○ Tracking logs ○ Surveys ○ Provider and/or enrollee interviews	✓	--	--	Magellan sourced data for this PIP from encounter and claims data systems. Claims data is analyzed within the FCC ALOS engagement report for this PIP.
6.4 Did the PIP design clearly define the data elements to be collected? • Accurate measurement depends on clear and concise definitions of data elements (including numerical definitions and units of measure)	✓	--	--	While not included within the QIA form, Magellan specified individual variables the Q4 SFY 2020 report, which appear to serve as data elements. For Measure #1, data elements included: • Count of youth <60 days of HFWA ("not engaged") • Count of discharged youth HFWA For Measure #2, data elements included: • Count of youth >180 days of HFWA ("implemented") • Count of discharged youth HFWA
6.5 Did the data collection plan link to the data analysis plan to ensure that appropriate data would be available for the PIP?	✓	--	--	Magellan outlined the data analysis plan within the QIA form. The quantitative analysis plan included: • Comparison with the goal/benchmark • Reasons for changes to goals • If benchmarks changed since baseline, list source and date of changes • Comparison with previous measurements • Trends, increases, or decreases in performance or changes in statistical significance • Impact of any methodological changes that could impact the results Additionally, Magellan utilized qualitative analysis to identify barriers and causes for less than desired performance. While not directly "linked" to the data collection plan, full completion of the data

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Question	Yes	No	NA	Comments
				analysis plan shows that Magellan had sufficient data for the PIP.
6.6 Did the data collection instruments allow for consistent and accurate data collection over the time periods studied?	✓	--	--	Administrative data for this PIP appears to be collected consistently over the time period. Magellan noted in the Q4 SFY 2020 report that the measure is a "rolling 12 month measure", encompassing the most recent past 12 months [pg. 170].
6.7 If qualitative data collection methods were used (such as interviews or focus groups), were the methods well-defined and designed to collect meaningful and useful information from respondents?	--	--	✓	N/A - Qualitative data collection methods were not used for this PIP. Data for this PIP was collected through a programmed pull of claims / encounter data.
6.8 Overall assessment: In the comments section, note any recommendations for improving the data collection procedures. **Note:** Include assessment of data collection procedures for administrative data sources and medical record review noted below.				N/A

Section 2: Assessment of Data Collection Procedures for Administrative Data Sources

Question	Yes	No	NA	Comments
6.9 If inpatient data was used, did the data system capture all inpatient admissions/discharges?	--	--	✓	N/A – Ancillary care data was used for this PIP.
6.10 If primary care data was used, did primary care providers submit encounter or utilization data for all encounters?	--	--	✓	N/A – Ancillary care data was used for this PIP.
6.11 If specialty care data was used, did specialty care providers submit encounter or utilization data for all encounters?	--	--	✓	N/A – Ancillary care data was used for this PIP.
6.12 If ancillary data was used, did ancillary service providers submit encounter or utilization data for all services provided?	✓	--	--	Per virtual discussion, Magellan stated that data for this PIP originates in Magellan's authorization system, which includes all discharges within the review period.
6.13 If LTSS data was used, were all relevant LTSS provider services included (for example, through encounter data, case management systems, or electronic visit verification (EVV) systems)?	--	--	✓	N/A – Ancillary care data was used for this PIP.
6.14 If EHR data was used, were patient, clinical, service, or quality metrics	--	--	✓	N/A – Ancillary care data was used for this PIP.

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Question	Yes	No	NA	Comments
validated for accuracy and completeness as well as comparability across systems?				

Section 3: Assessment of Data Collection Procedures for Medical Record Review

Question	Yes	No	NA	Comments
6.15 Was a list of data collection personnel and their relevant qualifications provided? • Data collection personnel require the conceptual and organizational skills to abstract data. These skills will vary depending on the nature of the data and the degree of professional judgment required. For example, trained medical assistants or medical records clerks may collect data if the abstraction involves verifying the presence of a diagnostic test report. However, experienced clinical staff (such as registered nurses) should be used to extract data to support a judgment about whether clinical criteria are met	--	--	✓	N/A - Medical record review does not apply to this PIP.
6.16 For medical record review, was inter-rater and intra-rater reliability described? • The PIP should also consider and address intra-rater reliability (i.e., reproducibility of judgments by the same abstractor at a different time)	--	--	✓	N/A - Medical record review does not apply to this PIP.
6.17 For medical record review, were guidelines for obtaining and recording the data developed? • A glossary of terms for each project should be developed before data collection begins to ensure consistent interpretation among and between data collection staff • Data collection staff should have clear, written instructions, including an overview of the PIP, how to complete each section of the form or instrument, and general guidance on how to handle situations not covered by the instructions. This is particularly important when multiple reviewers are collecting data	--	--	✓	N/A - Medical record review does not apply to this PIP.

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Worksheet 1.7. Review Data Analysis and Interpretation of PIP Results

Assess whether the data analysis and interpretation was appropriate by answering the following questions. Insert comments to explain "No" and "Not Applicable" responses.

Question	Yes	No	NA	Comments
7.1 Was the analysis conducted in accordance with the data analysis plan?	✓	--	--	Magellan outlined the data analysis plan within the QIA form. The quantitative analysis plan included: • Comparison with the goal/benchmark • Reasons for changes to goals • If benchmarks changed since baseline, list source and date of changes • Comparison with previous measurements • Trends, increases, or decreases in performance or changes in statistical significance • Impact of any methodological changes that could impact the results Additionally, Magellan utilized qualitative analysis to identify barriers and causes for less than desired performance. Magellan provided each item within the data analysis plan in Section 3B.1-2 of the QIA form.
7.2 Did the analysis include baseline and repeat measurements of project outcomes?	✓	--	--	Magellan compared data for the performance measures across a baseline period (May 2018 – August 2018), as well as two remeasurement periods (7/1/2018-6/30/2019; 7/1/2019-6/30/2020). Magellan reported the following rates for each period: **Measure #1** Engagement: Percent of youth and families not reaching engagement threshold (>60 days) • Baseline: 16% • Remeasurement 1: 16% • Remeasurement 2: 15% **Measure #2** Implementation: Percent of youth and families reaching implementation threshold (>180 days) • Baseline: 59% • Remeasurement 1: 62% • Remeasurement 2: 61% Both measures failed to meet comparison goals. Magellan aimed to decrease Measure #1 to 10 percent (90

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Question	Yes	No	NA	Comments
				percent engagement) and increase Measure #2 to 80 percent.
7.3 Did the analysis assess the statistical significance of any differences between the initial and repeat measurements?	✓	--	--	Magellan tested for statistical significance using Fisher's Exact Test for each measurement, including Baseline vs. R1 and R1 vs. R2.
7.4 Did the analysis account for factors that may influence the comparability of initial and repeat measurements?	✓	--	--	Magellan outlined external factors that may have influenced the comparability of initial and repeat measurements in the data analysis plan. For example: "The Financing model went from Monthly Per Diem in SFY 2017 to FFS in SFY 2018….The network experienced many disruptions of providers terminating with network beginning with the announcement of changes, into the first quarter, and throughout the year….Families and youth transitioned out at higher rates based on changes in network providers." Additionally, Magellan adjusted the baseline for implementation once improvement was identified within Measure #2 after Remeasurement 1. Magellan made this change to progress "towards a standard of excellence."
7.5 Did the analysis account for factors that may threaten the internal or external validity of the findings?	✓	--	--	Data analysis addressed factors that may have threatened internal / external validity of results, including the transformation of the financing model from monthly per diem to fee-for-service in SFY 2018.
7.6 Did the PIP compare the results across multiple entities, such as different patient subgroups, provider sites, or MCPs? • Comparing the performance across multiple entities involves greater statistical design and analytical considerations than those required for a project assessing performance of a single entity, such as an MCP, over time	--	--	✓	N/A - The analysis did not include comparison across different patient groups or MCPs.
7.7 Were PIP results and findings presented in a concise and easily understood manner?	✓	--	--	In addition to presenting a Data/ Results table in Section 2 of the QIA form with performance measure goals, calculations, and significance tests, Magellan offered an analysis of results within the data analysis section. Magellan outlined external factors that

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Question	Yes	No	NA	Comments
				impacted results and outlined barriers / opportunities for future improvement.
7.8 To foster continuous quality improvement, did the analysis and interpretation of the PIP data include lessons learned about less-than-optimal performance? • Analysis and interpretation of the PIP data should be based on a continuous improvement philosophy and reflect on lessons learned and opportunities for improvement	✓	--	--	The data analysis plan offered by Magellan discussed barriers and opportunities identified through the analysis, as well as impact of interventions. Data analysis also included identification of "causes for less than desired performance" throughout the measurement period. This discussion led directly to the interventions table in Section 4 (see Worksheet 1.8 for analysis).
7.9 Overall assessment: In the comments section, note any recommendations for improving the analysis and interpretation of PIP results				N/A

Worksheet 1.8. Assess the Improvement Strategies

Assess whether the selected improvement strategies were appropriate for achieving improvement by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
8.1 Was the selected improvement strategy evidence-based, that is, was there existing evidence (published or unpublished) suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes (as measured by the PIP variables)?	✓	--	--	Magellan implemented numerous improvement strategies / interventions throughout the course of this PIP. Per Section 5 of the QIA form (Interventions Table), interventions included: 1. "Technical assistance given on the new authorization process related to move to FFS and providers leaving or considering leaving the network, causing disruption in youth engagement and implementation." 2. "Transition of Care process moved away from providers and to Magellan CME for connection to new providers." 3. "Engagement and Implementation measures added to Provider Scorecard." 4. "Scorecard review in all-providers meeting quarterly with talking points for staff, reference to manual, direction to talk with network in monthly 1:1s, and reminder that past and current materials on website."

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Question	Yes	No	NA	Comments
				5. "Provider newsletter included quarterly results." 6. "Talking points on measures quarterly" 7. "Posting on Provider Website in Scorecard." 8. "1:1 Provider review of scorecard scores with network monthly." 9. "Letter of education available if needed for high disengagement or low implementation." 10. "Scorecard quarter over quarter trending with QIC and EQIC quarterly." While not based on published evidence, interventions were developed based on a barrier analysis and discussions of "less than desired" performance within data analysis section. Each intervention directly addressed one barrier.
8.2 Was the strategy designed to address root causes or barriers identified through data analysis and quality improvement processes? • Interventions that might have a short-term effect, but that are unlikely to generate long-term change (such as a one-time reminder letter to enrollees or providers) are insufficient • It is expected that interventions associated with significant improvement will be system interventions (such as educational efforts, policy changes, or targeting of additional resources) • It is expected that interventions should be measurable on an ongoing basis (e.g., quarterly, monthly) to monitor intervention progress	✓	--	--	Magellan conducted a barrier analysis for each performance measure. Barriers led directly to the development of improvement strategies / interventions. Barriers included: 1. "Education on provider authorization and payment processes to stabilize the network and alignment of operationalizing engagement with wraparound process at 60 days." 2. "Providers leaving the network were not transitioning youth to other providers." 3. "Provider awareness of own performance compared to the WY CME and other providers." 4. "Provider education on measure and feedback from providers on barriers and solutions for measures." 5. "Provider awareness of measures" 6. "Provider direction talking with own staff." 7. "Transparency on measures for all stakeholders." 8. "1:1 assistance to providers on understanding and responding to measures." 9. "No provider has had a letter of education directly for high disengagement or low

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Question	Yes	No	NA	Comments
				implementation. Providers identified in the documentation measure at <95 percent for at least two months in a row have included providers with low engagement and implementation." 10. "Quality Improvement Committee accountability and feedback" Barriers address systemic issues (e.g., providers not transitioning youth to other providers; lack of provider education; lack of transparency), allowing interventions to have long-term impacts on the CME program.
8.3 Was the rapid-cycle PDSA approach used to test the selected improvement strategy? • The steps in the PDSA cycle[5] are to: ○ **Plan.** Plan the test or observation, including a plan for collecting data, and interpreting the results ○ **Do.** Try out the test on a small scale ○ **Study.** Set aside time to analyze the data and assess the results ○ **Act.** Refine the change, based on what was learned from the test. Determine how to sustain the intervention, if successful • If tests of change were not successful (i.e., did not achieve significant improvement), a process to identify possible causes and implement solutions should be identified	✓	--	--	Per virtual discussion, Magellan leverages the rapid-cycle PDSA approach for all quality improvement initiatives, although this is not specified in quality improvement documentation.
8.4 Was the strategy culturally and linguistically appropriate?[6]	✓	--	--	Per virtual discussion, this PIP seeks to engage additional youth in the CME program and promote full implementation of program benefits. Cultural competence is a key component of HFWA services.
8.5 Was the implementation of the strategy designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes (e.g., patient risk factors, Medicaid program changes, provider education, clinic policies or practices)?	✓	--	--	Interventions addressed systemic barriers to quality improvement that can impact PIP outcomes of engagement and implementation, including lack of provider education on provider authorization and payment processes, lack of provider awareness of own performance, and lack of transparency for all stakeholders.

[5] Institute for Healthcare Improvement: Science of Improvement, Testing Changes. Available at http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

[6] More information on culturally and linguistically appropriate services may be found at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

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Question	Yes	No	NA	Comments
				Additionally, interventions included the development of new policies and procedures for the CME program (e.g., transition of care process).
8.6 Building on the findings from the data analysis and interpretation of PIP results (Step 7), did the PIP assess the extent to which the improvement strategy was successful and identify potential follow-up activities?	✓	--	--	Within data analysis, Magellan included a section for assessing the impact of interventions. For both measures, Magellan found that offering technical assistance to providers, improving the transition of care process, and using network 1:1 conversations and letters of education for providers improved performance across measurement periods.
8.7 Overall assessment: In the comments section, note any recommendations for improving the implementation strategies.				Magellan should describe leveraging the PDSA cycle to select interventions within the QIA form. Additionally, Magellan should describe strategies for assuring cultural and linguistic appropriateness of the topic within documentation.

Worksheet 1.9. Assess the Likelihood that Significant and Sustained Improvement Occurred

Assess the likelihood that significant and sustained improvement occurred by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
9.1 Was the same methodology used for baseline and repeat measurements?	✓	--	--	Magellan used the same methodology for calculating each performance measure across all measurement periods: 1. **Measure #1**: [Count of youth <60 days of HFWA ("not engaged")] / [Count of discharged youth HFWA] 2. **Measure #2**: [Count of youth >180 days of HFWA ("implemented")] / [Count of discharged youth HFWA]
9.2 Was there any quantitative evidence of improvement in processes or outcomes of care?	✓	--	--	While not meeting performance goals, both performance measures showed evidence of improvement across the measurement periods. For Measure #1, after remaining at 16 percent for Remeasurement 1 (SFY 2019), the percent of youth and families not reaching engagement threshold decreased to 15 percent in SFY 2020. This improvement from the baseline was seen across all four quarters in 2020.

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Question	Yes	No	NA	Comments
				Magellan noted improvement from the baseline to Remeasurement 1 for measure #2, with the percent of youth and families reaching implementation threshold increasing from 59 percent to 62 percent. However, improvement leveled off across the period, with the performance measure decreasing to 61 percent for Remeasurement 2.
9.3 Was the reported improvement in performance likely to be a result of the selected intervention? • It is not necessary to demonstrate conclusively (e.g., through controlled studies) that a change is an effect of the intervention; it is sufficient to show that the change might reasonably be expected to result from the intervention • It is not necessary to undertake data analysis to correct for secular trends (e.g., changes that reflect continuing growth or decline in a measure because of external forces over an extended period). The measured improvement should reasonably be determined to have resulted from the intervention	✓	--	--	In data analysis, Magellan noted that improvement observed across the period appeared to be part of a response to interventions. Magellan also outlined the specific interventions that impacted performance within each measure and timeframe (e.g., for measure #1 in SFY 2020, "the use of Network 1:1 conversation and letters of education focused on other quality issues" led to improvement).
9.4 Is there statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention?	--	✓	--	Since all 2-tailed p values were determined to be greater than .05, there was no statistical evidence that observed improvement is statistically significant / result of the intervention.
9.5 Was sustained improvement demonstrated through repeated measurements over time?	--	✓	--	While generally improving from baseline measurements, Magellan did not report sustained improvement across all measurement periods for either performance measure, nor were improvements statistically significant.
9.6 Overall assessment: In the comments section, note any recommendations for improving the significance and sustainability of improvement as a result of the PIP.				N/A

Worksheet 1.10. Perform Overall Validation of PIP Results

Provide an overall validation rating of the PIP results. The "validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection,

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conducted accurate data analysis and interpretation of PIP results, and produced evidence of significant improvement. Insert comments to explain the rating.

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	As detailed above, Magellan adhered to acceptable methodology throughout the Engagement and Implementation PIP. However, improvement was not shown to be statistically significant.

Worksheet 1.11. Framework for Summarizing Information about Performance Improvement Projects (PIPs)

1. General PIP Information

Managed Care Plan (MCP) Name: Wyoming Department of Health Care Management Entity (CME) Program

PIP Title: Engagement and Implementation Improvement

PIP Aim Statement:

- "Does the change in authorization process improve the percent of youth and families reaching engagement threshold (>60 days)?"
- "Does the change in authorization process improve the percent of youth and families reaching implementation threshold (>180 days)?"

Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply)

☐ State-mandated (state required plans to conduct a PIP on this specific topic)
☐ Collaborative (plans worked together during the planning or implementation phases)
☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state)
☒ Plan choice (state allowed the plan to identify the PIP topic)

Target age group (check one):

☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children

*If PIP uses different age threshold for children, specify age range here: Children aged 4-20 years old

Target population description, such as duals, LTSS or pregnant women (please specify):

Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)

N/A

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

1. "Technical assistance given on the new authorization process related to move to FFS and providers leaving or considering leaving the network, causing disruption in youth engagement and implementation."
2. "Engagement and Implementation measures added to Provider Scorecard"

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

3. "Scorecard review in all-providers meeting quarterly with talking points for staff, reference to manual, direction to talk with network in monthly 1:1s, and reminder that past and current materials on website." 4. "Provider newsletter included quarterly results" 5. "Talking points on these measures quarterly" 6. "Posting on Provider Website in Scorecard." 7. "1:1 Provider review of scorecard scores with network monthly." 8. "Letter of education available if needed for high disengagement or low implementation."
MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools) 1. "Transition of Care process moved away from providers and to Magellan CME for connection to new providers." 2. "Scorecard quarter over quarter trending with QIC and EQIC quarterly."

3. Performance Measures and Results (Add rows as necessary)

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Engagement: percent of youth and families not reaching engagement threshold (>60 days)	May – August 2018	n=73; 16% rate	☐ Not applicable—PIP is in planning or implementation phase, results not available	n=222; 15% rate	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.8014
Implementation: percent of youth and families reaching implementation threshold (>180 days)	May – August 2018	n=73; 59% rate	☐ Not applicable—PIP is in planning or implementation phase, results not available	n=222; 61% rate	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.8513

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☒ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: Magellan should: • Include measurement timeframes, including baseline measurements and remeasurements, and the PIP study population within aim statements. • Clearly define the PIP population within the QIA form by age, length of enrollment, diagnoses, procedures, and other characteristics as applicable. • Outline numerators and denominators used for each performance measure within the QIA form. • Directly reference the PDSA cycle within the QIA form and describe the process of developing improvement strategies using the cycle.

END OF WORKSHEETS FOR PROTOCOL 1

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Appendix D: Additional Methodology for Protocol 2

Table 2 provides an example of a SOW operational requirement, the corresponding SOW performance measure, and the corresponding set of measures and goals. Table 3, on the following page, further describes each level of analysis and the applicable range of outcomes for each level.

Table 1. Example SOW Operational Requirement, SOW Performance Measure, Measures, and Goals based on SFY 2020 SOW OP-01

SOW Operational Requirement
The Contractor must provide a provider network certification process focusing on ethical practices. Training components may be included within the required System of Care (SOC) and HFWA values training. Contractor should address ethical issues on a case-by-case basis and at re-credentialing.
SOW Performance Measure
The Contractor must provide percent of HFWA providers in the network who complete training including ethics. The AGENCY reserves the right to request additional information be included. Requested data must be included on the next quarterly report.
Measures and Related Goals
• **OP-01aR1:** Rate of providers in network meeting all requirements: 100% • **OP-01aR2:** Rate of providers in network not meeting all requirements: 0% • **OP-01aR3:** Rate of providers in network who received training on abuse, neglect, and exploitation identification and reporting procedures annually as part of the re-certification process: 100% • **OP-01bR:** Rate of providers completing annual recertification: 100% • **OP-01cR:** Rate of new providers completing initial provider training: 100%

Table 2. Description of Five Tiers of Analysis

Level	Description of Analysis	Possible Outcomes of Analysis	Example
Level 1	**Assess an *individual* measure satisfied its corresponding goal.** Supporting data included in the quarterly and annual reports is measured against target metrics to determine if the findings met the listed goal. Magellan submits quarterly reports to WDH, and Guidehouse reviewed these and the annual report	• **Goal Met**: Reported data meets established goal. • **Goal Not Met**: Reported data does not meet established goal. If a target is 100 percent, any measure at 99 percent or below received "Goal Not Met" designation. • **Not Applicable:** There was no applicable data in SFY 2020 for this measure.	For measure OP-01aR1, "Rate of providers in network meeting all requirements," the goal was 100 percent but the annual total from the annual report indicates 93 percent, so the outcome is "Goal Not Met."

Level	Description of Analysis	Possible Outcomes of Analysis	Example
	which captures all data from the quarterly reports.		
Level 2	**Assess whether Magellan fully met *all* measures associated with SOW operational requirement.** Many SOW operational requirements include multiple associated measures.	• **Yes**: All measures within the SOW operational requirement met their corresponding goals. • **No**: At least one of the measures within the SOW operational requirement did not meet the corresponding goal. • **Not Applicable:** There was no applicable data in SFY 2020 for this measure.	For OP-01, OP-01aR1, OP-01aR2, OP-01aR3, OP-01bR, and OP-01cR were not met. Therefore, the outcome is "No," as Magellan did not meet any of the associated goals.
Level 3	**Assess whether the measure established for the SOW performance measure is applicable for addressing the SOW performance measure, regardless of whether or not it was met**. This tier determines whether a listed measure is appropriate and relevant in addressing the SOW performance measure.	• **Yes**: The measure is relevant in addressing the SOW performance measure. • **No**: The measure is not relevant or sufficient in addressing the SOW performance measure.	For OP-01aR3, the measure of "Rate of providers in network who received training on abuse, neglect, and exploitation identification and reporting procedures annually as part of the re-certification process" addresses the SOW performance measure language "The Contractor must provide percent of HFWA providers in the network who complete training including ethics." Therefore, the outcome for this measure is "Yes," as the measure addresses the SOW performance measure.
Level 4	**Assess whether the SOW performance measure is fully addressed by all associated measures.** Similar to Level 3, this tier analyzes the measures' efficacy in addressing the SOW performance measure. The focus is not on whether	• **Yes**: The performance SOW measure is fully addressed by its listed measures. • **No**: All listed measures, considered together, do not sufficiently address the SOW performance measure. One or more	For OP-01, all five measures associated with the SOW performance measure align with statements from the SOW performance measure, and there are no parts of the SOW performance measure which have not been addressed. Therefore, the

Level	Description of Analysis	Possible Outcomes of Analysis	Example
	an individual measure is relevant to meeting the SOW performance measure but whether the listed measure(s) together fully address the SOW performance measure.	measures must be added or amended for the SOW performance measure to be fully addressed by its listed measures.	outcome is “Yes,” the SOW performance measure is fully addressed by the measures.
Level 5	**Assess whether the SOW performance measure addresses its corresponding SOW operational requirement.** A SOW performance measure accompanies every SOW operational requirement.	• **Yes**: The SOW performance measure adequately addresses the SOW operational requirement. • **Partially**: The SOW performance measure addresses part, but not all, of the SOW operational requirement. • **No**: No portion or aspect of the SOW performance measure addresses the SOW operational requirement.	For OP-01, the SOW operational requirement indicates that "The Contractor must provide a provider network certification process focusing on ethical practices." Since the SOW performance measure addresses all parts of the SOW operational requirement, the outcome is “Yes.”

Appendix E: Protocol 2 - Operational Requirements Review Tool

Instructions for OPs Tool:

This is the review tool used by the EQRO reviewers to assess Magellan's compliance during SFY 2020 in accordance with the language from the SFY 2020 contract/SOW. Reviewers have populated the following areas in the Contract Review tab:

#: The unique number assigned to the goal in the tool. Note that many operational requirements have more than one goal.

Contract Section: The Contract Section (OP-Number) as stated in the contract.

Operational Requirement: The Contract Requirement as stated in the contract.

Performance Measure: The Performance Measure as stated in the contract to meet the Contract Requirement.

OP: The operational requirement number which aligns with the contract, as identified in Magellan's quarterly reports.

Reported Measure: Reported measures included in the Quarterly Reports, if available.

Goal: Thresholds identified by Magellan in the Quarterly Reports.

Findings for SFY 2020: Reported findings included in the reviewed document, if available, by SFY quarter for review.

Review Findings (Levels 1-5): Reviewers' assessment of Magellan's compliance with the SOW Operational Requirements, SOW Performance Measures, measures, and goals.

Summary of SFY 20 Compliance with Operational Requirements

Overview

Number of OPs	31
Number of Measures	74

Level 1 Analysis - Does the individual measure's supporting data meet the goal?

Compliance Result	% of Measures
Goal Met	48.6%
Goal Not Met	41.9%
Not Applicable	9.5%
Total	100.0%

Level 2 Analysis - Do all measures within the SOW operational requirement meet their goals?

Compliance Result	% of OPs
Yes	41.9%
No	48.4%
Not Applicable	9.7%
Total	100.0%

Level 3 Analysis - Does the measure address the SOW performance measure?

Compliance Result	% of Measures
Yes	95.9%
Partially	2.7%
No	1.4%
Total	100.0%

Level 4 Analysis - Is the SOW performance measure fully addressed by the measures?

Compliance Result	% of OPs
Yes	77.4%
No	22.6%
Total	100.0%

Level 5 Analysis - Does the SOW performance measure satisfy the SOW operational requirement?

Compliance Result	% of OPs
Yes	61.3%
Partially	35.5%
No	3.2%
Total	100.0%

SFY20 Contract Review

#	Contract Section	SOW Operational Requirement	SOW Performance Measure	OP	Reported Measure	Goal	Findings for SFY 2020					Level 1	Level 2	Level 3	Level 4	Level 5
							Q1	Q2	Q3	Q4	Annual Total					
1	OP-01	The Contractor must provide a provider network certification process focusing on ethical practices. Training components may be included within the required System of Care (SOC) and HFWA values training. Contractor should address ethical issues on a case-by-case basis and at re-credentialing.	The Contractor must provide percent of HFWA providers in the network who complete training including ethics. The AGENCY reserves the right to request additional information be included. Requested data must be included on the next quarterly report.	OP01aR1	Rate of providers in network meeting all requirements	100%	97%	91%	90%	97%	93.2%	Goal Not Met	No	Yes	Yes	Yes
2				OP01aR2	Rate of providers in network not meeting all requirements	0%	3%	9%	10%	3%	6.8%	Goal Not Met		Yes		
3				OP01aR3	Rate of providers in network who received training on abuse, neglect, and exploitation identification and reporting procedures annually as part of the re-certification process	100%	100%	91%	90%	97%	94.0%	Goal Not Met		Yes		
4				OP01bR	Rate of providers completing annual recertification	100%	95%	100%	67%	89%	91.4%	Goal Not Met		Yes		
5				OP01cR	Rate of new providers completing initial provider training	100%	53%	67%	68%	225%	74.1%	Goal Not Met		Yes		
6	OP-02	The Contractor must notify the youth and/or the families of admission to the CME. All successful and attempted contacts should be documented by the Contractor.	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.	OP02R	Rate of enrollment notification letters sent within 2 business days of determination	100%	98%	97%	100%	98%	98.5%	Goal Not Met	No	Yes	Yes	Partially
7	OP-03	The Contractor must ensure Family Care Coordinators (FCC) complete a Strengths Needs and Cultural Discovery (SNCD) for each family according to the HFWA process.	The Contractor must provide a complete SNCD submitted prior to the first child and family team (CFT) meeting. Data showing compliance with this requirement shall be included in the quarterly data report.	OP03R	Rate of SNCDs completed prior to initial CFT meeting	100%	80%	87%	84%	84%	83.7%	Goal Not Met	No	Yes	Yes	Yes
8	OP-04	After the family have selected their FCC, Contractor must ensure that FCC contact the family timely.	The Contractor must ensure that the FCC must contact every youth and/or family within three (3) working days after being chosen as the FCC to begin the HFWA process.	OP04R	Rate of new referrals contacted by chosen FCC within 3 working days	100%	69%	56%	57%	48%	57.7%	Goal Not Met	No	Yes	Yes	Yes

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9	OP-05	The Contractor must ensure the FCC works with the family, youth, and CFT at the start of the wraparound process to develop a POC based on the individual family and child or youth needs, strengths and preferences. All POC's must include team member signatures, specifically youth (if age appropriate) parent/guardian, along with FCC at a minimum. The FCC must collaborate with child and family serving agencies that are involved with the child or youth and his or her family.	The Contractor must ensure that a POC must be developed within forty-six (46) calendar days of initial youth enrollment. Data showing compliance with this requirement shall be included in the quarterly data report.	OP05R	Rate of enrollments with POCs developed within 46 days of enrollment	100%	82%	80%	74%	49%	73.3%	Goal Not Met	No	Yes	Yes	Partially
10	OP-06	The Contractor must ensure each FCC establishes a crisis plan as part of the child's overall POC to assist in stabilizing the child and family while helping to manage crises. The initial crisis plan shall be developed during the initial SNCD process and updated with the POC.	The Contractor must develop a crisis plan with the HFWA team, which must be included with every POC for all enrolled youth. Data showing compliance with this requirement shall be included in the quarterly data report.	OP06R	Rate of POCs with crisis plans	100%	99%	100%	99%	100%	99.4%	Goal Not Met	No	Yes	Yes	Partially
11	OP-07	The Contractor must ensure the FCC invites the chosen Family Support Partner (FSP) and/or Youth Support Partner (YSP) to participate in the wraparound process and CFT meetings.	The Contractor must provide the current number of enrollees and the percentage of youth enrolled with FSP and the percentage of youth enrolled that have YSP. Data showing compliance with this requirement shall be included in the quarterly data report.	OP07R1	Rate of enrollees enrolled with FSP	100%	42%	45%	47%	50%	46.2%	Goal Not Met	No	Yes	Yes	Partially
12				OP07R2	Rate of enrollees enrolled with YSP	100%	8%	8%	10%	11%	9.6%	Goal Not Met		Yes		
13	OP-08	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).	The Contractor must ensure that the FCC will not have more than ten (10) enrolled youth at a time. A provider will not have more than ten (10) enrolled youth as an FSP and will not have more than twenty-five (25) enrolled youth as a YSP. Percentage of individual providers showing this requirement is met will be reported quarterly.	OP08aR	Rate of FCC providers with <= 10 enrolled youth	100%	96%	97%	96%	98%	96.7%	Goal Not Met	No	Yes	Yes	Yes
14				OP08bR	Rate of FSP/YSP providers with <= 10 enrolled youth under FSP and with <= 25 enrolled youth under YSP	100%	99%	99%	100%	100%	99.4%	Goal Not Met		Yes		
15	OP-09	The Contractor must ensure the FCC holds regularly scheduled CFTs and updates to the POC based on the needs of the family, in accordance to the Agency-defined timeframes.	The Contractor must hold a CFT and update the POC within the last thirty (30) days of a ninety (90) day authorization. Data showing compliance with this requirement shall be included in the quarterly data report.	OP09aR1	Rate of CFT meetings held during the last 30 days (two weeks prior to 7/1/2019) of the authorization period	100%	66%	65%	62%	53%	61.0%	Goal Not Met	No	Yes	Yes	Partially
16				OP09aR2	Rate of POCs completed during the last 30 days (two weeks prior to 7/1/2019) of the authorization period	100%	73%	67%	66%	49%	62.7%	Goal Not Met		Yes		
17				OP09bR1	Rate of POCs in which services authorized and reflect participants' needs	100%	84%	86%	91%	100%	89.5%	Goal Not Met		Yes		

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18				OP09bR2	Rate of POCs with participant/guardian signature affixed	100%	85%	86%	91%	100%	89.8%	Goal Not Met		Yes		
19				OP09bR3	Rate of POCs where services and supports are provided in type, scope, amt, duration, frequency	100%	85%	86%	91%	100%	89.8%	Goal Not Met		Yes		
20				OP09cR	Rate of POCs approved with verification of choice	100%	100%	100%	100%	100%	100.0%	Goal Met		Yes		
21				OP09dR	Rate of application authorized enrollees who verified they received training on rights, recognition of, and reporting processes for instances of abuse, neglect, and exploitation	100%	100%	100%	100%	100%	100.0%	Goal Met		Yes		
22	OP-10	The Contractor must ensure the FCC maintains regular in-person and telephone contact with both the youth and his or her caregiver based on the Agency-defined timeframes. The CFT is considered face-to-face contact.	The Contractor must ensure that after HFWA enrollment begins, The FCC will contact both the youth, dependent upon age, and his/her caregiver at least one (1) time per week via phone and will have face-to-face contact with the child and his caregiver a minimum of two (2) times per month. Data showing compliance with this requirement shall be included in the quarterly data report.	OP10aR	Rate of enrollees contacted by phone at least once a week	95%	66%	72%	77%	70%	71.6%	Goal Not Met	No	Yes	Yes	Yes
23				OP10bR	Rate of enrollees contacted in person at least twice a month	95%	95%	93%	93%	83%	90.7%	Goal Not Met		Yes		
24	OP-11	The Contractor must document whether or not an enrolled youth has an identified primary care provider (PCP).	The Contractor must demonstrate the percentage of enrolled youth with a PCP. Percentages of data showing compliance with this requirement shall be included in the quarterly data report.	OP11R	Rate of enrollees with PCP documented	95%	100%	99%	98%	96%	98.1%	Goal Met	Yes	Yes	Yes	Yes
25	OP-12	The Contractor must ensure the FCC engages representatives from other child serving systems that have involvement within their community. Example: DFS, permanency planning, foster care, changes in custody, are evident in the POC.	The Contractor must provide a quarterly report showing the percentage of CFTs held with invited formal supports.	OP12R	Rate of CFT meetings with invited formal supports	100%	48%	55%	56%	62%	55.3%	Goal Not Met	No	Yes	Yes	Yes

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26	OP-13	The Contractor must ensure FCCs communicate an out-of-home placement and work with children and youth who are in out-of-home placements to determine if services and supports can be safely, effectively, and appropriately provided in the community.	The Contractor must provide the number of enrolled youth in out-of-home placement during the reporting period and the percentage of youth disenrolled due to out-of-home placement.	OP13aQ	Number of enrollees in OOH placements	N/A	15	25	49	37	126.0	Goal Met	Yes	Yes	Yes	No
27				OP13bR	Rate of enrollees disenrolled due to OOH placements	N/A	2%	1%	1%	1%	1.2%	Goal Met		Yes		
28	OP-14	The Contractor shall ensure that children and youth placed out-of-home settings are evaluated through the CASII and ESCII and level of care (LOC).	The Contractor must demonstrate the following: Total number of enrollees with a documented level of care satisfying Agency criteria for participation in the program/Total number of enrollees. This metric shall be reported as a percentage. Total number of annual re-evaluations conducted on or prior to the expiration date of the previous evaluation/assessment/Total number of re-evaluations conducted. This metric shall be reported as a percentage. New evaluations are required, a new CASII/ECSII upon return to community. Show the percent of youth returned to the community from out-of-home, with a new evaluation. Report showing number of new evaluations quarterly.	OP14aR	Rate of enrollees meeting all evaluation requirements (LOC, CASII, CANS) for enrollment	100%	90%	92%	95%	89%	91.5%	Goal Not Met	No	Yes	Yes	Yes
29				OP14bR	Rate of annual re-evaluations conducted prior to or on expiration date	N/A	73%	73%	82%	83%	78.9%	Goal Met		Yes		
30				OP14cR1	Rate of OOH placements returned to community with new LOC evaluations	N/A	N/A	14%	44%	88%	50.0%	Goal Met		Yes		
31				OP14cR2	Rate of OOH placements returned to community with new CASII evaluations	N/A	N/A	N/A	44%	75%	41.7%	Goal Met		Yes		
32				OP14cR3	Rate of OOH placements returned to community with new LOC and CASII evaluations	N/A	N/A	N/A	33%	75%	37.5%	Goal Met		Yes		
33				OP14dR	CASII/ ESCII status: Rate of enrollees with a valid CASII/ ESCII	100%	93%	97%	99%	98%	96.8%	Goal Not Met		Yes		
34				OP14eR	CANS status: Rate of enrollees with a valid CANS	100%	97%	96%	96%	89%	94.2%	Goal Not Met		Yes		
35				OP14fR	LOC attestation status: Rate of enrollees with a valid LOC attestation	100%	100%	100%	100%	100%	99.8%	Goal Not Met		Yes		
36				OP14gR	Rate of assessments completed by qualified evaluator	100%	100%	100%	100%	100%	100.0%	Goal Met		Yes		
37	OP-15	The Contractor must ensure each FCC has knowledge of the current medications for children and youth they serve. If there is a concern, CME will consult with Seattle Children's Hospital (SCH).	The Contractor must provide a quarterly report with the number of consultations CME has with SCH.	OP15Q	Number of consultations with Seattle Children's Hospital	N/A	0	0	0	0	0.0	Goal Met	Yes	Yes	Yes	Partially

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38	OP-16	The Contractor must assist families with the application or admission process for children and youth referred to the Contractor. Report quarterly to the Agency on the number of children and youth referred, and turnaround time for referrals.	The Contractor must report quarterly to the Agency on the number of children and youth referred, and turnaround time for referrals. The Contractor must respond to any referral or request for enrollment within three (3) working days. The Agency reserves the right to request that additional information be included. Requested data must be included on the next quarterly report.	OP16R	Rate of referrals responded to within 3 working days	100%	100%	100%	100%	100%	100.0%	Goal Met	Yes	Yes	Yes	Yes
39				OP16Q	Average turnaround time for referrals (days)	N/A	3	3	3	4	13.0	Goal Met		Yes		
40	OP-17	The Contractor must ensure FSPs hold monthly family support group meetings with enrolled youth in every county/region in Wyoming, and YSPs hold monthly youth support meetings in all counties/ regions. During the monthly meetings, FSPs should include information regarding family voice and choice.	The Contractor must provide a quarterly report identifying all FSP and YSP support group meetings held in the previous quarter including the location and attendees.	OP17	Family Support Group Meetings (See Attached Appendix)	N/A	N/A	N/A	N/A	N/A	N/A	Not Applicable	Not Applicable	Yes	Yes	Partially
41	OP-18	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.	The Contractor must provide a quarterly report of all enrolled youth and families served in the reporting period and a report of Contractor's staff's presence in each geographic region.	OP18aQ	Number of enrollees served (paid claims)	N/A	526	542	608	548	2224.0	Goal Met	Yes	Yes	Yes	Yes
42				OP18bR	Rate of regions with staff member present	100%	100%	100%	100%	100%	100.0%	Goal Met		Yes		

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43	OP-19	The Contractor will only conduct prior authorization (PA)/utilization management (UM) of HFWA, respite and Youth and Family Training (YFT) and Support Services provided to enrolled youth. The Agency currently has an alternate agreement in place for conducting PA and UM for children and youth requiring a PRTF level of care or acute psychiatric stabilization according to the Agency's criteria. The Contractor must work with this vendor frequently to ensure timely and efficient referral between programs. The PA/UM process referenced above will require the Contractor to implement Medical Necessity reviews and decisions for eligibility into the CME. During the approved period this will include a concurrent review process to monitor clinical intervention tied to eligibility justification, delivery of benefits (HFWA, Respite, and YFT) and adherence to any benefit limitations. The mechanism and documents to be reviewed for the concurrent review will include the plan of care (POC), crisis plan, CASII, and CANS.	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 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. 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 authorization decision and provide notice no later than three (3) working days after receipt of the request for service. This may be extended 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 the Contractor's review results in an adverse action, the Contractor shall provide a thirty (30) calendar day advance notification to the enrollee and the enrollee's family care coordinator prior to implementing a change in program eligibility and/or service amount, duration or frequency. The Contractor must report quarterly on the status of the Contractor's relationship with the PA/UM vendor. The Agency reserves the right to request that additional information be included. Requested data must be included on the next quarterly report.	OP19aR	Rate of standard auth decisions within timeframe	100%	100%	94%	98%	99%	98.0%	Goal Not Met	No	Yes	No	Yes
44				OP19bR	Rate of extended standard auth decisions made within timeframe	100%	97%	94%	98%	96%	96.3%	Goal Not Met		Yes		
45				OP19cR	Rate of expedited auth decisions within timeframe	100%	N/A	N/A	N/A	0%	0.0%	Goal Not Met		Yes		
46				OP19dR	Rate of extended expedited auth decisions made within timeframe	100%	N/A	N/A	N/A	N/A	N/A	Not Applicable		Yes		

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47	OP-20	Flex funds are funds used for expenditures in support of the youth and family's POC for a youth and family receiving services from providers. A reasonable cost for flex funding is one that, in its nature and amount, does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. Unallowable costs include, but are not limited to the following: A. Alcoholic Beverages; B. Bad Debts; C. Contributions and Donations; D. Defense and prosecution of criminal and civil proceedings, claims, appeals and patent infringement; E. Entertainment Costs (unless specific written approval has been provided in advance by the Agency); F. Fines and Penalties; G. Interest on Borrowed Capital/Lines of Credit; H. Costs of Organized Fundraising; I. Costs of Investments Counsel/Management; J. Lobbying; and K. Renovation/remodeling and Capital Projects (unless specific written approval has been provided in advance by the Agency).	The Contractor must provide a quarterly report describing how flex funds were spent. The report should include the recipient, the amount, reason for the flex fund distribution, the date of distribution, and a brief description of the flex funds use/purpose.	OP20aQ	Number of enrollees receiving flex funds	N/A	2	1	0	2	5.0	Goal Met	Yes	No	No	Yes
48				OP20bQ	Reasons for flex fund requests	N/A	N/A	N/A	N/A	N/A	N/A	Not Applicable		Yes		
49				OP20cQ	Uses of flex funds	N/A	N/A	N/A	N/A	N/A	N/A	Not Applicable		Yes		
50	OP-21	The Contractor must notify the Agency immediately and in writing of the following: Any event that affects the health, safety, and welfare of an individual, as well as administrative and quality of care complaint.	The Contractor shall notify the Agency within two (2) working days of any critical incident event. Data showing compliance with this requirement shall be included in the quarterly data report.	OP21R	Rate of QOC incident notification timeliness	85%	100%	100%	100%	100%	100.0%	Goal Met	Yes	Yes	Yes	Partially
51	OP-22	The Contractor must send complaints received about the Contractor to the Agency.	The Contractor must respond to any complaint received directly or by the Agency in regard to Contractor performance within five (5) working days after receiving the complaint. Data showing compliance with this requirement shall be included in the quarterly data report.	OP22R	Rate of contractor complaint response timeliness	85%	100%	100%	100%	100%	100.0%	Goal Met	Yes	Yes	Yes	Partially

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52	OP-23	The Contractor is responsible for the accurate and timely submission of all quarterly reporting requirement metrics outlined in the following sections of the Quality Monitoring, Improvement, Assessment, and Federal Reporting Requirements in Attachment A: Statement of Work: A. Initial and Re-evaluation for Enrolled Enrollees: Level of Care B. Application of Evaluation Instruments: CASII, ECSII, CANS, and Level of Care C. Qualified Providers D. Service Coverage and Individual Plan of Care E. Health and Welfare	The Contractor must provide quarterly reports to the Agency that demonstrates alignment with reporting metrics in the identified sections. In addition, the Contractor must submit an annual report that summarizes all quarterly findings to the Agency.	OP23	Reporting Requirements (Quarterly as Appendix)	N/A	N/A	N/A	N/A	N/A	N/A	Not Applicable	Not Applicable	Yes	Yes	Partially
53	OP-24	The Contractor must report all critical incidents.	The Contractor must report all critical incidents in accordance to Wyoming State Statute and processes defined in the 1915(b) and 1915(c) program waivers. Data showing compliance with this requirement shall be included in the quarterly data report.	OP24aD	Number of critical incidents reported (Calculated)	N/A	16	23	15	19	73.0	Goal Met	Yes	Yes	No	Yes
54				OP24aR1	Rate of critical incidents followed up on	N/A	0%	0%	0%	0%	0.0%	Goal Met		Yes		
55				OP24aR2	Rate of critical incidents that were addressed according to state statute	N/A	100%	100%	100%	100%	100.0%	Goal Met		Yes		
56				OP24bR	Rate of deaths resulting in provider corrective action	N/A	N/A	N/A	N/A	N/A	N/A	Not Applicable		Yes		
57	OP-25	The Contractor must ensure all providers within its provider network are enrolled Medicaid providers.	The Contractor must ensure new and existing providers are enrolled as Medicaid Providers. Data showing compliance with this requirement shall be included in the quarterly data report.	OP25R	Rate of in-network providers enrolled in Medicaid	100%	100%	100%	100%	100%	99.9%	Goal Not Met	No	Yes	Yes	Yes
58	OP-26	The Contractor must provide an annual report to the Agency detailing the Contractor's expanding availability and service capacity from the past year.	The Contractor must provide an annual report to the Agency detailing the Contractor's expanding availability and service capacity from the past year. Data reported annually.	OP26	Scalability (Annual as Appendix)	N/A	N/A	N/A	N/A	N/A	N/A	Not Applicable	Not Applicable	Yes	Yes	Yes

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59	OP-27	The Contractor must demonstrate a relationship with multiple agencies, organizations, and resources (at the State and local level), including, but not limited to: Family-based or family-run organizations; State and local agencies serving population of focus; Community-based organizations; Schools; Informal resources in the community, including SOC resources; Child Welfare and Juvenile Justice stakeholders and systems; and Current resources such as 211 (resource to human services referrals).	The Contractor must provide quarterly reports that include number of meetings with stakeholders, agencies, organizations, and resources across the State. This includes all QIC and Advisory council meetings.	OP27aQ	Number of advisory council meetings	N/A	1	1	1	1	4.0	Goal Met	Yes	Yes	No	Yes
60				OP27b1Q	Number of attendees with family-based representation	N/A	1222	537	591	625	2975.0	Goal Met		Yes		
61				OP27b2Q	Number of attendees with State or local agency representation	N/A	43	47	89	35	214.0	Goal Met		Yes		
62				OP27b3Q	Number of attendees with community-based org. representation	N/A	1406	858	1111	1127	4502.0	Goal Met		Yes		
63				OP27b4Q	Number of attendees with school representation	N/A	0	68	0	0	68.0	Goal Met		Yes		
64				OP27b5Q	Number of attendees with informal resource representation	N/A	91	9	122	45	267.0	Goal Met		Yes		
65				OP27b6Q	Number of attendees with child welfare/ juvenile stakeholder representation	N/A	0	0	10	0	10.0	Goal Met		Yes		
66				OP27b7Q	Number of attendees with other representation	N/A	0	0	0	0	0.0	Goal Met		Yes		
67	OP-28	The Contractor must work closely with the Agency for referring children and youth to the appropriate waiver.	The Contractor will demonstrate that the Contractor will make referrals to the Agency for all youth in need of CMH waiver within two (2) calendar days of discovery.	OP28R	Rate of referral to C Waiver within timeframe	100%	100%	100%	100%	100%	100.0%	Goal Met	Yes	Partially	No	Yes
68	OP-29	The Contractor must use its IT System track and report claims data via line level detail per unit of service. Data shall be submitted to the Agency's MMIS.	The Contractor must track utilization data at least monthly. Report the percent of providers submitting claims within ninety (90) calendar days. Data showing compliance with this requirement shall be included in the quarterly data report.	OP29aQ1	Total number of paid claims processed by Magellan (date of adjudication)	N/A	6030	5599	7025	8045	26699.0	Goal Met	Yes	Yes	No	Partially
69				OP29bQ1	Total number of encounters sent to the State during the reporting period (date of submission)	N/A	5581	6147	7185	8119	27032.0	Goal Met		Yes		
70				OP29aQ2	Total number of paid claim units processed by Magellan (date of adjudication)	N/A	23166	21053	27537	27079	98835.0	Goal Met		Yes		
71				OP29bQ2	Total number of encounter units sent to the State during the reporting period (date of submission)	N/A	21294	22877	28199	27357	99727.0	Goal Met		Yes		
72				OP29cR	Rate of claims submitted by providers within 90 days of service end date	95%	98%	97%	99%	98%	98.2%	Goal Met		Partially		

#	Contract Section	SOW Operational Requirement	SOW Performance Measure	OP	Reported Measure	Goal	Findings for SFY 2020					Level 1	Level 2	Level 3	Level 4	Level 5
							Q1	Q2	Q3	Q4	Annual Total					
73	OP-30	The Contractor must conduct satisfaction surveys for both enrolled enrollees and all network providers.	The Contractor must provide results of enrollee satisfaction surveys to the Agency for guardians/parents and youth 18 or older upon transition from HFWA asking specifically if they would recommend HFWA to anyone else. These results will be required annually and utilized to inform the performance improvement process. The Contractor will also provide results of provider satisfaction surveys to all current network providers throughout Wyoming, annually.	OP30	Satisfaction Surveys (Annual as Appendix)	85%	N/A	N/A	N/A	N/A	71.4%	Goal Not Met	No	Yes	No	Yes
74	OP-31	The Contractor must submit, annually, an independently audited financial statement that attests to the fair and accurate presentation of the Contractor's financial position.	The Contractor must provide an audited financial statement, which includes, but is not limited to, cash flow statement, statement of activities/income statement and statement of financial position, or balance sheet and expenses specific to this contract to demonstrate solvency. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards and to the Agency on an annual basis.	OP31	Financial Statement (Annual as Appendix)	N/A	N/A	N/A	N/A	N/A	N/A	Goal Met	Yes	Yes	Yes	Yes

Wyoming Department of Health (WDH) - Care Management Entity (CME) Program
Quarterly Summary of Measures

OP	Measure	Magellan Goals	Q1	Q2	Q3	Q4	Annual Total
OP01aR1	Rate of providers in network meeting all requirements	100%	97%	91%	90%	97%	93%
OP01aR2	Rate of providers in network not meeting all requirements	0%	3%	9%	10%	3%	7%
OP01aR3	Rate of providers in network who received training on abuse, neglect, and exploitation identification and reporting procedures annually as part of the re-certification process	100%	100%	91%	90%	97%	94%
OP01bR	Rate of providers completing annual recertification	100%	95%	100%	67%	89%	91%
OP01cR	Rate of new providers completing initial provider training	100%	53%	67%	68%	225%	74%
OP02R	Rate of enrollment notification letters sent within 2 business days of determination	100%	98%	97%	100%	98%	98%
OP03R	Rate of SNCDs completed prior to initial CFT meeting	100%	80%	87%	84%	84%	84%
OP04R	Rate of new referrals contacted by chosen FCC within 3 working days	100%	69%	56%	57%	48%	58%
OP05R	Rate of enrollments with POCs developed within 46 days of enrollment	100%	82%	80%	74%	49%	73%
OP06R	Rate of POCs with crisis plans	100%	99%	100%	99%	100%	99%
OP07R1	Rate of enrollees enrolled with FSP	100%	42%	45%	47%	50%	46%
OP07R2	Rate of enrollees enrolled with YSP	100%	8%	8%	10%	11%	10%
OP08aR	Rate of FCC providers with <= 10 enrolled youth	100%	96%	97%	96%	98%	97%
OP08bR	Rate of FSP/YSP providers with <= 10 enrolled youth under FSP and with <= 25 enrolled youth under YSP	100%	99%	99%	100%	100%	99%
OP09aR1	Rate of CFT meetings held during the last 30 days (two weeks prior to 7/1/2019) of the authorization period	100%	66%	65%	62%	53%	61%
OP09aR2	Rate of POCs completed during the last 30 days (two weeks prior to 7/1/2019) of the authorization period	100%	73%	67%	66%	49%	63%
OP09bR1	Rate of POCs in which services authorized and reflect participants' needs	100%	84%	86%	91%	100%	90%
OP09bR2	Rate of POCs with participant/guardian signature affixed	100%	85%	86%	91%	100%	90%
OP09bR3	Rate of POCs where services and supports are provided in type, scope, amt, duration, frequency	100%	85%	86%	91%	100%	90%
OP09cR	Rate of POCs approved with verification of choice	100%	100%	100%	100%	100%	100%
OP09dR	Rate of application authorized enrollees who verified they received training on rights, recognition of, and reporting processes for instances of abuse, neglect, and exploitation	100%	100%	100%	100%	100%	100%
OP10aR	Rate of enrollees contacted by phone at least once a week	95%	66%	72%	77%	70%	72%
OP10bR	Rate of enrollees contacted in person at least twice a month	95%	95%	93%	93%	83%	91%
OP11R	Rate of enrollees with PCP documented	95%	100%	99%	98%	96%	98%
OP12R	Rate of CFT meetings with invited formal supports	100%	48%	55%	56%	62%	55%
OP13aQ	Number of enrollees in OOH placements	N/A	15	25	49	37	126
OP13bR	Rate of enrollees disenrolled due to OOH placements	N/A	2%	1%	1%	1%	1%
OP14aR	Rate of enrollees meeting all evaluation requirements (LOC, CASII, CANS) for enrollment	100%	90%	92%	95%	89%	92%
OP14bR	Rate of annual re-evaluations conducted prior to or on expiration date	N/A	73%	73%	82%	83%	79%
OP14cR1	Rate of OOH placements returned to community with new LOC evaluations	N/A	N/A	14%	44%	88%	50%
OP14cR2	Rate of OOH placements returned to community with new CASII evaluations	N/A	N/A	N/A	44%	75%	42%
OP14cR3	Rate of OOH placements returned to community with new LOC and CASII evaluations	N/A	N/A	N/A	33%	75%	38%
OP14dR	CASII/ ESCII status: Rate of enrollees with a valid CASII/ ESCII	100%	93%	97%	99%	98%	97%
OP14eR	CANS status: Rate of enrollees with a valid CANS	100%	97%	96%	96%	89%	94%

OP	Measure	Magellan Goals	Q1	Q2	Q3	Q4	Annual Total
OP14fR	LOC attestation status: Rate of enrollees with a valid LOC attestation	100%	100%	100%	100%	100%	100%
OP14gR	Rate of assessments completed by qualified evaluator	100%	100%	100%	100%	100%	100%
OP15Q	Number of consultations with Seattle Children's Hospital	N/A	0	0	0	0	0
OP16R	Rate of referrals responded to within 3 working days	100%	100%	100%	100%	100%	100%
OP16Q	Average turnaround time for referrals (days)	N/A	3	3	3	4	13
OP17	Family Support Group Meetings (See Attached Appendix)	N/A	N/A	N/A	N/A	N/A	N/A
OP18aQ	Number of enrollees served (paid claims)	N/A	526	542	608	548	2224
OP18bR	Rate of regions with staff member present	100%	100%	100%	100%	100%	100%
OP19aR	Rate of standard auth decisions within timeframe	100%	100%	94%	98%	99%	98%
OP19bR	Rate of extended standard auth decisions made within timeframe	100%	97%	94%	98%	96%	96%
OP19cR	Rate of expedited auth decisions within timeframe	100%	N/A	N/A	N/A	0%	0%
OP19dR	Rate of extended expedited auth decisions made within timeframe	100%	N/A	N/A	N/A	N/A	N/A
OP20aQ	Number of enrollees receiving flex funds	N/A	2	1	0	2	5
OP20bQ	Reasons for flex fund requests	N/A	N/A	N/A	N/A	N/A	N/A
OP20cQ	Uses of flex funds	N/A	N/A	N/A	N/A	N/A	N/A
OP21R	Rate of QOC incident notification timeliness	85%	100%	100%	100%	100%	100%
OP22R	Rate of contractor complaint response timeliness	85%	100%	100%	100%	100%	100%
OP23	Reporting Requirements (Quarterly as Appendix)	N/A	N/A	N/A	N/A	N/A	N/A
OP24aD	Number of critical incidents reported (Calculated)	N/A	16	23	15	19	73
OP24aR1	Rate of critical incidents followed up on	N/A	0%	0%	0%	0%	0%
OP24aR2	Rate of critical incidents that were addressed according to state statute	N/A	100%	100%	100%	100%	100%
OP24bR	Rate of deaths resulting in provider corrective action	N/A	N/A	N/A	N/A	N/A	N/A
OP25R	Rate of in-network providers enrolled in Medicaid	100%	100%	100%	100%	100%	100%
OP26	Scalability (Annual as Appendix)	N/A	N/A	N/A	N/A	N/A	N/A
OP27aQ	Number of advisory council meetings	N/A	1	1	1	1	4
OP27b1Q	Number of attendees with family-based representation	N/A	1222	537	591	625	2975
OP27b2Q	Number of attendees with State or local agency representation	N/A	43	47	89	35	214
OP27b3Q	Number of attendees with community-based org. representation	N/A	1406	858	1111	1127	4502
OP27b4Q	Number of attendees with school representation	N/A	0	68	0	0	68
OP27b5Q	Number of attendees with informal resource representation	N/A	91	9	122	45	267
OP27b6Q	Number of attendees with child welfare/ juvenile stakeholder representation	N/A	0	0	10	0	10
OP27b7Q	Number of attendees with other representation	N/A	0	0	0	0	0
OP28R	Rate of referral to C Waiver within timeframe	100%	100%	100%	100%	100%	100%
OP29aQ1	Total number of paid claims processed by Magellan (date of adjudication)	N/A	6030	5599	7025	8045	26699
OP29bQ1	Total number of encounters sent to the State during the reporting period (date of submission)	N/A	5581	6147	7185	8119	27032
OP29aQ2	Total number of paid claim units processed by Magellan (date of adjudication)	N/A	23166	21053	27537	27079	98835
OP29bQ2	Total number of encounter units sent to the State during the reporting period (date of submission)	N/A	21294	22877	28199	27357	99727
OP29cR	Rate of claims submitted by providers within 90 days of service end date	95%	98%	97%	99%	98%	98%
OP30	Satisfaction Surveys (Annual as Appendix)	85%	N/A	N/A	N/A	N/A	N/A
OP31	Financial Statement (Annual as Appendix)	N/A	N/A	N/A	N/A	N/A	N/A

Appendix F: Protocol 2 - Outcome Measures Review Tool

SOW Section	Outcome Name	Outcome Requirement	Outcome Performance Measure	Outcome Performance Penalty	Q1	Q2	Q3	Q4	Status of Goal	Findings and Comments
OUT-1	Out-of-Home (OOH) Placements	The Contractor shall, report the number of OOH placements of Contractor youth OOH=Out of Home (anything other than a family or adoptive placement)	Report quarterly for the previous quarter the Denominator - number of youth enrolled with the Contractor and the Numerator - number of youth in OOH placement	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next reporting period (following quarter)	N:12 D: 234 %: 5%	N:26 D: 243 %: 11%	N:17 D: 282 %: 6%	N:12 D: 227 %: 5%	Meets Requirement	Magellan reported the number and percent of OOH placements on a quarterly basis.
OUT-2	Decreased Length of Stay (LOS) for Inpatient and Residential Treatment admissions	The Contractor shall report the overall length of stays for inpatient and residential treatment for youth enrolled in the CME.	Report quarterly for the previous quarter the Average LOS in OOH placement. Average LOS is equal to the average of PRTF and acute psychiatric hospitalization stays.	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next reporting period (following quarter)	PRTF: 28 AIP: 6	PRTF: 30 AIP: 27	PRTF: 31 AIP: 5	PRTF: 34 AIP: 7	Meets Requirement	Magellan reported the average length of stay for PRTF and AIP on a quarterly basis.
OUT-3	Recidivism	The Contractor shall decrease the recidivism of youth served by the Contractor moving from a lower level of care to a higher level of care.	Report quarterly for the previous quarter the Denominator - number of youth enrolled with the Contractor and the Numerator - number of youth moved to a higher level of care while served by the Contractor LOC hierarchy = (lowest to highest) is home, Foster Care (FC), Therapeutic Foster Care (TFC), group home, crisis bed, RTC, PRTF, Acute Psychiatric hospitalization	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next reporting period (following quarter)	N: 7 D: 234 %: 3%	N: 10 D: 243 %: 4%	N: 16 D: 282 %: 6%	N: 10 D: 227 %: 4%	Meets Requirement	Magellan reported the number of youth who moved to a higher level of care on a quarterly basis.
OUT-4	Recidivism (LOC) at six (6) months post CME graduation	The Contractor shall report recidivism of youth served by the Contractor and who graduated from the CME program who are moving from a lower LOC to a higher LOC within six (6) months of graduation from the CME	Report quarterly on the previous quarter the Denominator - number of youth graduated from the CME and the Numerator - number of graduated youth moved to a higher level of care (PRTF or Acute Psychiatric hospitalization) within six (6) months of graduation from the CME	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next reporting period (following quarter)	N/A	N/A	N/A	N/A	Not Applicable	Q4 Report indicates that Magellan does not report this metric until SFY2020 per WDH instruction.
OUT-5	Compliance with EPSDT	The Contractor shall report the CME enrolled youth's compliance with EPSDT standards	Report quarterly on the previous quarter the Denominator - number of youth enrolled in the CME and the Numerator - number of CME enrolled youth with an EPSDT visit	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next reporting period (following quarter)	N: 19 D: 234 %: 8%	N: 13 D: 243 %: 5%	N: 13 D: 282 %: 5%	N: 8 D: 227 %: 4%	Meets Requirement	Magellan reported number of youth with EPSDT visits on a quarterly basis.

Appendix F. Protocol 2 - Outcome Measures Review Tool

SOW Section	Outcome Name	Outcome Requirement	Outcome Performance Measure	Outcome Performance Penalty	Q1	Q2	Q3	Q4	Status of Goal	Findings and Comments
OUT-6	Appropriate Use of Psychiatric Medication	The Contractor shall report on the number of CME enrolled youth not meeting the state standards for psychotropic medications (too much, too many, too young, polypharmacy) as reported by the Pharmacy Unit	Report quarterly on the previous quarter the Denominator - number of youth enrolled with the Contractor and the Numerator - number of CME enrolled youth not meeting the state standards	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next reporting period (following quarter)	N: 0 D: 234 %: 0%	N: 0 D: 243 %: 0%	N: 0 D: 282 %: 0%	N: 0 D: 227 %: 0%	Meets Requirement	Magellan reported the number of youth not meeting medication standards/SCH referral.
OUT-7	Cost Savings (Healthcare Costs)	The Contractor shall report healthcare costs to Medicaid for the CME enrolled youth	Average PMPM healthcare costs of CME enrolled youth as compared to the target eligible population of non-CME enrolled youth with PRTF stays or Acute Psychiatric hospitalizations	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next reporting period (following quarter)	CME: $5,371.79 PRTF: $17,869.32	CME: $6,334.70 PRTF: $19,729.61	CME: $6,814.14 PRTF: $20,283.45	CME: $5,463.00 PRTF: $23,022.80	Meets Requirement	Magellan reported average cost of CME youth and average cost of PRTF youth on a quarterly basis.
OUT-8	Fidelity to the high fidelity wraparound (HFWA) Model	The Contractor shall report fidelity to the HFWA model as measured by the Wraparound Fidelity Index (WFI-EZ)	Report quarterly for the previous quarter the percentage of fidelity to the HFWA compared to the SFY16 baselines of seventy-two percent (72%) which is the national fidelity average for this time frame	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by one quarter of a percent (0.25%) and the decreased PMPM will continue until the next reporting period (following quarter)	Jul: 74.6 Aug: 74.6 Sep: 74.1	Oct: 73 Nov: 73.8 Dec: 76.1	Jan: 80.6 Feb: 72.3 Mar: 79.3	Apr: 82.4 May: 74.8 Jun: 75.6	Meets Requirement	Magellan reported fidelity to the HFWA model as measured by the Wraparound Fidelity Index (WFI-EZ) on a monthly basis.
		The Contractor shall report the number of WFI-EZ surveys administered to capture a valid and representative sample of the experiences of enrollees served	Report quarterly the number of WFI-EZ surveys administered during the quarterly period compared to the same quarter in SFY16	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by one quarter of a percent (0.25%) and the decreased PMPM will continue until the next reporting period (following quarter)	Jul: 0 Aug: 0 Sep: 104	Oct: 27 Nov: 48 Dec: 51	Jan: 26 Feb: 25 Mar: 64	Apr: 33 May: 29 Jun: 37	Meets Requirement	Magellan reported the number of WFI-EZ surveys administered on a monthly basis.
OUT-9	Family and Youth Participation at state-level Steering Committees	The Contractor shall report family and youth participation on state-level Steering Committees	Report quarterly for the previous quarter the Denominator - number of state-level Steering Committee attendees who represent family and youth enrollees and the Numerator - number of CME enrollees	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next reporting period (following quarter)	N: 20 D: 25 %: 80%	N: 2 D: 7 %: 29%	N: 14 D: 23 %: 61%	N: 9 D: 18 %: 50%	Meets Requirement	Magellan reported the number of Steering Committee attendees who represent family and youth enrollees on a quarterly basis.
OUT-10	Family and Youth Participation in Communities	The Contractor shall report family and youth participation on the CME's community advisory boards, Support groups and other stakeholder meetings facilitated by the Contractor	Report quarterly for the previous quarter the Denominator - number of family and youth participants attending advisory boards, support groups and other stakeholder meetings facilitated by the contractor and the Numerator - number of CME enrollees	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next reporting period (following quarter)	Jul: 345/413 (84%) Aug: 297/641 (46%) Sep: 580/1066 (54%)	Oct: 190/480 (40%) Nov: 210/626 (34%) Dec: 137/413 (33%)	Jan: 192/626 (31%) Feb: 165/524 (31%) Mar: 234/773 (30%)	Apr: 192/567 (34%) May: 229/631 (36%) Jun: 204/632 (32%)	Meets Requirement	Magellan reported the number of attendees representing families at advisory board meetings on a monthly basis.

Appendix G: Protocol 3 - Compliance Review Tool

Note: "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.

#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
MCP Standards, Including Enrollee Rights and Protections					
1	**Availability of services** **Medicaid:** 42 C.F.R. §§ 438.206 (availability of services) and 42 C.F.R. § 10(h) provider directory) **CHIP:** 42 C.F.R. § 457.1230(a)	The state's provider-specific network adequacy requirements and standards (and exceptions, if any).	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]		Review Not Required
2		The state's requirements for the MCP provider directory.	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]	12.4.2020: Members and providers have access to contracted providers via the Youth and Families Magellan of Wyoming website. Protocol 3 Enrollee Services PAHP Provider Directory includes a link to the electronic provider directory (https://www.magellanofwyoming.com/youth-families/find-a-provider/). Upon searching for a provider within the directory, Magellan notes that the listing is updated "every day." Per Network Provider Data Maintenance and Data Integrity, providers are responsible for reporting changes to Magellan within 10 business days of the change [pg. 5]. Additionally, data is made available in machine readable formats, including the ability to export as XML or PDF.	Fully Met
3		Information on the documentation that the state uses to support its certification that the MCP complied with the state's requirements for availability and accessibility of services, including the adequacy of the provider network.	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. A software program produces a report that is analyzed for compliance with the State access and capacity requirements. The analysis is part of the Contractor's performance evaluation. [SOW pg. 18] Geographic Presence 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]	12.4.2020: Appendix F for Q4 - Geo Mapping, as part of OP-18, includes a county map of providers and eligible members in Wyoming, separated by service (Family Care Coordination, Family Support Services, Youth Support Partners, Respite Services). Appendix F is also generated quarterly and available in each quarter's Executive Summary and Appendix, which satisfies a requirement from the SOW. However, the geo map available in Appendix F does not include mapping of referral and subsequent enrollment patterns, which is required in the SOW. Per Protocol 3 Enrollee Services PAHP Provider Directory, a full provider listing is available on the Contractor's website. Please see Requirement #8 for additional information on network adequacy.	Fully Met

Note: "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.

#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
4	**Furnishing of services and timely access** **Medicaid**: 42 C.F.R. § 438.206(c)(1): Furnishing of services and timely access **CHIP**: 42 CFR § 457.1230(a): Availability of services	Obtain a copy of the state Medicaid/CHIP agency's standards for timely enrollee access to care and services required of Medicaid/CHIP and MCPs.	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]		Review Not Required
5	**Access and cultural considerations** **Medicaid**: 42 C.F.R. § 438.206**(**c**)(**2**)**: Furnishing of services and cultural considerations. **CHIP**: 42 CFR § 457.1230**(**a**)**: Access standards	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]		Review Not Required
6		The requirements the state has communicated to the MCP with respect to how the MCP 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]		Review Not Required

Note: "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.

#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
7	**Assurances of adequate capacity and services** **Medicaid**: 42 C.F.R. § 438.207: Assurances of adequate capacity and services **CHIP**: 42 CFR § 457.1230(b): Assurances of adequate capacity and services	Medicaid/CHIP agency documentation and submission timing standards to assure that the MCP has an appropriate range of preventive, primary care, specialty, and LTSS services that are adequate for the anticipated number of enrollees in the MCP's service area.	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]	12.9.2020: In specifying the required contents of Plans of Care, the 2019-2020 WY Provider Handbook notes that "the Plan of Care must include...Documentation as to whether the youth has a primary care physician." [pg. 67]. Magellan reports the "Rate of enrollees with PCP documented" as part of OP-11, which is included in the quarterly Committee Data Files and quarterly Executive Summary and Appendices. Per Committee Data File - Q4, for SFY 2020 overall, 98.1 percent of enrollees had a documented primary care provider. While the 2019-2020 WY Member Handbook does not provide information to members on how to contact a designated FCC, it does specify when it is best for a member to contact the FCC. For example: - "Be in contact with your chosen Family Care Coordinator within three working days of referral to set a time to meet in person." [pg. 10] - "If the plans are not working, talk about your concerns at the next Child and Family Team meeting. Or, contact your Family Care Coordinator." [pg. 10] Additionally, the 2019-2020 WY Provider Handbook sets minimum member contact guidelines for the FCC to follow: "Contact both the youth and his/her caregiver (depending on age) as often as necessary, but no less than phone call a week and two face-to-fact meetings in a month." [pg. 22] Please see Requirement #10 for additional information on coordinating the provision of CME services with FFS Medicaid services. Because there is not information for the member on how to contact the FCC, this requirement is partially met. 2.9.2021: Per discussion with Magellan on 2/5, there is no expectation that the enrollee is to reach out to the FCC prior to initial contact initiated by the FCC. If the member were to make this contact, they would likely find FCC contact information in the provider directory. Since Wyoming is comprised of relatively smaller communities and most referrals are initiated by providers, enrollee engagement with providers prior to enrollment in the program is common.	Partially Met

Note: "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.

#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
8		Medicaid/CHIP agency documentation and submission timing standards to assure that the MCP maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.	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. The data is used to monitor the above topics by obtaining information from the beneficiaries, resolving issues, and identifying and addressing trends. If deficiencies are noted the Contractor must perform corrective action until compliance is met. [SOW pg. 19]	12.9.2020: Magellan describes the provider network's sufficiency in number, mix, and geographic distribution in Network Development Plan Calendar Year 2021. Despite experiencing its highest turnover in SFY 2019 amid the change to fee-for-service, Magellan managed to add providers in the majority of roles (Family Care Coordinator, Family Support Partner, and Respite) in the second half of SFY 2019 [pg. 12]. This points to sufficient range of services furnished by an adequate provider network. Additionally, Appendix F for Q4 - Geo Mapping represents quarterly documentation of the geographic distribution of CME providers. Appendix F shows that provider distribution generally aligns with member distribution. According to the geo map, most eligible members of CME services are located in counties in the central and southeastern portion of the state (e.g., Natrona - 54 members; Laramie - 35 members; Sweetwater - 30 members). This aligns with the location of most providers, who are also located in central and southeastern counties (e.g., Natrona - 18 FCCs; Platte - 18 FCCs; Albany - 16 FCCs). However, Appendix F for Q4 - Geo Mapping also notes potential provider shortages, especially in the northwestern corner of Wyoming. Park, Teton, Hot Springs, and Washakie counties all have eligible members but no active FCC providers. Although there are providers in nearby counties (e.g., Big Horn, Fremont), counties in the northwestern corner of Wyoming cover large portions of land, and travel time may pose barriers to access. Beyond FCCs, the geo map notes a particularly scarce supply of Youth Support Partners, with only 2 providers located across Sweetwater and Johnson counties. Lastly, Appendix F for Q4 - Geo Mapping also shows signs of a potential uneven distribution of CME providers in Wyoming. Multiple counties - including Campbell, Carbon, Converse, Lincoln, and Niobrara - all have more active FCCs than eligible members. Although Magellan submits the requested documentation quarterly, documentation does not support that Magellan "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," so this requirement is partially met.	Partially Met
9	**Coordination and continuity of care for all enrollees** **Medicaid**: 42 C.F.R. § 438.208: Coordination and continuity of care **CHIP:** 42 C.F.R. § 457.1230(c): Coordination and continuity of care	The state's requirements regarding the obligation to and methods by which an MCP must: Ensure enrollees have an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee. The enrollee must be provided information on how to contact their designated person or entity.	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. The Contractor is required to implement procedures to coordinate the services it furnishes to the enrollee with the services the enrollee receives from community and social support providers. The Contractor is required to ensure that each network provider furnishing services to enrollees maintains and shares an enrollee health record in accordance with Medicaid requirements as specified in the CMS 1500 manual. [SOW pg. 25] The Contractor must document whether or not an enrolled youth has an identified primary care provider (PCP). [SOW pg. 7]		Review Not Required

Note: "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.

#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
10		Coordinate the services the MCP furnishes to enrollees (between settings, between MCPs, between MCP and FFS, and with services provided by community and social supports).	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. The Contractor is required to implement procedures to coordinate the services it furnishes to the enrollee with the services the enrollee receives from community and social support providers. The Contractor is required to ensure that each network provider furnishing services to enrollees maintains and shares an enrollee health record in accordance with Medicaid requirements as specified in the CMS 1500 manual. [SOW pg. 25] The Contractor is required to utilize the model enrollee handbook and state developed notices to describe any transition of care policies for enrollees and potential enrollees. The transition of care policies must include information to enrollees informing them that they have access to services consistent with the access they previously had under their previous network provider, and that when appropriate, will be assisted to find another network service provider that has access to historical data, plan of care and other documents necessary to implement the transition in a seamless and timely manner with the goal of preventing or reducing the risk of hospitalization or institutionalization.[SOW pg. 16]	12.13.2020: The 2019-2020 WY Provider Handbook provides guidelines for coordinating HFWA services. Providers are required to "ensure current medications are updated in the Plan of Care, include updates when medication changes are made, and communication with the primary care physician, other relevant healthcare providers and Magellan." [pg. 67] The 2019-2020 WY Member Handbook addresses coordination with both primary care physicians and the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit available to children. The Handbook informs members that the FCC "will work with you and your preferred primary medical health care provider." If an enrollee does not have a primary care physician, FCCs will help families find a physician, if desired. [pg. 21] 1.25.2021: The Member Handbook also includes transition of care information for enrollees. Specifically, the Handbook outlines the four phases of the HFWA process (Engagement and Preparation; Initial Planning; Plan Implementation; Transition to Discharge) and explains next steps needed for transition between phases / discharge after Phase 4. [pg. 12-18] The Handbook makes clear that "if [member] needs include physical or behavioral health services that are not covered within High Fidelity Wraparound, your Family Care Coordinator will help you find those services." [pg. 10] However, the Handbook does not specify that enrollees have access to services consistent with the access they had under their previous network provider. In WYClinical Project Implementation Action Items, Magellan outlines numerous performance measures related to coordination with primary care providers and other care settings. For example, once the primary care provider has been identified, measure EM 6-40 requires CME providers to "send a brochure describing the CME's service offerings to each enrollee's PCP...within three (3) business days of identification." [pg. 6] However, this document was in use outside of the SFY 2020 review period. Other care coordination performance measures outlined in WYClinical Project Implementation Action Items require CME providers to coordinate with key youth-facing stakeholders, including the Health Management contractor, school systems, and State or local public agency staff. Measures include: - EM 6-52: "Work collaboratively with the Health Management (HM) contractor in order to coordinate care for children identified for CME services. Coordination between Contractors includes sharing related information, knowledge, and identified barriers to care; support being provided related to Social Determinants of Health; and ensuring alignment of education and messages in order to ensure the best outcome(s) for the client, while avoiding duplication of Contractor effort. The coordination and process will be discussed and agreed upon by both Contractors." [pg. 7] - EM 6-53: "Develop strong, positive relationships with the local school systems and courts as a part of the development of a strong system of care and oversee consistency with enrollees' Individualized Education Programs (IEP)." [pg. 8] - EM 6-54: "Engage the child's school and local school system in the CFT and care planning process." [pg. 8] - EM 6-55: "Work with State or local public agency staff when critical barriers arise to	Partially Met

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#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
				effective coordination of care." [pg. 8] However, this document was in use outside of the SFY20 review period. The 2019-2020 WY Provider Handbook lists maintaining enrollee medical records "in accordance with Health and Human Services and the CMS 1500 Provider Manual, all other applicable federal, state and local laws, rules and regulations" as a requirement for network provider participation. [pg. 31] Since the Member Handbook does not include all relevant transition of care information, this requirement is partially met.	
11		Make a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees.	The Contractor must ensure the FCC works with the family, youth, and CFT at the start of the wraparound process to develop a POC based on the individual family and child or youth needs, strengths and preferences. All POC's must include team member signatures, specifically youth (if age appropriate) parent/guardian, along with FCC at a minimum. The FCC must collaborate with child and family serving agencies that are involved with the child or youth and his or her family. [SOW pg. 5] The Contractor must ensure that a POC must be developed within forty-six (46) calendar days of initial youth enrollment. Data showing compliance with this requirement shall be included in the quarterly data report. [SOW pg. 5] The Contractor must ensure Family Care Coordinators (FCC) complete a Strengths Needs and Cultural Discovery (SNCD) for each family according to the HFWA process. [SOW pg. 5]	12.13.2020: While Medicaid regulations require MCPs to "make a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment", WDH requires Magellan to develop Plans of Care within forty-six (46) calendar days of initial youth enrollment in the Statement of Work [pg. 5] Magellan reports data showing compliance with the requirement that CME providers develop Plans of Care within 46 days of initial youth enrollment. This data is available in Executive Summary and Appendices, released by Magellan quarterly. The data has a one month lag, so data below represents the three months In SFY 2020, Magellan generally complied with WDH's POC timeliness requirements: - Q1: 78 percent of POCs developed within 46 days of enrollment; [pg. 2] - Q2: 75 percent of POCs developed within 46 days of enrollment; [pg. 2] - Q3: 75 percent of POCs developed within 46 days of enrollment; [pg. 2] - Q4: No data available in Executive Summary. Committee Data File - Q4 - Final indicates 62 percent of POCs developed within 46 days of enrollment (using March-May data). Additionally, the 2019-2020 WY Member Handbook describes the HFWA process and phases. During Phase 1 (1-30 days to complete), enrollees complete initial assessments including the Strength, Needs, and Culture Discovery (SNCD); Child and Adolescent Needs and Strengths (CANS); and Adverse Childhood Experiences (ACEs) survey. [pg. 14] During Phase 2 (31-60 days to complete), the Plan of Care is developed [pg. 15-16]. Committee Data File - Q4 - Final indicates 84 percent of SNCDs were completed prior to initial CFT meeting (OP03) for SFY 2020. Although Magellan reports on initial assessments and POCs being developed within the 90 day timeframe, data shows varying compliance with the requirements, so this requirement is partially met.	Partially Met

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#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
12		Share with the state or other MCPs serving the enrollee the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities.	None	1.11.2021: For the purpose of the EQR, Magellan provided samples of enrollee records. These include enrollee needs assessments (CANS_20191010_220244500 (3)_Redacted, CASII_Redacted, LOC_Redacted, SNCD_20200505_180813_Redacted), Plans of Care (CSOC_Initial_20191109_184308_Redacted), progress notes, choice of provider forms, and disenrollment letters. Both the SNCD and CASII tools show evidence of coordination with other programs / supports, including school systems, other providers, and other agencies. For example, excerpts from the SNCD tool template: "_____ is currently attending school through the K12 program. He has done really well in this school setting and this was noted as a stable support during the most recent CFT meeting with the therapist." [pg. 4] "The family is also transferring medication management responsibilities to Dr. _____, a pediatrician who works closely with Seattle Children's Hospital for medication management support as needed." [pg. 5] "The family continues to work with Wyoming Children's Law Center for support with the adoption." [pg. 5] While evidence of coordination and information sharing between programs is present in the needs assessment tool examples, information related to sharing findings of the assessment with the State or other MCPs serving the enrollee specifically to prevent duplication of assessment activities is unclear. This requirement is partially met. 2.9.2021: Per discussion with Magellan on 2/3, SNCDs are available to each individual provider through the web portal, Magellanprovider.com. However, assessment sharing with the State remains unclear.	Partially Met
13		Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards.	The Contractor is required to ensure that each network provider furnishing services to enrollees maintains and shares an enrollee health record in accordance with Medicaid requirements as specified in the CMS 1500 manual. [SOW pg. 25]	12.13.2020: The 2019-2020 WY Provider Handbook lists maintaining enrollee medical records "in accordance with Health and Human Services and the CMS 1500 Provider Manual, all other applicable federal, state and local laws, rules and regulations" as a requirement for network provider participation. [pg. 31]	Fully Met
14		Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with applicable privacy requirements.	The Contractor must provide specific information in the enrollee handbook that includes: A. Information about enrollee’s rights and responsibilities (including their right to be treated with respect and in due consideration for his or her dignity and privacy); [SOW pg. 16]	12.13.2020: Magellan explicitly outlines privacy rights for CME enrollees in the Confidentiality section of 2019-2020 WY Member Handbook. The Handbook indicates that information is shared only with enrollee and family consent, obtained through signing a release of information form. The release of information form allows Magellan, FCCs, FSPs, and CFTs to share information. [pg. 24] The Handbook also notes that in the event that the enrollee threatens to harm themselves or others, or someone believes that abuse or neglect may be happening, information will be shared with the Department of Family Services office in the county where the enrollee lives. [pg. 24] The 2019-2020 WY Member Handbook also indicates that enrollees have the right to "Be treated with respect, dignity and privacy." [pg. 25] Although documentation provided by Magellan is not specific to protecting privacy while coordinating care, as specified in associated Medicaid policy, the entire CME program revolves around care coordination.	Fully Met

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#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
15	**Additional coordination and continuity of care requirements: LTSS** **Medicaid**: 42 C.F.R. § 438.208: Coordination and continuity of care **CHIP:** 42 C.F.R. § 457.1230(c): Coordination and continuity of care	Methods used by the Medicaid/CHIP agency to identify to the MCP enrollees who need LTSS.	None	Not Applicable. Requirements around LTSS do not apply to the CME program, which delivers care coordination services to children with complex behavioral needs.	Not Applicable
16		Whether the MCP is required to meet identification, assessment, and treatment planning requirements for dually-enrolled beneficiaries.	None	Not Applicable. Requirements around LTSS do not apply to the CME program, which delivers care coordination services to children with complex behavioral needs.	Not Applicable
17		Any Medicaid/CHIP agency LTSS assessment mechanisms requirements, including the requirement to use appropriate providers or individuals meeting the Medicaid/CHIP agency's LTSS service coordination requirements.	None	Not Applicable. Requirements around LTSS do not apply to the CME program, which delivers care coordination services to children with complex behavioral needs.	Not Applicable
18		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]	Not Applicable. Requirements around LTSS do not apply to the CME program, which delivers care coordination services to children with complex behavioral needs.	Not Applicable
19	**Additional coordination and continuity of care requirements: SHCN** **Medicaid:** 42 C.F.R. § 438.208: Coordination and continuity of care **CHIP**: 42 C.F.R. § 457.1230(c): Coordination and continuity of care	Methods used by the Medicaid/CHIP agency to identify to the MCP 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 SPMI). Level of care is determined by use of several assessment tools, such as CASII, ECSII, CANs, ACEs.	Not Applicable
20		Whether the MCP is required to implement mechanisms for identifying, assessing, and producing a treatment plan for 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 SPMI). Level of care is determined by use of several assessment tools, such as CASII, ECSII, CANs, ACEs.	Not Applicable
21		Whether the MCP is required to meet identification, assessment, and treatment planning requirements for dually-enrolled beneficiaries.	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. The CME program serves Medicaid eligible youth aged 4 -20 years old.	Not Applicable

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#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
22		Any Medicaid/CHIP agency SHCN assessment mechanisms requirements, including the requirement to use appropriate providers or individuals meeting the Medicaid/CHIP agency's LTSS service coordination requirements.		Not Applicable. All members of the CME program have SHCNs because all youth have behavioral/mental health diagnoses (e.g. SED or SPMI). Level of care is determined by use of several assessment tools, such as CASII, ECSII, CANs, ACEs.	Not Applicable
23		Whether the Medicaid/CHIP agency requires the MCP to produce a treatment or service plan for enrollees with SHCN that are determined through assessment to need a course of treatment or regular care monitoring.		Not Applicable. All members of the CME program have SHCNs because all youth have behavioral/mental health diagnoses (e.g. SED or SPMI). Level of care is determined by use of several assessment tools, such as CASII, ECSII, CANs, ACEs.	Not Applicable
24		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]	12.13.2020: According to SFY2020 WY CME Program Description Final Approved, Magellan manages the WY CME Quality Program, which designs, measures, and evaluates the performance of clinical care and patient safety, disease management, preventive health services, and member services [pg. 7]. The structure of the WY CME Quality Program is specified further in Quality Improvement Program Policy. The Quality Program includes a Corporate and Strategic Business Unit (SBU), which oversees individual Operating Units, organized by topic (e.g., UM, SPD, PBM, Patient Management, Case Management). [pg. 3] Magellan specifies objectives for the WY CME Quality Program in WY CME QI_WorkPlan Final. Work plan objectives are organized by topic (e.g., Stakeholder Involvement, Best Practices, External Review, Compliance) and specify CME Reporting Committee, CME Owner, and Review Cycle / Frequency. The WY CME QI_WorkPlan Final also indicates Magellan will "monitor performance measures" and "report core indicators to QI department quarterly". [pg. 7] Magellan also pursues multiple Performance Improvement Projects (PIPs), Quality Improvement Initiatives (QIAs), and Quality Assessment and Performance Improvement (QAPI) program initiatives through the Quality Program. Each initiative includes a specific data collection methodology and quantifiable performance measures. Initiatives pursued in SFY 2020 captured in documentation provided by Magellan include: - Engagement and Implementation - Enrollment Initiative - Improving Minimum Contact Engagement for Family Care Coordinators 1.4.2021: As part of the Magellan CME Quality Annual Program Evaluation, Magellan reports data to evaluate over- and/or under-utilization of services. Magellan reported number of enrollments, encounters, authorizations, and paid claims for HFWA services of Family Care Coordination (FCC), Family Support Partner (FSP), Youth Support Partner (YSP), Youth and Family Training (YFT), and Respite Care for SFY 2020. Notably, Magellan found that YFT and Respite services were under-utilized during the period. [pg. 55] Magellan meets all criteria for this requirement.	Fully Met

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#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
25	**Disenrollment** **Medicaid**: 42 C.F.R. § 438.56: Disenrollment: Requirements and limitations **CHIP:** 42 C.F.R. § 457.1212: Disenrollment	Obtain from the Medicaid/CHIP agency Information on: Reasons for which the MCP may request the disenrollment of an enrollee.	Disenrollment for enrollees requested by the Contractor will be reviewed and approved by the State. The following are causes for disenrollment: A. Youth is no longer Medicaid eligible; B. Youth moves out of state; C. Youth ages out of the program; D. Youth is incarcerated; E. Youth is no longer financially eligible; F. Youth is no longer clinically eligible; G. Youth is determined eligible for any excluded program/population as detailed in the Agency's 1915(b) waiver, Section A. Part I E, (Excluded Populations); or H. Youth is in an out of home placement longer than 180 days The Contractor may not request disenrollment because of: A. An adverse change in the enrollee's health status; B. The enrollee's utilization of medical services; C. The enrollee's diminished mental capacity; D. The enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Contractor's ability to furnish services to the enrollee or other enrollees). [SOW pg. 15]	12.13.2020: Consistent with the SOW, the 2019-2020 WY Provider Handbook indicates the following causes for member disenrollment [pg. 18]: 1) Youth is no longer Medicaid eligible; 2) Youth moves out of state; 3) Youth ages out of the program; 4) Youth is incarcerated; 5) Death of participant; 6) Youth is no longer financially eligible (Member receives this notice from the Medicaid Agency); 7) Youth successfully completes the program; 8) Youth is no longer clinically eligible; - Member clinically ineligible to receive services based on either CASII/ECSII and level of care - Inactive Plan of Care 9) Youth or family lack of cooperation by family/participant in plan development, plan implementation, refusal to sign or abide by service plan, including the refusal of critical services; 10) Youth is determined eligible for any excluded program/population as detailed in the Agency's 1915(b) waiver, Section A. Part I E, (Excluded Populations); 11) Youth is in an out of home placement longer than 180 days. Also consistent with the SOW, the 2019-2020 WY Provider Handbook outlines reasons Magellan may not request member disenrollment [pg. 19]: 1) An adverse change in the enrollee's health status; 2) The enrollee's utilization of medical services; 3) The enrollee's diminished mental capacity; 4) The enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Magellan's ability to furnish services to the enrollee or other enrollees). In Disenrollment letter redacted, Magellan provides a sample of a notice provided to members who have been disenrolled from the CME program. The notification includes the following potential reasons for disenrollment [pg. 1-2]: - All goals of the family/participant have been met; - No evidence of service plan in place or engagement with the family for care coordination; - Lack of cooperation by family/participant in plan development, plan implementation, refusal to sign or abide by service plan, including the refusal of critical services; - Out of home placement of the participant (group home, residential treatment, psychiatric hospital or similar program) for longer than 180 days; - Family/participant's choice to terminate waiver services; - Relocation of family/participant outside the State of Wyoming; - Incarceration of participant (custody of a state, local or federal law enforcement agency); - Death of participant; - Enrollment with an alternate State Waiver/ Program (DD Waiver); - No longer eligible for Medicaid; - No longer meets clinical eligibility for continued High Fidelity Wraparound enrollment	Fully Met

Note: "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.

#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
26		Methods by which the MCP assures the 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]		Review Not Required
27		Whether the state chooses to limit disenrollment.	Disenrollment requested by the enrollee may occur for cause at any time. [SOW pg. 14]	12.13.2020: Consistent with the SOW, the 2019-2020 WY Provider Handbook indicates that "a youth or guardian may request disenrollment for any reason." The Handbook also provides the following examples of reasons for a youth to request disenrollment from the CME program [pg. 19]: - Poor quality of care (Clinical alerts Quality, through the Care Worker, that a member requested a discharge for quality of care); - Lack of access to services covered under the contract; - Lack of access to providers experienced in dealing with the enrollee's care needs	Fully Met
28		Medicaid/CHIP agency enrollee disenrollment request policies.	The enrollee (or his or her representative) must submit an oral or written request to the Contractor requesting disenrollment. Causes for disenrollment may include reasons such as a move out of state, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's care needs. [SOW pg. 14] 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]	12.13.2020: Magellan outlines the following enrollee disenrollment request policies in the 2019-2020 WY Provider Handbook: - The guardian must submit an oral or written request to Magellan requesting disenrollment either directly or through the plan of care. - Disenrollment for enrollees, requested by the Magellan, are reviewed and approved by the State. - Should Magellan fail to make a disenrollment determination within the specified timeframe, the disenrollment is considered approved for the effective date that would have been established had the Magellan made a determination in the specified timeframe. [pg. 19-20] As indicated in the 2019-2020 WY Provider Handbook, Magellan sends all enrollees "Notices of Disenrollment" letters, regardless of the cause. However, if enrollees lose program eligibility because the State of Wyoming ended their Medicaid eligibility, Magellan will only send the Notice of Disenrollment letter because the state took the adverse action. Magellan also clearly notes the requirement to provide a copy of the disenrollment letter sent to the enrollee to the State, so it may verify that Magellan did not require disenrollment for reasons other than those permitted under the contract. [pg. 20] The Handbook also notes that disenrollment requests can be filed by providers if the youth and family fail to engage in the HFWA process prior to submission of the initial POC. Provider disenrollment requests must be submitted in writing via email to Clinical. [pg. 19] 2.15.2021: Magellan submits disenrollment counts quarterly via Appendix G of the quarterly report. This includes discharge reasons and counts. WDH also receives a copy of each disenrollment letter sent.	Fully Met
29		Whether the Medicaid/CHIP agency allows the MCP to process enrollee requests for disenrollment.	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 pg. 14-15]		Review Not Required

Note: "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.

#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
30		Whether the Medicaid/CHIP agency requires enrollees to seek redress through the MCP's grievance system before the Medicaid/CHIP agency makes a disenrollment determination on the enrollee's request.			Review Not Required
31	**Coverage and authorization of services** **Medicaid:** 42 C.F.R. § 438.210(a–e)*: Coverage and authorization of services, including 42 C.F.R. § 440.230 Sufficiency of amount, duration, and scope; 42 C.F.R. § Part 441, Subpart B: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21;* and 42 C.F.R. § 438.114, Emergency and post-stabilization services **CHIP**: 42 C.F.R. § 457.1230(d):	Obtain from the state any amount, duration, and/or scope of service requirements that are greater than those set forth in 42 C.F.R. § 440.230 or, for enrollees under the age of 21, as set forth in 42 C.F.R. § Part 441, Subpart B.	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. The Contractor shall review one hundred percent (100%) of all plans of care submitted and report this information to the Agency quarterly. The Contractor shall require all contracted providers to submit plans of care that meet Agency defined requirements for the provision of waiver services as part of the provider network. All plans of care components are evaluated for adequacy, applicability, assurance that the plan meets the youth and family needs as identified by the various evaluation/assessments performed and that appropriate safeguards are identified to protect the health and welfare of the waiver youth. The Contractor shall submit data to the Agency annually showing remediation for individual problems related to the plan of care. [SOW pg. 24] The Contractor must ensure each FCC establishes a crisis plan as part of the child's overall POC to assist in stabilizing the child and family while helping to manage crises. The initial crisis plan shall be developed during the initial SNCD process and updated with the POC. [SOW pg. 5]	12.17.2020: The 2019-2020 WY Provider Handbook describes that all services much be identified in the Plan of Care, and the POC is submitted to CME for review and authorization. [pg. 22] The 2019-2020 WY Provider Handbook specifies that POCs must contain certain elements, including "A plan based on the individual family and child or youth needs, strengths and preferences" and a crisis plan. [pg. 16] Per the 2019-2020 WY Member Handbook, the initial crisis plan is developed during phase 1 (1-30 days). [pg. 14-15] Magellan submits POC review data quarterly via Committee Data Files. Quarterly Committee Data Files provide the total number of Plans of Care, as well as the total number of Plans of Care reviewed: - Q1: 202 POCs reviewed; 66 percent of total POCs. - Q2: 210 POCs reviewed; 78 percent of total POCs. - Q3: 256 POCs reviewed; 82 percent of total POCs. - Q4: 143 POCs reviewed; 50 percent of total POCs. Since Magellan did not review 100 percent of all submitted plans of care, this requirement is partially met. Quarterly Committee Data Files also provide data on Magellan's compliance with incorporating crisis plans into the POC: - Q1: 99 percent of POCs include crisis plans; - Q2: 100 percent of POCs include crisis plans; - Q3: 99 percent of POCs include crisis plans; and - Q4: 100 percent of POCs include crisis plans 2.9.2021: Per discussion with Magellan on 2/3, the remediation process related to plans of care is tracked within the non-authorization report. The report includes number of administrative non-authorizations, clinical non-authorizations, untimely filings, and details for each determination, listed by provider. While the non-authorization report is not sent to the State, information from the report is included as part of OP-19 reporting.	Partially Met

Wyoming Department of Health – SFY 2020 External Quality Review Technical Report
Appendix G: Protocol 3 - Compliance Review Tool

Note: "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.

#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
32	Coverage and authorization of services 42 C.F.R. § 457.1228: Emergency and post-stabilization services *Note: 42 C.F.R. § 438.210(a)(5), § 438.210(b)(2)(iii), § 440.230 and §441 Subpart B do not apply to CHIP	Obtain from the state any statutory, regulatory and policy definitions of “medical necessity”, as well as any quantitative and non-quantitative treatment limitation limits set forth in those sources.	The Contractor will only conduct prior authorization (PA)/utilization management (UM) of HFWA, respite and Youth and Family Training (YFT) and Support Services provided to enrolled youth. The Agency currently has an alternate agreement in place for conducting PA and UM for children and youth requiring a PRTF level of care or acute psychiatric stabilization according to the Agency’s criteria. The Contractor must work with this vendor frequently to ensure timely and efficient referral between programs. The PA/UM process referenced above will require the Contractor to implement Medical Necessity reviews and decisions for eligibility into the CME. [SOW pgs. 8-9]	12.17.2020: In Benefit Certification & Appeal General Guidelines, Magellan outlines their process for Medical Necessity reviews and decisions for eligibility into the CME program. Magellan states that "Clinical criteria is applied using the available clinical information to decide the medical necessity of the benefit request," which is "applied consistently for similarly situated insured individuals." Clinical criteria is obtained during the benefit certification or appeal, and uses Magellan Care Guidelines (Milliman Care Guidelines (MCG) for higher levels of care; Magellan Medical Necessity Criteria for specialty outpatient services; American Society of Addiction Medicine (ASAM) for Substance Use Disorder (SUD) services where required by state or account and other state or account mandated criteria). Magellan Care Guidelines are reviewed and assessed annually for consistency with current UM policies, system scripting or algorithms, adopted clinical practice guidelines and CMS Medicare’s coverage determinations. [pg. 3, 10] The benefit certification and appeal process is structured as follows: [pg. 13-15] 1. Initial Administrative Review: Staff collect general information (i.e. demographics, requestor and coverage requested) and other structured clinical related data. 2. Initial Clinical Review: Clinical staff perform reviews of the clinical aspects of the requested benefit/coverage against the approved and established clinical criteria. Reviewers collect information in addition to the data collected during initial review and review the request for medical necessity using the appropriate approved clinical criteria. Reviewers use the same clinical criterion for the requested level of care throughout the member’s episode of care and appeal, if applicable. 3. Peer Clinical Review: Additional clinical staff review the benefit request to make a medical necessity decision resulting in an approved certification or adverse benefit determination. When a request is for services that Magellan or the account consider to be experimental or investigational services, the benefit certification process is initiated to decide the medical necessity of the requested benefit based upon the approved clinical criteria. [pg. 9] Magellan also outlines processes for when clinical information is not made available during the benefit certification process (also known as administrative-based decision of a benefit request). In this case, requesters are notified immediately (verbally and in writing) of additional clinical information needed and the timeframe within which the provider has to submit the clinical information, as well as in what manner the information may be submitted (i.e., verbally and/or in writing.) [pg. 8] It is clear that Magellan has implemented processes to establish Medical Necessity reviews and decisions for eligibility into the CME. Manual_CMS-1500_07.01.2020 specifies the Agency's alternate agreement with WYhealth, in place for prior authorization for Psychiatric Residential Treatment Facility (PRTF). [pg. 15]	Fully Met
33		Obtain from the state Medicaid/CHIP agency the state-established standards for MCP 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]		Review Not Required

Note: "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.

#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
34		Any Medicaid/CHIP agency drug authorization requirements, including whether the Medicaid/CHIP agency requires approval of outpatient drugs before its dispensing under Section 1927(d)(5)(A) of the Act.	The Contractor must ensure each FCC has knowledge of the current medications for children and youth they serve. If there is a concern, CME will consult with Seattle Children's Hospital (SCH). [SOW pg. 8] The Contractor must provide a quarterly report with the number of consultations CME has with SCH. [SOW pg. 8]	12.17.2020: In the 2019-2020 WY Provider Handbook, Magellan requires all CME providers to discuss the youth's current medications in CFT meetings. A listing of current medications must be included and regularly updated in the Plan of Care. [pg. 15] Magellan provides quarterly reports of the number of consultations the CME has with Seattle Children's Hospital (SCH) in Committee Data Files. According to Committee Data File - Q4 - Final, Magellan had no consultations with SCH in SFY 2020.	Fully Met
35	**Information requirements for all enrollees** **Medicaid:** 42 C.F.R. § 438.100(b)(2)(i) Enrollee right to receive information in accordance with 42 C.F.R. § 438.10: Information requirements **CHIP:** 42 C.F.R § 457.1220: Enrollee rights 42 C.F.R § 457.1207: Information requirements	Whether the Medicaid/CHIP agency, enrollment broker, or MCP must provide all required information to enrollees.	The Contractor must make its written materials available to enrollees including, at a minimum, provider directories, policies and procedures, enrollee handbooks, enrollee rights and responsibilities, appeal and grievance notices, appeals, denial and termination notices, and fair hearing procedures with timeframes as specified in the Agency's rules on beneficiary fair hearing processes. 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. 15-16]	12.17.2020: In the 2019-2020 WY Member Handbook, Magellan outlines member rights and responsibilities [pg. 23], enrollee grievances [pg. 26], enrollee appeals [pg. 27], and rights to a State fair hearing with associated timeframes for request (120 days from Magellan's notice of resolution) [pg. 28]. The Member Handbook can be made available in the member's preferred language, such as Spanish, or in a format such as Braille, upon contacting Magellan by phone. [pg. 5] Protocol 3 Enrollee Services PAHP Provider Directory provides a public-facing provider directory made available to enrollees. The 2019-2020 WY Member Handbook also provides details regarding the amount, duration, and scope of benefits made available to members by the CME program. Magellan outlines expectations and services provided by each provider type (Family Care Coordinator, Family Support Partner, Youth Support Partner, Respite, paid supports, and non-paid supports) and other benefits provided through the CME program (flex funds, Youth and Family Training, telehealth). [pg. 9-10] Magellan also outlines the phases of HFWA services in the Member Handbook, including (1) Engagement and preparation; (2) Initial planning; (3) Plan implementation; and (4) Transition to discharge. [pg. 12-18]. The Engagement and preparation section includes required procedures and documentation for obtaining benefits, including the Strengths, Needs, and Culture Discovery (SNCD), the Child and Adolescent Needs and Strengths (CANS) Inventory, and the Adverse Childhood Experiences (ACEs) survey. [pg. 12] For the purpose of the External Quality Review, Magellan provided notices sent to members, including Grievance Acknowledgement Letter, Grievance Resolution Letter, and Enrollee Appeal Response Letter. Each notice follows the same format and is made available in Spanish / can be translated upon request. The Member Handbook is available electronically on Magellan's website, which also indicates that members can request a hard copy. At the time of review, the website is: https://www.magellanofwyoming.com/youth-families/why-wraparound/family-youth-guide/. However, it is unclear if Magellan "advises the enrollee in paper or electronic form that the information is available on the Internet" (as specified in the SFY 2020 Contract). Additionally, copies of grievance / appeal notices are not included in the Member Handbook, and it is unclear if they are made available to members. 2.10.2021: Per discussion with Magellan on 2/3, copies of the Member Handbook are routinely provided to enrollees. However, it remains unclear if Magellan advises enrollees of online access to the Member Handbook, or if grievances and appeals notices are made available to enrollees as part of the Member Handbook. This requirement is partially met.	Partially Met

Note: "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.

#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
36		Medicaid/CHIP agency developed definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care.	None	12.20.2020: WDH's SOW does not specify the required managed care terminology indicated in 42 CFR § 438.10 (c)(4)(i). Upon initial review of Wyoming's Administrative Rules for the Department of Health, some of the managed care terms are defined in administrative rule, but are not referenced in the SOW. Additionally, Magellan's glossary of key terms for members in 2019-2020 WY Member Handbook does not address all Medicaid/CHIP agency developed definitions for managed care terminology, as specified in the associated MCP standard. [pg. 31-33] 1.11.2021: Wyoming defines most managed care terminology listed in the requirement within Wyoming Department of Health's Medicaid Administrative Rule, including Chapter 1 (Definitions), Chapter 3 (Provider Participation), Chapter 10 (Pharmaceutical Services), and Chapter 26 (Covered Services). Wyoming defines the following terms in State administrative rule: - Co-payment (1-9) - Durable medical equipment (1-13) - Emergency medical condition (defined as "Emergency") (1-13) - Emergency services (defined as "Emergency hospital services") (26-2) - Habilitation services and devices (defined as "Habilitative services") (26-2) - Home health care (defined as "home") (1-16) - Hospice services (26-3) - Hospitalization (defined as "hospital") (1-16) - Hospital outpatient care (defined as "Outpatient hospital services") (1-22) - Medically necessary (1-19) - Physician services (defined as "Physician") (1-24) - Plan (defined as "Plan of care") (1-24) - Preauthorization (defined as "Prior authorization") (1-25) - Participating provider (defined as "Provider") (1-26) - Prescription drug coverage (defined as "prescription drug") (10-3) - Provider (1-26) - Rehabilitation services and devices (defined as "Rehabilitative services") (26-3) - Skilled nursing care (defined as "Skilled nursing service") (1-28) While the State does not directly define other terms listed in the requirement, Wyoming offers the following disclaimer in rules that do not specify definitions: "Except as otherwise specified in Chapter 1 of the Wyoming Department of Health's Medicaid Rules, the terminology used in this Chapter is the standard terminology and has the standard meaning used in health care, Medicaid, and Medicare." Since Wyoming has defined 18 of the 32 specified managed care terms in state Administrative Rule, and does not clarify which definitions Magellan should use, this requirement is partially met.	Partially Met

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#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
37		Medicaid/CHIP agency developed model enrollee handbooks and enrollee notices.	The Contractor must make its written materials available to enrollees including, at a minimum, provider directories, policies and procedures, enrollee handbooks, enrollee rights and responsibilities, appeal and grievance notices, appeals, denial and termination notices, and fair hearing procedures with timeframes as specified in the Agency's rules on beneficiary fair hearing processes. 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. [SOW pg. 15-16]	1.4.2021: As described in Requirement 35 above, 2019-2020 WY Member Handbook contains all required elements. However, it is not clear if Magellan uses "State developed enrollee notices" and "Agency model enrollee handbook," so this requirement is partially met.	Partially Met
38		The language(s) that the Medicaid/CHIP agency determines are prevalent in the MCP's geographic service area, and all non-English languages that the Medicaid/CHIP identifies.	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]		Review Not Required
39		Policies relevant to written material language and format, for example, policies relevant to inclusion of taglines.	The Contractor shall ensure that all written materials are provided in an easily understood language and format. Written materials must also be made available in alternative formats upon request of the potential enrollee or enrollee at no cost. Auxiliary aids and services must also be made available upon request of the potential enrollee or enrollee at no cost. 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. Written materials must include the toll-free and TTY/TDY telephone number of the Contractor's member/customer service unit. [SOW pg. 17]	12.20.2020: The 2019-2020 WY Member Handbook is made available in the member's preferred language, such as Spanish, or in formats such as Braille, upon request. Magellan provides the phone number (toll-free and TDD/TTY) and website through which a member can request written material in a preferred language / format. [pg. 5] Additionally, the Member Rights section includes "Get things translated for free" [p.25] and Magellan indicates it "provides free aids and services to people with disabilities to communicate effectively with us..." [p.36]. For the purpose of the External Quality Review, Magellan also made available marketing materials from SFY 2020, including the 2019 Family Recruitment Postcard, Family and Respite Brochures, CME Program Infographics, Health Awareness content, social media postings, and other materials. Magellan provides a translated version of the Family Brochure in Spanish. Other materials provided are written in English. Magellan also provided links to further marketing materials in Quick Links to Magellan of Wyoming Marketing, which encompassed member newsletters, Circle of Strength member newsletters, stakeholder newsletters, press releases, and the Magellan of Wyoming website and Facebook page. Newsletters are written using accessible language, but incorporate small fonts. Additionally, Magellan makes Circle of Strength member newsletters available in Spanish; all other materials appear to be available only in English. However, it is not clear whether Magellan adheres to WDH's requirements regarding "easily understood" language and taglines, so this requirement is partially met.	Fully Met

Note: "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.

#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
				understood" language and taglines, so this requirement is partially met. 2.9.2021: Per discussion with Magellan on 2/3, Magellan ensures all enrollee-facing materials are written at a sixth grade reading level and also follows a comprehensive review process, engaging legal and marketing departments. If materials directly affect families and providers, Magellan may convene a small focus group to ensure content is accurate and helpful. Magellan relies on FCCs to help interpret / promote understanding of materials directly with enrollees.	
40		Any interpretation services that the Medicaid/CHIP agency makes available to enrollees.	The Contractor must notify its enrollees that oral interpretation, written translation and auxiliary aids and services are available upon request at no cost for enrollees with disabilities, and provide information on how to access those services. [SOW pg. 17]	12.20.2020: Magellan outlines aids and services provided to people who have disabilities free of cost in the 2019-2020 WY Member Handbook. These include: - Qualified American Sign Language (ASL) interpreters; - Written information in other formats (large print, audio, accessible electronic formats, other formats); - Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages; and - Auxiliary aids and services [pg. 34] Magellan also provides an email address to access these services (WyomingInfo@MagellanHealth.com)	Fully Met
41		How the Medicaid/CHIP agency defines 'reasonable time' for purposes of providing the enrollee handbook to enrollees.	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]		Review Not Required
42		Medicaid/CHIP agency developed or approved language describing grievance, appeal, and fair hearing procedures and timeframes, for inclusion in the enrollee handbook.	The Contractor must make its written materials available to enrollees including, at a minimum, provider directories, policies and procedures, enrollee handbooks, enrollee rights and responsibilities, appeal and grievance notices, appeals, denial and termination notices, and fair hearing procedures with timeframes as specified in the Agency's rules on beneficiary fair hearing processes. [SOW pg. 15-16]	12.20.2020: Magellan outlines process and timeframes for grievances, appeals, and fair hearings in the 2019-2020 WY Member Handbook. Magellan also provides points of contact for each process. [pg. 28-31]	Fully Met
43		Medicaid/CHIP agency policy on whether enrollee are required to pay costs for services while an appeal or state fair hear is pending – and the final decision is adverse to the enrollee – for purposes of the enrollee handbook.	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] 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. 22-23]	12.20.2020: In 2019-2020 WY Member Handbook, Magellan outlines the appeals process for members, including timeframes and benefits continuation. Magellan makes it clear that members "have 60 calendar days from the date of [Magellan's] written adverse determination letter to file an appeal." [pg. 27] Additionally, Magellan outlines conditions under which a member's benefits must be continued, including: - [Member], [member's] authorized representative or provider, with written consent, file the appeal timely. (Timely filing means filing on or before the later of the following: within 10 days of Magellan mailing the notice of action; or the intended effective date of Magellan's proposed action). - The appeal involves the termination, suspension or reduction of a previously authorized course of treatment; - The services were ordered by an authorized provider; - The original period covered by the original authorization has not expired; and - The member requests extension of benefits. [pg. 28] Also in 2019-2020 WY Member Handbook, Magellan explains to members that "if care was continued and Magellan or the Hearing Officer upholds the initial non-authorization decision, Magellan may have you repay for the care you received during the appeal review." Further, Magellan explains "if Magellan or the Hearing Officer overturns the initial non-authorization, Magellan will issue an authorization for the services in question." [pg. 29]	Fully Met

Note: "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.

#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
				While not included in the Member Handbook, Medicaid Adverse Benefit Determination Appeal - CO.MCD.243.07-2020 includes information regarding when services were not furnished while an appeal was pending: "If Magellan or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, Magellan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination." [pg. 13] Magellan meets all criteria for this requirement.	
44		Any content required by the state for the enrollee handbook that is not covered in 42 CFR 438.10(g).	None	12.20.2020: According to the SFY 2020 Contract, the State does not require content beyond 42 CFR § 438.10(g).	Not Applicable
45		Information on how the state has defined a “significant change” in the information MCPs are required to give enrollees pursuant to 42 C.F.R. § 438.10(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]	12.20.2020: Reviewed materials, including the 2019-2020 WY Member Handbook, do not address "significant changes" in Magellan's operations that impact service. WDH has recently developed a definition of "significant change" that impacts the Contractor's service as part of the State Managed Care Quality Strategy pending approval from CMS.	Fully Met
46		Any applicable Medicaid/CHIP 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]		Review Not Required

Note: "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.

#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
47	**Enrollee right to receive information on available treatment options** **Medicaid**: 42 C.F.R. § 438.100(b)(2)(iii) Enrollee right to receive information on available treatment options and alternatives . . . including requirements of 42 C.F.R. § 38.102: Provider-enrollee communications **CHIP:** 42 C.F.R. § 457.1222: Provider-enrollee communication	Information on whether or not the MCP 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]	12.20.2020: Within the 2019-2020 WY Member Handbook, Magellan provides a full listing of provider types (Family Care Coordinator, Family Support Partner, Youth Support Partner, Respite, paid supports, and non-paid supports) and other benefits provided through the CME program (flex funds, Youth and Family Training, telehealth). [pg. 9-10] Further, Magellan specifies that "there are not any services we do not cover because of moral or religious objections" in the 2019-2020 WY Member Handbook. Magellan also explains that members have the right to "receive information about the benefits provided by [Magellan] and about benefits you might have, that are not provided by [Magellan]." [pg. 24]	Fully Met
48	**Enrollee right to participate in decisions regarding his or her care and be free from any form of restraint** **Medicaid**: 42 C.F.R. § 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 related: 42 C.F.R. § 438.3(j): Advance directives	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 C.F.R. § 431.20 to develop such a description of state laws and to distribute it to all MCPs. Revisions to this description as a result of changes in State law are to be sent to MCPs 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

Note: "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.

#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
49	**CHIP:** 42 C.F.R. § 457.1220: Enrollee rights	Information on whether or not the MCP 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
50	**Compliance with other Federal and state laws** **Medicaid**: 42 C.F.R. § 438.100(d): Compliance with other federal and state laws **CHIP**: 42 C.F.R. § 457.1220: Enrollee rights	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 MCPs to comply.	None		Review Not Required
51	**Provider Selection** **Medicaid**: 42 C.F.R. § 438.214: Provider selection **CHIP**: 42 C.F.R. § 457.1233(a): Provider selection	Obtain from the state information on any credentialing, re-credentialing, or other provider selection and retention requirements established by the state that address acute, primary, behavioral, substance use disorder, and MLTSS providers, as appropriate.	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]		Review Not Required
52	**Sub-contractual relationships and delegation** **Medicaid**: 42 C.F.R. § 438.230: Subcontractual relationships and delegation **CHIP:** 42 C.F.R. § 457.1233(b): Subcontractual relationships and delegation	Obtain from the state the “periodic schedule” established by the State according to which the MCP 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

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#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
53	**Practice Guidelines** **Medicaid:** 42 C.F.R. § 438.236: Practice guidelines **CHIP:** 42 C.F.R. § 457.1233(c): Practice guidelines	Information on any state statutory, regulatory, or policy requirements concerning MCP practice guidelines.	The Contractor is required to use practice guidelines developed using the core values and principles of the HFWA practice. Practice guidelines should be adopted in consultation with contracting health care professionals and must be reviewed and updated periodically, as appropriate. The Contractor must disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply will be consistent with the guidelines. [SOW pg. 19]	1.25.2021: Magellan provided numerous guidelines (also referred to as "policy and standards") used to govern HFWA processes, including utilization management and service authorization (Medicaid Service Authorization Determination Policy, Benefit Certification and Appeal General Guidelines), quality improvement (Quality Improvement Program Policy), and grievances and appeals (Medicaid Adverse Benefit Determination, Medicaid Enrollee Grievances). The guidelines appear to be updated periodically (see "Corporate Policy Life History") and are approved by staff with clinical expertise. However, it is unclear if these guidelines are distributed to enrollees / providers, and if guidelines are developed in consultation with providers. While not specified as "practice guidelines", Magellan also provided training materials that leveraged the core values and principles of HFWA practice. These include Manual - Doing the Work 6-13-19 Final and Foundations - Aug 2020. Since practice guidelines do not meet all criteria outlined in the requirement, this requirement is partially met. 2.9.2021: Per discussion with Magellan on 2/3, Magellan provided the following information on practice guidelines: •Practice guidelines are developed through the National Wraparound Initiative; •Magellan consults current research to inform practice guideline adoption (trauma informed care, motivational interviewing); •In development / adoption of guidelines, Magellan conducts their own research and reviews guidelines through a number of committees (including QIC). Magellan also showed evidence of adapting national practice guidelines to the needs of the Wyoming CME population (e.g., modified transition planning; leveraging CANS data to inform processes) However, it is still unclear if guidelines are disseminated to "all affected providers" and enrollees, as stated in the requirement. This requirement is partially met.	Partially Met
54	**Health information systems** **Medicaid:** 42 C.F.R. § 438.242 **CHIP**: 42 C.F.R. § 457.1233(d):	Information on whether or not the state has required the MCP to undergo, or has otherwise received, a recent assessment of the MCP'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 MCP. 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]		Review Not Required
55		State specifications for data on enrollee and provider characteristics that must be collected by the MCP.	The performance measures provide information on ... health plan/provider characteristics, and beneficiary characteristics. [SOW pg. 14]		Review Not Required

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#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
56		Information on whether or not the state has conducted a recent review and validation of the MCP's encounter data, or required the MCP to undergo, or has otherwise received, a recent validation of the MCP's encounter data. If the state has required or received such a validation review, obtain a copy of the review from the state or the MCP. Also obtain contact information about the person or entity that conducted the validation and to whom follow-up questions may be addressed.	None		Review Not Required
57		State specifications for how MCPs are to (1) collect data elements necessary to enable the mechanized claims processing retrieval systems to provide for electronic transmission of claims data in the format consistent with the Transformed Medicaid Statistical Information System (T-MSIS); (2) collect and transmit data on enrollee and provider characteristics specified by the state, on all services furnished to enrollees through an encounter data system; and (3) Ensure that data received from providers is accurate and complete.	The Contractor must use its IT System track and report claims data via line level detail per unit of service. Data shall be submitted to the Agency's MMIS. [SOW pg. 12] The Contractor must track utilization data at least monthly. Report the percent of providers submitting claims within ninety (90) calendar days. Data showing compliance with this requirement shall be included in the quarterly data report. [SOW pg. 12] 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]		Review Not Required
58		Specifications for submitting encounter data to the Medicaid/CHIP agency in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format.	The Contractor shall also submit FFS claims regarding services delivered by network providers through the MMIS for payment. Claims will be submitted to the Agency and to CMS in standardized Accredited Standards Committee (ASC) X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats, and the ASC X12N 835 format, as appropriate. [SOW Amendment One pg. 3]	1.22.2021: Claim or Encounter Data System Flowchart illustrates the claims/encounter data process. One flowchart section indicates "837 Claim File Submitted to Magellan via Clearinghouse" and also indicates "837 Claim Submitted to Magellan via Internet Connection." Other parts within the flowchart indicate "835 Remittance." Altogether, it appears Magellan uses 837 and 835 formats.	Fully Met

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Appendix G: Protocol 3 - Compliance Review Tool

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#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
59		Make all collected data available to the state and upon request to CMS.	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. This data must be included in a quarterly report from the Contractor to the Agency and will be used by the Agency and Contractor to monitor the following: quality of care, enrollment/disenrollment, and coordination/continuity of care, coverage/authorization and grievances. [SOW pg. 13-14] The Contractor must accurately maintain records of grievances and appeals, in a manner accessible to the Agency and available upon request to CMS.[SOW pg. 21]	12.20.2020: Magellan provides quarterly data reports in Committee Data Files. Reports provide information on enrollment referrals, waiver referrals, engagement timeliness, service authorizations, claims and encounters, complaints against the Contractor, and disenrollment. However, quarterly reports did not include information on appeals or denials of referrals. According to Medicaid Enrollee Grievances - MR.MCD.403.05-2020, Magellan provides separate reporting for grievances. Specifically, Magellan provides aggregated data reports of initial grievances, grievance appeals, clinical grievances, and non-clinical grievances to the Quality Improvement (QI) committee for trending and to identify opportunities for improvement. [pg. 7] 1.4.2020: Magellan provided the record list of Wyoming CME Account Complaints/Grievances within WY CME Member grievance reporting. This document exemplifies the grievance records maintained by Magellan, which include date received, due date, type of issue, enrollee name, disposition status, and disposition type. Magellan also provided WY Member Grievance 302371, which offers additional records / fields that Magellan maintains for grievances and complaints. However, it is not clear if grievance data is reported to WDH quarterly. In Medicaid Adverse Benefit Determination, Magellan outlines requirements for recordkeeping of appeals in accordance with 42 CFR § 438.416. [pg. 13] However, Magellan provided WY CME appeals information 7.1.2019-6.30.2020 for the purpose of the EQR, which stated: "No appeals for the time frame 7/1/2019-6/30/2020." It is not clear if Magellan reports appeals data quarterly. Further information on the recordkeeping process followed by Magellan for appeals will be needed to fully satisfy this requirement. 2.9.2021: Per discussion with Magellan on 2/3, grievances are tracked in a web reporting system, while appeals are tracked locally in a spreadsheet. Magellan stated that OP-22 pertains to provider complaints, and that "grievances" always refers to enrollees. Since a local spreadsheet may not be accessible to the Agency, this requirement is partially met.	Partially Met
60		The state's procedures and quality assurance protocols to ensure that enrollee encounter data submitted by the MCP is a complete and accurate representation of the services provided to its enrollees.	The Contractor is required to screen the data received from network providers for completeness, logic, and consistency. The Contractor shall submit claims data to the Agency at a frequency and level of detail, based on program administration, oversight, and program integrity needs, and as specified by CMS and the Agency. The Contractor shall certify all claims data submitted for services rendered are accurate, complete, and truthful based on the Contractor's actual knowledge, information, and belief. [SOW Amendment One, pg. 3]	1.22.2021: Accuracy of Claims Processing - OP.364.03-2020 - Policy describes Magellan's process and standards ensuring claims accuracy. Magellan audits 2 percent of all completed claims [pg. 2]. Magellan also provided WY CME Claims Audit Results 7.1.19-6.30.20, which demonstrates results from claim auditing. Although Magellan's processes for claims accuracy are documented, the State's processes are unclear. This requirement is partially met.	Partially Met

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Appendix G: Protocol 3 - Compliance Review Tool

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#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
Quality Assessment and Performance Improvement					
61	**Quality Assessment and Performance Improvement: General rules** **Medicaid**: 42 C.F.R. § 438.330(a): General rules **CHIP:** 42 C.F.R. § 457.1240(b): Quality assessment and performance improvement program	In the event that CMS specifies national performance measures or PIP topics, whether or not the state has requested an exemption from the national performance measures or PIPs.	None		Review Not Required
62	**Basic elements of quality assessment and performance improvement program** **Medicaid**: 42 C.F.R. § 438.330(b): Basic elements of quality assessment and performance improvement programs **CHIP:** 42 C.F.R. § 457.1240(b): Quality assessment and performance improvement program	The state's specifications for performance improvement projects (PIPs) required per paragraph (d) of this section.	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. [SOW pg. 27]	12.13.2020: According to SFY2020 WY CME Program Description Final Approved, Magellan manages the WY CME Quality Program, which designs, measures, and evaluates the performance of clinical care and patient safety, disease management, preventive health services, and member services. [pg. 7] The structure of the WY CME Quality Program is specified further in Quality Improvement Program Policy. The Quality Program includes a Corporate and Strategic Business Unit (SBU), which oversees individual Operating Units, organized by topic (e.g., UM, SPD, PBM, Patient Management, Case Management). [pg. 3] 12.30.2020: Magellan provided multiple quality improvement activities (QIAs) / performance improvement projects (PIPs) for the purpose of the EQR. These include: Engagement and Implementation PIP, Enrollment Initiative QIA, and Improving Minimum Contact Engagement for Family Care Coordinators. PIPs / QIAs outline interventions that intend to achieve improvement in access and quality of care within the CME program. Each PIP / QIA includes quantifiable measures / indicators to measure performance and evaluate the effectiveness of interventions. Additionally, PIPs / QIAs outline baseline methodology, data collection methodologies, frequency, and common barriers to achievement. Magellan provides performance improvement projects that meet all specifications as required under 42 CFR § 438.330(d).	Fully Met
63		The state's specifications for how the MCP should identify, measure and report performance measures required per paragraph (c) of this section.	See *Performance Measure Reporting* . [SOW pg. 27-30]		Review Not Required

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#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
64		The state's requirements for detection by the MCP of over- and under-utilization.	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. Activities of the QAPI program must include mechanisms to detect both underutilization and overutilization of service. [SOW pg. 27]	1.4.2021: As part of the Magellan CME Quality Annual Program Evaluation, Magellan reports data to evaluate over- and/or under-utilization of services. Magellan reported number of enrollments, encounters, authorizations, and paid claims for HFWA services of Family Care Coordination (FCC), Family Support Partner (FSP), Youth Support Partner (YSP), Youth and Family Training (YRT), and Respite Care for SFY 2020. Notably, Magellan found that YFT and Respite services were under-utilized during the period. [pg. 55] Magellan includes mechanisms to detect over- and/or under-utilization of services as part of the QAPI program.	Fully Met
65		The state's requirements for assessment by the MCP of the quality and appropriateness of care furnished to enrollees with special health care needs, as defined in the state's quality strategy under 438.340 (as cross-referenced for CHIP in 457.1240(e)).	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 SPMI). Level of care is determined by use of several assessment tools, such as CASII, ECSII, CANs, ACEs.	Not Applicable
66		The state's requirements for assessment by the MCP of the quality and appropriateness of care furnished using LTSS, if applicable, including assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan.	None	Not Applicable. Requirements around LTSS do not apply to the CME program, which delivers care coordination services to children with complex behavioral needs.	Not Applicable
67		The state's requirements for the MCP's participation in efforts by the State to prevent, detect, report, investigate and remediate critical incidents, that occur within the delivery of LTSS as well as to track and trend results in order to make systems improvements, if applicable.	The Contractor must report all critical incidents in accordance to Wyoming State Statute and processes defined in the 1915(b) and 1915(c) program waivers. Data showing compliance with this requirement shall be included in the quarterly data report. [SOW pg. 11] The Contractor must, on an ongoing basis, identify, address, and seek to prevent the occurrence of abuse, neglect, and exploitation. The Contractor shall review one hundred percent (100%) of all plans of care submitted and report this information to the Agency quarterly. The Contractor shall include documentation of appropriate action demonstrating remediation for individual problems related to health and welfare. Data related to incident report trends, problem providers, corrective action plans, provider contract suspensions and all other related actions must be reported. [SOW pg. 26]	Not Applicable. Requirements around LTSS do not apply to the CME program, which delivers care coordination services to children with complex behavioral needs.	Not Applicable

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#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
68	**Performance measurement** **Medicaid**: 42 C.F.R. § 438.330(c): Performance measurement **CHIP**: 42 C.F.R. § 457.1240(b): Quality assessment and performance improvement program	Information on the standard performance measures identified by the state.	See *Performance Measure Reporting.* [SOW pg. 27-30]		Review Not Required
69		For an MCP providing long-term services and supports, the standard performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving long-term services and supports.	None	Not Applicable. Requirements around LTSS do not apply to the CME program, which delivers care coordination services to children with complex behavioral needs.	Not Applicable
70		Information on whether the MCP calculates the performance measure and reports to the state or whether the MCP provides data to the state, which then calculates the PM.	Data on performance measures is reported to the Agency quarterly or as otherwise listed in the contractual requirements negotiated between the Agency and Contractor. The quarterly reports to the Agency aid in the identification of opportunities for quality improvement and the assessment of Contractor effectiveness. [SOW pg. 14] See *Performance Measure Reporting.* [SOW pg. 27-30]	1.4.2021: Within Committee Data Files, Magellan submits calculated performance measures, as well as the numerators and denominators, to the Agency on a quarterly basis.	Fully Met
71	**Performance improvement projects** **Medicaid:** 42 C.F.R. § 438.330(d) and **CHIP**: 42 C.F.R. § 457.1240(b)	Information on any PIP requirements specified by the state.	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]	1.4.2021: Magellan reported status and results of performance improvement projects (PIPs) to the Agency within Q4 Executive Summary and Appendices. Reports provided by Magellan appear to satisfy all requirements specified by the State. For example, within the Engagement and Implementation PIP, Magellan outlined impact of interventions [pg. 156], measured performance using indicators [pg. 153], offered rationales for interventions [pg. 146], analyzed interventions based on performance measures [pg. 155], and identified further interventions / opportunities for improvement [pg. 155-160]. Magellan provided data for other PIPs within the period, including Improving Minimum Contact Engagement for Family Care Coordinators [pg. 132] and Provider Scorecards [pg. 169]. PIP reports provided by Magellan meet all criteria for this requirement.	Fully Met
72		Information on how often the state requests that each MCP report the status and results of each project conducted per paragraph (d)(1) of this section.	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]		Review Not Required

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#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
73		Information on if the state permits an MCP exclusively serving dual eligibles to substitute an MA Organization quality improvement project conducted under § 422.152(d) of this chapter for one or more of the performance improvement projects otherwise required under this section.	None		Review Not Required
74	**QAPI evaluations review** **Medicaid**: 42 C.F.R. § 438.330(e)(2): Program and review by the state **CHIP**: 42 C.F.R. § 457.1240(b): Quality assessment and performance improvement program	Information on whether the state requires its MCPs to develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program. If so, information on the frequency with which that evaluation must be conducted, and on the state's requirements for how MCPs conduct that process.	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]		Review Not Required
Grievance System					
75	**Grievance Systems** **Medicaid**: 42 C.F.R. § 438.228: Grievance and appeal systems	Obtain information on: Whether or not the Medicaid/CHIP agency delegates responsibility to the MCP for providing each 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 or review to reconsider their request for the covered service.	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. Notices must also include information regarding the expedition of the right to appeal, and the continuation of benefits, per Section 11 of this Statement of Work. [SOW pg. 21]	1.25.2021: Magellan did not provide a written notice of adverse action notification for the purpose of the EQR. 1.4.2021: While the appeals and grievances process attachment to the notice explains continuation of benefits during the State fair hearing process, the notice does not appear to address the expedition of the right to appeal. This information is made available to enrollees in the 2019-2020 WY Member Handbook; however, the Statement of Work requires this information to be included within the standard notice distributed to enrollees in the event of an adverse benefit determination. Magellan has partially met the criteria for this requirement. 2.11.2021: Magellan provided the Notice of Action - Non-Authorization after virtual discussion. The letter shows evidence of written notice of adverse action. The letter includes explanations for the determination, as well as directions for entering the appeals process / right to a hearing.	Fully Met

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#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
76	**General requirements** **Medicaid:** 42 C.F.R. § 438.402: General requirements **CHIP:** 42 C.F.R. § 457.1260: Grievance system	Information on: Whether enrollees are required or permitted to file a grievance with either the state or the MCP, or both.	None	1.4.2021: The 2019-2020 WY Member Handbook provided to enrollees by Magellan clearly articulates the process for filing a grievance. Enrollees are directed to file a grievance directly with Magellan in the event they are dissatisfied with any matter other than an adverse benefit determination. Magellan also provides the mailing address and phone number enrollees may use to file a grievance with Magellan. The Handbook further explains that enrollees can request a hearing directly with the State if they are unhappy with the outcome of a grievance filed with Magellan. The Handbook also includes a State mailing address and phone number for requesting a hearing. [pg. 26] Since Magellan provides information on the process of filing a grievance with the MCP, this requirement is fully met.	Fully Met
77		Whether providers, or authorized representatives, can act on behalf of the enrollee to request an appeal, file a grievance, or request a state fair hearing or review request.	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]	1.4.2021: According to the 2019-2020 WY Member Handbook, enrollees may have an authorized representative request an appeal or State fair hearing on their behalf. The Handbook explains to members that "You, or someone you name to act for you (your "authorized representative"), may file your appeal. The person filing for you must have your written consent." [pg. 27] Further, authorized representatives are permitted to request a State fair hearing on behalf of participants: "You, or someone you choose with your written permission, have a right to a State fair hearing with the Wyoming Department of Health if the adverse action is upheld by Magellan." [pg. 28] Magellan also makes timeframes and methods for filing appeals clear within the 2019-2020 WY Member Handbook: "You have 60 calendar days from the date of our written adverse determination letter, to file an appeal. You may request a standard or expedited appeal by calling or writing." [pg. 27] The Handbook mentions that enrollees can request and/or receive assistance with filing grievances, but does not specify that an authorized representative is permitted to file on behalf of an enrollee. [pg. 26] In Medicaid Adverse Benefit Determination, Magellan cites 42 CFR § 438.402: "If State law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee. When the term "enrollee" is used throughout this policy, it includes providers and authorized representatives..." [pg. 3] The policy also makes clear that authorized representatives may not request continuation of benefits on behalf of enrollees, because enrollees may be held liable for payment of continued services in the event an adverse action is upheld. Since Magellan incorporates this information within the Member Handbook, this requirement is fully met.	Fully Met
78		Whether state offers external medical review.	None	1.5.2021: Medicaid Adverse Benefit Determination cites applicable regulations (42 CFR 438.402(1)(i)(B)) and states that "the State may offer and arrange for an external medical review." Additionally, the document cites CFR that specify the conditions that must be met in order for external medical review to occur: "1. The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing; 2. The review must be independent of both the State and MCO; 3. The review must be offered without any cost to the enrollee; 4. The review must not extend any of the timeframes specified in 42 CFR § 438.408 as outlined in this policy; and 5. The review must not disrupt the continuation of benefits in § 438.420 as outlined in this policy." [pg. 13]	Fully Met

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#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
79	**Timely and Adequate Notice of Adverse Benefit Determination** **Medicaid:** 42 C.F.R. § 438.404: Timely and adequate notice of adverse benefit determination **CHIP**: 42 C.F.R. § 457.1260: Grievance system	Information on the timeframes within which it requires MCPs to make standard (initial) coverage and authorization decisions and provide written notice to requesting enrollees. These timeframes will be the required period within which MCPs 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 MCP) and the enrollee's right to file an MCP appeal.	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]		Review Not Required
80	**Handling of Grievances and Appeals** **Medicaid**: 42 C.F.R. § 438.406: Handling of grievances and appeals **CHIP**: 42 C.F.R. § 457.1260: Grievance system	Information on any state requirements concerning handling of grievances and appeals that differ from those required under 438.406. *Note: See the 'Disenrollment' section in Worksheet 3.2 above for grievances during disenrollment.	The Contractor must establish and maintain a grievance and appeal system, composed of the grievance, one-level appeal, and State fair hearing process, under which enrollees, or providers, acting on their behalf, may file and track grievances and appeal, and adverse action notifications. [SOW pg. 20] Grievances filled only with the Contractor may be filled orally or in writing at any time. However, 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]	1.5.2021: Magellan appears to have established policies in accordance with the Statement of Work requirements. According to Medicaid Enrollee Grievances - MR.MCD.403.05-2020, Magellan "tracks and maintains records about the receipt and disposition of grievances in a Magellan approved system, for example, the Comment Resolution Tracking Application (CART)." [pg. 4] The 2019-2020 WY Member Handbook also notes that members have transparency into this system: "You have the right to review your file before or during the appeal process. You may present information in person, by telephone or in writing. If you would like to review your file, records or any other documents about your appeal, or to present additional information, please let us know when you file your appeal." [pg. 27]. Magellan also appears to follow the timeframes outlined in the Statement of Work for this requirement. Medicaid Enrollee Grievances - MR.MCD.403.05-2020 states that 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)." [pg. 4]. Additionally, this 90-day timeframe "may be extended up to fourteen (14) calendar days." [pg. 4] Magellan also follows timeframes for delayed notification / extension of a grievance review: "Magellan makes reasonable efforts to give the enrollee prompt oral notice of the delay; Within two (2) calendar days, Magellan gives the enrollee written notice of the reason for the decision to extend the timeframe and informs the enrollee of the right to file a grievance if he or she disagrees with the decision to extend the time frame." [pg. 4] 1.11.2021: Magellan also appears to maintain records of grievances in quarterly data reports, within OP-22 (Complaints against Contractor). Data reported for OP-22 in Committee Data File - Q4 show two complaints about Magellan across SFY 2020. Magellan responded to both complaints within five business days, or a 100 percent timeliness rate. 1.25.2021: State requirements concerning the handling of grievances and appeals do not differ from the requirements included within 42 CFR § 438.406. Since Magellan has crafted internal policy that adheres to Statement of Work requirements and has reported data to show compliance, this requirement is fully met.	Fully Met

Note: "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.

#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
81	**Resolution and notification: Grievances and appeals** **Medicaid:** 42 C.F.R. §438.408: Resolution and notification, Grievances and appeals **CHIP**: 42 C.F.R. § 457.1260: Grievance system	Information on: The state-established standard time frames during which the state requires MCPs to (1) dispose of a grievance and notify the affected parties of the result, and (2) 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 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]		Review Not Required
82		The methods prescribed by the state that the MCP must follow to notify an enrollee of the disposition of a grievance.	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		Review Not Required

Note: "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.

#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
			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 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]		
83		Information on whether providers, or authorized representatives, can act on behalf of the enrollee to request an appeal, file a grievance, or request a state fair hearing request.	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]	1.4.2021: According to the 2019-2020 WY Member Handbook, enrollees may have an authorized representative request an appeal or State fair hearing on their behalf. The Handbook explains to members that "You, or someone you name to act for you (your "authorized representative"), may file your appeal. The person filing for you must have your written consent." [pg. 27] Further, authorized representatives are permitted to request a State fair hearing on behalf of participants: "You, or someone you choose with your written permission, have a right to a State fair hearing with the Wyoming Department of Health if the adverse action is upheld by Magellan." [pg. 28] Magellan also makes timeframes and methods for filing appeals clear within the 2019-2020 WY Member Handbook: "You have 60 calendar days from the date of our written adverse determination letter, to file an appeal. You may request a standard or expedited appeal by calling or writing." [pg. 27] The Handbook mentions that enrollees can request and/or receive assistance with filing grievances, but does not specify that an authorized representative is permitted to file on behalf of an enrollee. [pg. 26] In Medicaid Adverse Benefit Determination, Magellan cites 42 CFR § 438.402: "If State law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee. When the term "enrollee" is used throughout this policy, it includes providers and authorized representatives..." [pg. 3] The policy also makes clear that authorized representatives may not request continuation of benefits on behalf of enrollees, because enrollees may be held liable for payment of continued services in the event an adverse action is upheld. Since Magellan incorporates this information within the Member Handbook, this requirement is fully met.	Fully Met

Note: "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.

#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
84	**Expedited resolution of appeals** **Medicaid**: 42 C.F.R. § 438.410: Expedited resolution of appeals **CHIP:** 42 C.F.R. § 457.1260: Grievance system	None	An oral notice of appeal or an oral inquiry seeking to appeal an adverse action must be treated as an appeal and both must be confirmed in writing, unless the enrollee requests an expedited appeal. The Contractor must also provide the enrollee or the authorized representative the opportunity to present legal and factual evidence and arguments, and review the case file, including medical records or other documentation sufficiently in advance of the resolution timeframe for standard and expedited appeal resolution. The Contractor will resolve each appeal and provide the enrollee notice of the decision, as expeditiously as the enrollee's health condition requires and no more than thirty (30) calendar days. [SOW pg. 21] If the Contractor denies a request for expedited resolution of an appeal, the Contractor must transfer the appeal to the standard timeframe of no longer than thirty (30) calendar days from the day the appeal was received. [SOW pg. 21]	1.5.2020: According to Medicaid Adverse Benefit Determination, Magellan complies with the requirement to "provide that oral inquiries seeking to appeal an Adverse Benefit Determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution." [pg. 4] Additionally, Magellan provides members "a reasonable opportunity to present evidence and testimony, and allegations of fact or law make legal and factual arguments, in person as well as in writing. Members are notified of the opportunity to submit, by telephone or in writing; information that the member believes is relevant or needed in order to make a meaningful appeal, including comments, documents or other information relating to the appeal." [pg. 4] Magellan also makes this information available to members in the 2019-2020 WY Member Handbook. According to the document, "[Members] may request a standard or expedited appeal by calling or writing...If the initial standard appeal request was made orally, a written signed appeal request must be submitted to Magellan. The date of the initial oral filing will be treated as the date of the appeal request." [pg. 27] The 2019-2020 WY Member Handbook also explains to members the difference between standard and expedited appeals. [pg. 27] Since Magellan complies with applicable CFR / Statement of Work requirements through internal policy and effectively communicates policy to members, Magellan has fully met this requirement.	Fully Met
85	**Information about the grievance system to providers and subcontractors** **Medicaid**: 42 C.F.R. § 438.414: Information about the grievance and appeal system to providers and subcontractors **CHIP:** 42 C.F.R. § 457.1260: Grievance system	Information on: · Whether the state develops or approves the MCP's description of its grievance system that the MCP is required to provide to all Medicaid/CHIP enrollees (per 438.10(g)(2)(xi). [Note that under regulations at 42 C.F.R. § 438.10(g)(1) the state must either develop a description for use by the MCP or approve a description developed by the MCP.]	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 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]		Review Not Required

Note: "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.

#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
86		If the states approves, rather than develops, the description of the MCP's grievance system, information on whether or not the state has already approved the MCP's description.	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]		Review Not Required
87	**Recordkeeping requirements** **Medicaid:** 42 C.F.R. § 438.416: Recordkeeping requirements **CHIP:** 42 C.F.R. § 457.1260: Grievance system	Information on any audits or other reviews of MCP records of grievances and appeals conducted by the state	The Contractor must also ensure that individuals making decisions regarding grievance and appeals are free of conflict, were not involved in any previous level of review or decision-making, have appropriate clinical expertise for treatment, if applicable, and must consider all submitted documents and information, considered at any level of the grievance and appeal process. The Contractor must accurately maintain records of grievances and appeals, in a manner accessible to the Agency and available upon request to CMS. Records of grievances or appeals must include a general description of the reason for the appeal or grievance, date received, date of each review or, if applicable, review meeting, resolution information for each level of the appeal or grievance, if applicable, date of resolution at each level, if applicable, and enrollee name for whom the appeal or grievance was filled. [SOW pg. 20-21]	1.4.2021: Magellan provided the record list of Wyoming CME Account Complaints / Grievances within WY CME Member grievance reporting. This document exemplifies the grievance records maintained by Magellan, which include date received, due date, type of issue, enrollee name, disposition status, and disposition type. Magellan also provided WY Member Grievance 302371, which offers additional records / fields that Magellan maintains for grievances and complaints. 1.11.2021: Magellan also appears to maintain records of grievances in quarterly data reports, within OP-22 (Complaints against Contractor). Data reported for OP-22 in Committee Data File - Q4 show 2 complaints about Magellan across SFY 2020. Magellan responded to both complaints within five business days, or a 100 percent timeliness rate. 1.4.2021: The recordkeeping process followed by Magellan for appeals remains unclear. In Medicaid Adverse Benefit Determination, Magellan outlines requirements for recordkeeping of appeals in accordance with 42 CFR § 438.416. [pg. 13] However, Magellan provided WY CME appeals information 7.1.2019-6.30.2020 for the purpose of the EQR, which stated: "No appeals for the time frame 7/1/2019-6/30/2020." Since it is unclear whether Magellan maintains records of appeals in a manner accessible to the Agency, this requirement is partially met. Additionally, it is not clear whether the State conducts any audits or review of records. 2.9.2021: Per discussion with Magellan on 2/3, grievances are tracked in web reporting system, while appeals are tracked locally in a spreadsheet. Since there were no appeals for the period, Magellan does not have any data to report.	Partially Met
88	**Continuation of benefits while the MCP appeal and the state Fair Hearing are pending** 42 C.F.R. § 438.420: Continuation of benefits while the MCO, PIHP, or PAHP appeal and the state fair	Information on any state requirements concerning continuation of benefits pending appeal and state fair hearing that differ from those required under 42 C.F.R. § 420.	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. The request for continuation of benefits must be filed within ten (10) calendar days or the intended effective date of adverse action notification, whichever is later. If, at the enrollee's request, the Contractor continues or reinstates the enrollee's benefits while the appeal or request for State fair hearing is pending, the benefits must continue until the enrollee withdraws the appeal, fails to timely request continuation of benefits, or a State fair hearing decision adverse to the enrollee is issued. If the final resolution of appeal or State fair hearing upholds the adverse action, the Contractor may recover in accordance with	1.4.2021: Magellan outlines the process for continuation of benefits during the internal appeals process and hearing process in accordance with 42 CFR § 420 across numerous documents, including the 2019-2020 WY Member Handbook [pg. 28] and Medicaid Adverse Benefit Determination [pg. 12]. Both documents align with CFR in stating that "timely" filing for continuation of benefits means filing on or before the later of within 10 calendar days of Magellan sending the notice of Adverse Benefit Determination, or the intended effective date of Magellan's proposed Adverse Benefit Determination. The Statement of Work indicates "within ten (10) calendar days or the intended effective date of adverse action notification, whichever is later." [pg. 23] 1.25.2021: State requirements concerning continuation of benefits pending appeal and State	Fully Met

Note: "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.

#	Federal regulation source(s)	Medicaid/CHIP Agency Regulation Sources	SFY2020 Contract Language	Findings from Document Review	Reviewer Determination
	the state fair hearing are pending (Note: This requirement does not apply to CHIP)		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. 22-23]	1.25.2021: State requirements concerning continuation of benefits pending appeal and State fair hearing do not differ from those included within 42 CFR § 438.420. Because Magellan includes information related to continuation of benefits during the internal appeals process and hearing process in accordance with applicable CFR and State regulations, this requirement is fully met.	
89		Information on any audits or other reviews of MCP records of appeals conducted by the state, to determine MCP compliance with federal continuation of benefits requirements.	None	1.11.2021: Chapter 4 of the Wyoming Department of Health's Medicaid Administrative Rules (Medicaid Administrative Hearings) includes information on maintaining services pending appeal. However, the rule does not include information on recordkeeping for continuation of benefits. Per discussions with WDH, WDH confirmed the State conducts reviews of Magellan's records of appeals to determine compliance with continuation of benefits requirements; however, there is no formal documentation describing this process, so this requirement is partially met.	Partially Met
90		Whether state permits managed care plans to recover the cost of services. See (d) reference to "state's usual policy."	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]	1.4.2021: Magellan communicates their right to recover the costs of the enrollee's continued benefits in the event an adverse action is upheld in a fair hearing within numerous documents, including the 2019-2020 Member Handbook and WY CME Enrollee Appeal Response Letter. According to Magellan: "If care was continued and Magellan or the Hearing Officer upholds the initial non-authorization decision, Magellan may have you repay for the care you received during the appeal review." [pg. 29, Member Handbook] Medicaid Adverse Benefit Determination further describes the grievances and appeals policies and procedures followed by Magellan. According to the document: "If Magellan or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, Magellan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination. 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." [pg. 13] Magellan meets all criteria for this requirement.	Fully Met
91	**Effectuation of reversed appeal resolutions** **Medicaid**: 42 C.F.R. § 438.424: Effectuation of reversed appeal resolutions. **CHIP**: 42 C.F.R. § 457.1260: Grievance system	Information on which entity- the state or the MCP- is required to pay for services when 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]		Review Not Required

Appendix H: Protocol 4 - Network Adequacy Review 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].	1.22.21: Magellan provided a listing of providers as of 6/29/2020, including 17 group provider organizations, 61 providers within those groups, and 22 solo providers. Magellan also submits documentation annually on provider network development and scalability, as part of the Q4 Executive Summary and Appendices [pg.79-87]. The Network Development/Scalability Report indicates there were 14 active agencies and 73 certified providers at the end of SFY 2020 - it is not clear why the data from the provider listing and the Network Report do not align. 2.12.21: Per virtual discussions, some fields within the provider listing may be disregarded as they are not relevant/useful for review. All providers are listed as Tier 1 because listing other tiers resulted in duplicates in the listing. Everyone on the list is active, regardless of the data indicators in the report. When asked about discrepancies in provider counts across documents, Magellan was not able to speak to the discrepancies since the employee who managed this information was no longer with the program. Regarding reconciling provider listings between Magellan and WDH, Magellan conducts a manual reconciliation process monthly. Magellan reported there are no longer discrepancies between the WDH and Magellan listings.	2. Incomplete

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2019 Contract Language	Findings from CME Documentation	Compliance Status
(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 **2019-2020 WY Member Handbook - Final** [p. 13]. Time and distance standards do not impact member access. Rather, CME measures capacity and network adequacy through provider: beneficiary ratios.	Not applicable.
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.

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2019 Contract Language	Findings from CME Documentation	Compliance Status
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.
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].	1.22.21: Committee Data File - Q4 indicates Magellan maintained 100 percent compliance with "rate of regions with staff member present" (OP-18) throughout the fiscal year. Additionally, Magellan maintained high compliance with provider: member ratios for FCCs and FSP/YSP throughout the fiscal year (FCCs had >95 percent compliance; FSP/YSP 100 percent compliance). The Q4 Executive Summary and Appendices also includes geographic mapping of providers and members [p. 61-65]. Per the 2019-2020 WY Member Handbook - Final [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. During previous discussions, Magellan indicated that if this were an issue, it would come up in the members' WFI-EZ survey responses. 2.12.21: When asked how Magellan demonstrates it has the capacity to serve the expected statewide enrollment, Magellan described analyzing geo-access data which indicates provider locations. However, geo-mapping does not appear to include "referral and subsequent enrollment patterns" required by the SOW. Magellan acknowledges that it is difficult to anticipate enrollment and that there is a delicate balance of identifying members and providers in parallel, based on the program's structure.	2. Incomplete

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2019 Contract Language	Findings from CME Documentation	Compliance Status
(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:			
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].	1.22.21: Documentation does not address these elements. To be discussed with Magellan. 2.12.21: Per discussions with Magellan, there is an ongoing clinical "reconciliation" process conducted weekly between WDH and Magellan, which Magellan sends back to WDH. Magellan uses the eligibility report and PO7 report to confirm Medicaid eligibility. Magellan alerts WDH if youth do not appear to have Medicaid.	1. Complete

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2019 Contract Language	Findings from CME Documentation	Compliance Status
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].	1.22.21: Documentation does not address these elements. 2.12.21: Magellan observes member enrollment and utilization, and uses utilization management to target provider recruitment. Most providers expand their service offerings once enrolled, which can also impact utilization management.	1. Complete
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].	1.22.21: Per **2019-2020 WY Provider Handbook**, FCCs, FSPs, and YSPs must complete "CME and state training and certification and re-certifications processes for HFWA..." and "demonstration of fidelity to National Wraparound Initiative standards through ongoing participation in wraparound fidelity monitoring, using the WFI-EZ [p. 27-28]. Providers are expected to complete two "Tiers" of trainings within 30 and 60 days of the certification request [p.38-39]; however per previous discussions with Magellan, these timeframes are goals and not mandated. Providers may even pause trainings and return at a later date. 2.12.21: Providers undergo recertification annually. Providers receive frequent training opportunities and are up to date on the latest trends and tools. For example, twice a month Magellan holds learning collaboratives with providers. Last fall, they had a session on working with LGBT youth.	1. Complete

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2019 Contract Language	Findings from CME Documentation	Compliance Status
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]. The Contractor must ensure all providers within its provider network are enrolled Medicaid Providers. [p. 11-12]	1.27.21: Magellan includes a "Network Development/Scalability Report" within the **Q4 Executive Summary and Appendices**. The report indicates there were 14 active agencies and 73 certified providers at the end of SFY 2020 [pg. 80-87]. **Q4 Executive Summary and Appendices** also indicates "Regional network coverage continues at 100 percent and referral need continues to be met" and "100 percent of network providers actively enrolled with WY Medicaid" [pg. 2]. Magellan monitors provider: member ratios and provider training compliance via performance measures submitted in the quarterly reports. **Committee Data File - Q4** indicates Magellan maintained high compliance with provider: member ratios for FCCs and FSP/YSP throughout the fiscal year (FCCs had >95 percent compliance; FSP/YSP 100 percent compliance). The rate of providers in network meeting all requirements was 94 percent for the entire year.	1. Complete
5e	(v)	The numbers of network providers who are not accepting new Medicaid patients.	No pertinent language from the SOW.	1.27.21: Documentation does not address these elements. 2.12.21: Magellan heavily relies on individual providers to keep network information updated, including whether they are accepting new members. This has historically been a challenge for Magellan. Magellan conducts significant provider outreach to ensure proper updates are made, but this is not always at 100 percent compliance. For this reason, the clinical team will always individually reach out to a provider to confirm availability before making a referral. If they aren't available, Clinical will encourage providers to change data. Magellan does have the ability to amend providers' information in the directory. For example, Magellan consults the Active Provider Report – if there was a provider on a referral hold or corrective action, the report would have flagged this internally. Magellan will update the provider directory based on flags. Magellan also holds discussions internally – if provider has 10 members and another referral, will trigger a discussion. As a precaution, whenever possible, Magellan requests that members identify a first and second provider option in case there are any availability issues.	1. Complete

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2019 Contract Language	Findings from CME Documentation	Compliance Status
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].	1.27.21: Magellan includes a "Network Development/Scalability Report" within the **Q4 Executive Summary and Appendices** [pg. 80-87], which provides the counts of all provider types overall and by region, as well as geographic maps. The maps indicate that members reside in 18 of Wyoming's 23 counties. Almost all counties with members also have FCCs and FSPs who have committed to serving that county; however, a few counties have members but no FCCs - Park, Teton, Hot Springs, and Washakie counties all have eligible members but no active FCC providers. Although there are providers in nearby counties (e.g., Big Horn, Fremont), counties in the northwestern corner of Wyoming cover large portions of land, and travel time may pose barriers to access. Beyond FCCs, the geomapping notes a scarce supply of Youth Support Partners, with only two providers across the entire state. Lastly, the geomapping also shows signs of a potential uneven distribution of CME providers in Wyoming. Multiple counties - including Campbell, Carbon, Converse, Lincoln, and Niobrara - all have more active FCCs than eligible members. Per the SOW, CME must serve all geographic areas. CME did not meet this requirement in SFY 2020 since four counties with members did not have FCCs. 2.12.21: Per discussions with Magellan, providers from neighboring counties cover any gaps. Travel between northwest counties is feasible since many of the communities are near the county lines. When Magellan when to 100 percent telehealth service delivery due to COVID-19, geographic gaps were no longer problematic.	2. Incomplete

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2019 Contract Language	Findings from CME Documentation	Compliance Status
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].	1.27.21: It is evident that interpreters and translation are available for Magellan communications and resources are available for individuals with disabilities [2019-2020 WY Member Handbook p. 25-27], and some providers are proficient in other languages (e.g., Spanish, sign language) [Q4 Executive Summary and Appendices p.80]. However, it is not clear how the providers themselves are sufficient for providing access to enrollees with limited English proficiency or disabilities.	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].	1.28.21: Access for physical and mental disabilities is addressed in 5g above. **2019-2020 WY Provider Handbook** 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.52]. Providers factor cultural considerations into the Strengths, Needs, and Cultural Discovery document [**2019-2020 WY Member Handbook** p.14]. **Q4 Executive Summary and Appendices** 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. 88-91].	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].	1.28.21: **2019-2020 WY Member Handbook - Final** provides a toll free 855 number to contact Magellan but does not indicate the hours of availability [pg. 1]. Additionally, Magellan offers optional telehealth services [p.12]. 2.12.21: Per discussions with Magellan, members can contact Magellan via phone 24/7. Magellan's CME local hours are Monday-Friday 8-5. If calls are received after hours, calls would go to voicemail and would be answered the next day. Call center staff will answer any call and will transfer to local numbers if needed. Local Magellan number is also advertised to members. Since staff are not available 24/7 to respond to enrollee calls, Magellan does not meet the SOW requirements.	2. Incomplete

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2019 Contract Language	Findings from CME Documentation	Compliance Status
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.

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2019 Contract Language	Findings from CME Documentation	Compliance Status
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.

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2019 Contract Language	Findings from CME Documentation	Compliance Status
(e) Publication of network adequacy standards.					
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].	1.29.21: 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.	1. Complete

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2019 Contract Language	Findings from CME Documentation	Compliance Status
§ 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 must:					
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.

Appendix I: Protocol 6 - Survey Worksheets

WFI-EZ ENROLLEE SATISFACTION SURVEY

Worksheet 6.1. Survey Purpose, Objectives, and Audience

Survey purpose, objectives, and audience: Wraparound Fidelity Index, Short Form (WFI-EZ)

- Purpose: The purpose of this evaluation is to determine the extent to which the services and supports that are being received by children, youth, and families enrolled in services in adhere to those primary activities of the wraparound process on an individual youth or family basis, and explore caregiver and youth satisfaction as well as youth outcomes.[1]
- Objectives: Not defined
- Audience: This annual report is to evaluate the strengths and opportunities to improve fidelity to the model, to bring this information to providers, families, youth, and stakeholders for planning further community involvement, and to provide a baseline to measure improvement for the next annual measurement.

Assess the clarity of the survey purpose and audience by answering the following questions. Insert comments to explain "No" and "Not applicable" responses.

Question	Yes	No	NA	Comments
Was there a clear, written statement of the survey purpose that addresses access, timeliness, and/or quality of care?	✓	--	--	Magellan indicates "The purpose of this evaluation is to determine the extent to which the services and supports that are being received by children, youth, and families enrolled in services in adhere to those primary activities of the wraparound process on an individual youth or family basis, and explore caregiver and youth satisfaction as well as youth outcomes." The purpose statement addresses quality of care since the survey is intended to help determine how services adhere to wrapround principles and measure satisfaction. *Source: WY HFWA WFI-EZ Annual Report June 2020*
Was the unit of analysis clearly stated?	✓	--	--	There are four types of respondents: 1. Parents or caregivers 2. Youths 11 years of age or older 3. Wraparound facilitators 4. Team members *Source: WY HFWA WFI-EZ Annual Report June 2020*
Did the unit of analysis include individual MCPs?	--	--	✓	Magellan is the only managed care plan within the CME program.

[1] WY HFWA WFI-EZ Annual Report June 2020

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
Was there a clear and measurable written study objective?	✓	--	--	Magellan describes the objectives as follows: "The Wraparound Fidelity Index, Short Form (WFI-EZ) is designed to assess the extent to which the core activities of wraparound are being implemented in service delivery, according to the model defined by the National Wraparound Initiative. The purpose of this evaluation is to determine the extent to which the services and supports that are being received by children, youth, and families enrolled in services in adhere to those primary activities of the wraparound process on an individual youth or family basis. Additionally, the Satisfaction Section will be used for the Satisfaction Survey to meet CME contract requirements. Wraparound coaches use the aggregate reporting on strengths and opportunities for recertification activity." *Source: WFI-EZ Methodology and Tool WY*
Was the audience for and intended use of the survey findings identified?	✓	--	--	Magellan indicates that survey findings are shared with providers, families, youth, and stakeholders for planning further community involvement, and to provide a baseline to measure improvement for the next annual measurement. *Source: WY HFWA WFI-EZ Annual Report June 2020*
Overall validation assessment: In the comments section, note any recommendations for improving the survey purpose, objective, and audience				Magellan could improve survey overview by describing the survey objectives.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Worksheet 6.2. Work Plan

Date of work plan: Magellan did not provide a work plan and clarified that all processes are adopted from the existing tool/survey developed by University of Washington. Although Magellan did not provide a specific work plan, the following documents included information regarding survey administration:

- Wraparound Fidelity Index Manual for Training, Administration, and Scoring of the WFI-EZ 1.0
- WFI-EZ 2018 Administration Instructions for Family Care Coordinators
- Wraparound Fidelity Index – Short Form (WFI-EZ) Methodology

Assess the adequacy of the work plan by answering the following questions. Insert comments to explain "No" and "Not applicable" responses. (Note: Validation of the work plan occurs in conjunction with Activity 5, Review Survey Implementation According to the Work Plan.)

Question	Yes	No	NA	Comments
Did the work plan include a project management plan (including key staff and roles)?	--	✓	--	Key staff and roles were not defined in reviewed documentation. Per virtual discussions, the Wyoming Family Support Coordinator receives a tracker of youth with WFI-EZ surveys due. The Family Support Coordinator emails surveys to eligible respondents. Additionally, Family Care Coordinators help ensure that all survey participants are given the full opportunity to complete the WFI-EZ survey. *Source: Virtual discussions with Magellan; WFI-EZ 2018 Administration Instructions for Family Care Coordinators*
Did the work plan include a project schedule (including timelines and deliverable dates)?	--	✓	--	WFI-EZ surveys are administered on a rolling basis once members become eligible. Once members meet the 150 day program enrollment threshold (and are approaching the 6-month interval), they are sent a survey. Members must be with their assigned FCC for 60 days before survey completion. Members have 30 days to complete the survey; however, the survey is left open until youth are discharged. Surveys are administered once per youth. *Source: Virtual discussions with Magellan*
Did the work plan specify project reporting requirements (including the number, format, and content of the reports)? • The work plan should include a description of any reports that the EQRO will be responsible to publicly	✓	--	--	Per virtual discussions, Magellan provides a final report to WDH. Final reports are not shared publicly. Magellan discusses survey results with providers, coaches, internal Quality Improvement Committee, and external Quality Improvement Committee (includes youth, providers, other stakeholders). Magellan

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
release, if this is part of the EQRO's scope of work				also pulls reports of descriptive and frequency statistics, summaries by item, domain, and total at least quarterly when a region reaches 20 youth. *Source: Virtual discussions with Magellan; Wraparound Fidelity Index – Short Form (WFI-EZ) Methodology*
Did the work plan include a data preparation plan, such as production of data files, data file format, and delivery?	--	✓	--	Magellan does not describe a data preparation plan. However, per virtual discussions, Magellan uses WrapTrack system which conducts all data summaries, reporting, and visuals. Magellan sends surveys via email. *Source: Virtual discussions with Magellan*
Did the work plan include a data analysis plan (including the use of a statistician as appropriate)? • The EQRO should use a statistician to develop an analysis plan that supports the survey purpose and objectives and is consistent with the intended use of results • If feasible, the EQRO should provide the state with a mock-up of the analysis before administering the survey. This will assure the survey analysis will be consistent with the intended use of results	--	✓	--	Magellan did not provide a data analysis plan.
Did the work plan include data security protocols and procedures for assuring the confidentiality of data in compliance with HIPAA?	--	✓	--	Magellan does not describe data security protocols and procedures for assuring compliance with HIPAA within reviewed documentation. However, per virtual discussions, surveys do not include identifiable data. Surveys are submitted anonymously – each youth receives a de-identified survey ID code. *Source: Virtual discussions with Magellan*
Overall validation assessment: In the comments section, note any recommendations for improving the work plan				Magellan should develop a work plan which governs implementation of the survey and includes project management details, timeframes, reporting requirements, etc.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Worksheet 6.3. Survey Instrument

Name of survey instrument: WFI-EZ

Assess the selection of the survey instrument by answering the following questions. Insert comments to explain "No" and "Not applicable" responses. Complete a separate worksheet for each survey instrument.

Question	Yes	No	NA	Comments
Was the selected survey instrument appropriate for the purpose of the survey and the unit of analysis?	✓	--	--	The survey instrument is appropriate for measuring the extent to which services align with wraparound principles.
Were new items developed for the survey?	--	✓	--	The survey is an existing survey developed by University of Washington. Magellan did not make any modifications to the survey.
If new items were developed, was a test of validity and reliability conducted for the new items?	--	--	✓	New items were not developed.
Was the overall survey instrument tested for face validity and content validity and found to be valid?	✓	--	--	Magellan does not perform any additional testing. The survey is used as is. Per the University of Washington, the WFI-EZ is a brief, self-administrated version of the WFI-4 survey. The WFI-4 survey has been tested for validity, including content validity, criterion-related validity, discriminant validity, construct validity. *Source: WFI-EZ Manual Final*
Was the overall survey instrument tested for reliability and found to be reliable?	✓	--	--	Magellan does not perform any additional testing. The survey is used as is. Per the University of Washington, the survey has "demonstrated good test-retest reliability and internal consistency." *Source: WFI-EZ Manual Final*
Was testing performed for the specific target population (e.g., Medicaid or CHIP) and languages?	--	✓	--	Magellan does not perform any additional testing. The survey is used as is.
Overall validation assessment: In the comments section, note any recommendations for improving the selection of the survey instrument				Magellan could improve its final report by describing more about the survey instrument. For example, if the survey instrument is an existing, validated survey, this increases confidence in the findings.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Worksheet 6.4. Sampling Plan

Assess the sampling plan by answering the following questions. Insert comments to explain "No" and "Not applicable" responses.

Question	Yes	No	NA	Comments
Was the study population clearly defined?	✓	--	--	All caregivers, youth over age 11, facilitators, and team members involved in wraparound services and with an FCC for at least 60 days at the six-month Plan of Care are offered a WFI-EZ survey. For SFY 2020, there were 120 eligible youth. *Source: WY HFWA WFI-EZ Annual Report June 2020*
Was the sampling frame clearly defined and appropriate based on the survey objectives?	--	✓	--	WY Family Support Coordinator receives a listing of youth with WFI-EZ surveys due. It is not clear which listing Magellan originally uses to identify eligible members. *Source: Virtual discussions with Magellan*
Was the sampling frame free from bias?	--	--	✓	The sampling frame was not described and therefore it is not clear whether it was free from bias.
Was the sampling method appropriate to the survey purpose?	✓	--	--	Magellan selects youth who have been involved with the program long enough to report meaningful information.
Was the sample size sufficient for the intended use of the survey (acceptable margin of error, level of certainty required)?	✓	--	--	For SFY 2020, there were 120 eligible youth and survey responses represented 110 of the eligible youth (92 percent). *Source: WY HFWA WFI-EZ Annual Report June 2020*
Were the procedures used to select the sample appropriate and protected against bias?	✓	--	--	Procedures for selecting the sample appear appropriate. All youth who meet certain criteria (length of enrollment in the program) are offered a survey. The University of Washington encourages survey administrators to use a strategic sampling plan that achieves representativeness and achieves a high (>80 percent) data collection completion success rate. *Source: WFI-EZ Manual Final*
Overall validation assessment: In the comments section, note any recommendations for improving the sampling plan				The sampling plan was well-defined overall; Magellan could add more detail regarding the sampling frame.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Worksheet 6.5. Strategy to Maximize Response

Assess the strategy for locating sample members and specific data needed to administer the survey by answering the following questions. Insert comments to explain "No" and "Not applicable" responses.

Question	Yes	No	NA	Comments
Was locating of sample members conducted to ensure complete contact information? Locating is a technique used to improve response rates by locating and contacting sample members. This includes verified collection of data, such as first and last name, home address, email address, phone number(s), date of birth, language preference, etc.	--	✓	--	Magellan does not contact members individually prior to survey release. Survey information is communicated to members within the Member Handbook. *Source: Virtual discussions with Magellan*
Were any of the following strategies included to maximize response: • Advance letter • Multiple and varied call attempts • Multi-mode surveys • Multiple languages	✓	--	--	Magellan employs multiple and varied attempts as well as multi-mode surveys. The survey is initially sent via email. If the survey has not been completed by the six-month Plan of Care meeting, a final attempt is made to collect the survey by paper. Additionally, Magellan offers the survey in both English and Spanish. *Source: Virtual discussions with Magellan; WY HFWA WFI-EZ Annual Report June 2020*
Were strategies customized to the study population (e.g., providers versus beneficiaries)?	✓	--	--	Enrollee outreach is focused on written materials (e.g., Member Handbook) whereas provider outreach is concentrated on provider meetings/calls. *Source: Virtual discussions with Magellan*
Was the method specified for calculating the response rate, and if so, was the method in accordance with industry standards?	✓	--	--	Magellan only counts full surveys. The WrapTrack system does not allow for more than eight blank responses. No surveys fell into this group during the review period. *Source: Virtual discussions with Magellan*
Was a plan included to conduct a non-response analysis?	--	✓	--	Magellan has not conducted non-response analyses for the WFI-EZ survey. However, Magellan has noticed trends in provider responses – providers who do not complete the survey tend to have lower fidelity score and tend to leave the network earlier. *Source: Virtual discussions with Magellan*

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
Overall validation assessment: In the comments section, note any recommendations for improving the response strategy				Magellan employs several strategies to maximize responses and has seen strong response rates.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Worksheet 6.6. Quality Assurance Plan

Date of Quality Assurance Plan: Not provided. Magellan did not provide a quality assurance plan and clarified that all processes are adopted from the existing tool/ survey developed by University of Washington.

Assess the quality assurance plan by indicating whether the following quality checks were included in the plan. Insert comments to explain "No" and "Not applicable" responses. (Note: The assessment of whether the plan was implemented appropriately is included in Worksheet 6.7.)

Question	Yes	No	NA	Comments
Sampling. Did the plan include a check to ensure the sample was constructed as specified in the sampling plan?	--	--	✓	Magellan did not provide a quality assurance plan.
Locating. Did the plan include a check that initial contact was made for every sample member?	--	--	✓	Magellan did not provide a quality assurance plan.
Mail data collection. Were the following quality checks included in the plan? • Was the survey reviewed for respondent reading level (surveys should be written at a 6th grade reading level to ensure most respondents are able to read and understand the content) • Were specifications and procedures developed for formatting, reproducing, and distributing the survey questionnaire? • Were contents of the mailing packet, such as the cover letter and questionnaire, reviewed for accuracy, print smearing, fading, and misalignment? • Were the returned mail surveys data entry reviewed for accuracy?	--	--	✓	The survey is not administered via mail.
Telephone data collection. Were the following quality checks included in the plan? • Were interviewer training and telephone scripts reviewed for accuracy? • Were telephone interviews monitored to confirm that interviewers read questions verbatim and accurately captured responses?	--	--	✓	The survey is not administered via telephone.
Web-based data collection. Did the plan include a check that the web-based instrument programming and content was tested for accuracy?	--	--	✓	Magellan did not provide a quality assurance plan.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
Data quality controls. Did the plan include procedures to handle responses that fail edit checks, treatment of missing data, and determination of usable/complete surveys? (Note: The plan should establish a pre-determined number of questions that must be answered by the respondent to be considered a usable case.)	--	--	✓	Magellan did not provide a quality assurance plan. However, per virtual discussions, the survey instrument would disallow certain skip patterns.
Overall validation assessment: In the comments section, note any recommendations for improving the quality assurance plan				Magellan should describe processes and procedures taken to ensure quality assurance of the survey. Additionally, Magellan should review the State's Medicaid Managed Care Quality Strategy to inform Magellan's development of quality assurance plan.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Worksheet 6.7. Survey Implementation According to the Work Plan

Assess the implementation of the survey by answering the following questions. Insert comments to explain "No" and "Not applicable" responses.

Question	Yes	No	NA	Comments
Was the weekly data collection plan implemented as described in the work plan?	--	--	✓	Magellan did not provide a work plan.
If deviations from the data collection plan occurred, were the reasons for the deviations explained?	--	--	✓	Magellan did not provide a work plan.
Were quality assurance checks implemented as specified in the quality assurance plan (see Worksheet 6.6)? If deviations occurred, please explain in the Comments column • Was the sampling plan verified to ensure the sample was constructed as specified? • Was initial contact made for every sample member? • Were specified quality checks made in accordance with the data collection mode (mail, telephone, web-based, or mixed mode)? • Were procedures developed to handle responses that fail edit checks, treatment of missing data, and removal of surveys or data determined to be unusable?	--	--	✓	Magellan did not provide a work plan.
Overall validation assessment: In the comments section, note any recommendations for improving the implementation of the survey				Magellan should develop a work plan and assess whether the survey is implemented in accordance with the work plan.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Worksheet 6.8. Survey Data Analysis and Final Report

Assess the data analysis and final report by answering the following questions. Insert comments to explain "No" and "Not applicable" responses.

Question	Yes	No	NA	Comments
Were post-processing procedures implemented to address the following: • Responses that failed edit checks • Missing data • Removal of surveys or data determined to be unusable	✓	--	--	Magellan only includes completed surveys in data analysis. *Source: Virtual discussions with Magellan*
Were weights created as appropriate for analyzing survey responses and generalizing results to the study population?	--	✓	--	It does not appear that weights were used for analyzing survey responses.
Was a nonresponse analysis conducted to determine if survey respondents differ from respondents on key variables important to the findings?	--	✓	--	Magellan has not conducted non-response analyses for the WFI-EZ survey. *Source: Virtual discussions with Magellan*
Were survey data analyzed following the analysis plan laid out in the work plan?	--	--	✓	Magellan did not provide a work plan.
Did the final report include a comprehensive overview of survey purpose/objective, implementation, and substantive findings?	✓	--	--	Magellan creates an annual final report which describes an overview of the survey, survey results/ findings, respondent characteristics, etc. *Source: WY HFWA WFI-EZ Annual Report June 2020*
Overall validation assessment: In the comments section, note any recommendations for improving the data analysis and final report				Overall, Magellan is able to leverage existing tools and resources for implementing the WFI-EZ, which enhances the survey's credibility.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

PROVIDER SATISFACTION SURVEY

Worksheet 6.1. Survey Purpose, Objectives, and Audience

Survey purpose, objectives, and audience: Provider Satisfaction Survey

- Purpose: Assess providers' satisfaction with the services and programs provided by Magellan[2]
- Objectives: Not defined
- Audience: Participating network providers (All participating providers who received at least one authorization or submitted a claim for service within the state fiscal year are selected to receive a questionnaire)[3]

Assess the clarity of the survey purpose and audience by answering the following questions. Insert comments to explain "No" and "Not applicable" responses.

Question	Yes	No	NA	Comments
Was there a clear, written statement of the survey purpose that addresses access, timeliness, and/or quality of care?	--	✓	--	Magellan did not provide a clear, written statement of the survey purpose. However, per virtual discussions, Magellan indicated the survey purpose – "The provider satisfaction survey allows Magellan to obtain feedback from providers on how things are going, see what needs providers have, and informs adjustments / improvements."
Was the unit of analysis clearly stated?	✓	--	--	Magellan indicates that the survey is aimed at participating network providers, including all participating providers who received at least one authorization or submitted a claim for service within the state fiscal year are selected to receive a questionnaire.
Did the unit of analysis include individual MCPs?	--	--	✓	Magellan is the only managed care plan within the CME program.
Was there a clear and measurable written study objective?	--	✓	--	Magellan did not provide a clear, measurable study objective.
Was the audience for and intended use of the survey findings identified?	✓	--	--	The survey results are reviewed by the members of the Wyoming Network Strategy Committee and the members of the Quality Improvement Committee to discuss barriers and discuss options to improve satisfaction in the areas where lower satisfaction was expressed.
Overall validation assessment: In the comments section, note any recommendations for improving the survey purpose, objective, and audience				Magellan should identify clear, written statements for the survey purpose and objectives.

[2] 2019 Magellan CME Quality Annual Program Evaluation

[3] 2019 Magellan CME Quality Annual Program Evaluation

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Worksheet 6.2. Work Plan

Date of work plan: None Provided. Magellan did not provide a work plan. Per virtual discussions, Magellan has internal, corporate policies which govern implementation of the provider satisfaction survey. However, corporate policies included general information about provider surveys and did not provide specific details about Wyoming CME's provider satisfaction survey.

Assess the adequacy of the work plan by answering the following questions. Insert comments to explain "No" and "Not applicable" responses. (Note: Validation of the work plan occurs in conjunction with Activity 5, Review Survey Implementation According to the Work Plan.)

Question	Yes	No	NA	Comments
Did the work plan include a project management plan (including key staff and roles)?	--	✓	--	Per virtual discussions, Magellan's corporate survey team manages the provider satisfaction survey and consults local Magellan Wyoming staff as needed.
Did the work plan include a project schedule (including timelines and deliverable dates)?	--	✓	--	Per virtual discussions, survey is distributed annually, typically in late spring/early summer. Providers have 2-4 weeks to complete the survey.
Did the work plan specify project reporting requirements (including the number, format, and content of the reports)? • The work plan should include a description of any reports that the EQRO will be responsible to publicly release, if this is part of the EQRO's scope of work	--	✓	--	Per virtual discussions, Magellan presents survey results to providers via provider calls and includes results in the Annual Program Evaluation and Annual Report (submitted to the State). There is not a final, standalone report for the survey and Magellan intends to develop a standalone report in the future.
Did the work plan include a data preparation plan, such as production of data files, data file format, and delivery?	--	✓	--	Magellan described obtaining raw data from the provider listing and cleaning the data to remove duplicates. Magellan indicates "the completed questionnaires are entered into a database and tabulated by the WY Care Management Network Department." Magellan does not provide any additional details about data preparation plans.
Did the work plan include a data analysis plan (including the use of a statistician as appropriate)? • The EQRO should use a statistician to develop an analysis plan that supports the survey purpose and objectives and is consistent with the intended use of results • If feasible, the EQRO should provide the state with a mock-up of the analysis before administering the survey. This will assure the survey	--	✓	--	Magellan did not provide a data analysis plan.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
analysis will be consistent with the intended use of results				
Did the work plan include data security protocols and procedures for assuring the confidentiality of data in compliance with HIPAA?	--	✓	--	Per virtual discussions, provider surveys do not collect any health information. The survey platform, Qualtrics, also has the ability to screen within survey results and flag potential PHI for review. Additionally, surveys are associated with randomly-generated IDs.
Overall validation assessment: In the comments section, note any recommendations for improving the work plan				Magellan should develop a work plan specific to the Wyoming CME Provider Satisfaction Survey to govern the implementation of the survey and describe key project management details.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Worksheet 6.3. Survey Instrument

Name of survey instrument: Provider Satisfaction Survey

Assess the selection of the survey instrument by answering the following questions. Insert comments to explain "No" and "Not applicable" responses. Complete a separate worksheet for each survey instrument.

Question	Yes	No	NA	Comments
Was the selected survey instrument appropriate for the purpose of the survey and the unit of analysis?	✓	--	--	Magellan administers a questionnaire via email, with guidance to respond through the online survey questionnaire. Magellan developed the survey in-house based on best practices.
Were new items developed for the survey?	--	--	✓	Not applicable since the survey is not based on an existing survey.
If new items were developed, was a test of validity and reliability conducted for the new items?	--	--	✓	Not applicable since the survey is not based on an existing survey.
Was the overall survey instrument tested for face validity and content validity and found to be valid?	✓	--	--	Magellan corporate survey staff indicated that the survey is tested for face and content validity. Magellan also conducts a liability assessment. No further detail was provided.
Was the overall survey instrument tested for reliability and found to be reliable?	--	--	✓	Magellan does not specify whether the survey was found to be reliable.
Was testing performed for the specific target population (e.g., Medicaid or CHIP) and languages?	--	--	✓	Magellan does not specify whether testing was performed for the specific population.
Overall validation assessment: In the comments section, note any recommendations for improving the selection of the survey instrument				Magellan has opportunities to provide more detailed documentation describe the survey instrument and testing procedures.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Worksheet 6.4. Sampling Plan

Assess the sampling plan by answering the following questions. Insert comments to explain "No" and "Not applicable" responses.

Question	Yes	No	NA	Comments
Was the study population clearly defined?	✓	--	--	Magellan indicates that the survey is aimed at participating network providers, including all participating providers who received at least one authorization or submitted a claim for service within the state fiscal year. Magellan chooses this threshold because submitting a claim/receiving service authorization demonstrates engagement with the program.
Was the sampling frame clearly defined and appropriate based on the survey objectives?	--	--	✓	Per virtual discussions, Magellan samples the entire provider eligibility pool. Survey staff confirm with Network and Quality staff to ensure provider information is accurate. The list of eligible providers is pulled close to survey distribution. It is not clear how the sampling frame relates to survey objectives since objectives were not specified.
Was the sampling frame free from bias?	✓	--	--	Magellan includes all eligible providers and does not appear to demonstrate bias in this process.
Was the sampling method appropriate to the survey purpose?	✓	--	--	The purpose of the survey is to obtain providers' feedback, so it is appropriate to survey all providers who demonstrate engagement with the program.
Was the sample size sufficient for the intended use of the survey (acceptable margin of error, level of certainty required)?	--	✓	--	In SFY 2019, Magellan distributed 90 surveys and received 19 responses, which does not sufficiently represent the survey population. For a 95 percent confidence interval and 5 percent margin of error, the ideal sample size would be 73 of 90. In SFY 2020, Magellan distributed 86 surveys and received 36 responses, for a cooperation rate of 42 percent. For a 95 percent confidence interval and 5 percent margin of error, the ideal sample size would be 70 of 86.
Were the procedures used to select the sample appropriate and protected against bias?	✓	--	--	Magellan includes all eligible providers and does not appear to demonstrate bias in this process.
Overall validation assessment: In the comments section, note any				Overall, Magellan's sample size/ response rate does not provide adequate representation of the provider network.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
recommendations for improving the sampling plan				Magellan should continuously work to improve response rates.

Worksheet 6.5. Strategy to Maximize Response

Assess the strategy for locating sample members and specific data needed to administer the survey by answering the following questions. Insert comments to explain "No" and "Not applicable" responses.

Question	Yes	No	NA	Comments
Was locating of sample members conducted to ensure complete contact information? Locating is a technique used to improve response rates by locating and contacting sample members. This includes verified collection of data, such as first and last name, home address, email address, phone number(s), date of birth, language preference, etc.	--	✓	--	Although Magellan confirms contact information is accurate, Magellan does not conduct "locating" or other one-on-one direct outreach.
Were any of the following strategies included to maximize response: • Advance letter • Multiple and varied call attempts • Multi-mode surveys • Multiple languages	✓	--	--	Per virtual discussions, Magellan does not send advance letters since they may be perceived as spam. Magellan also does not call providers directly. The survey is offered in one method (electronic). The survey is generally offered in English but can be translated into non-English languages upon request.
Were strategies customized to the study population (e.g., providers versus beneficiaries)?	--	✓	--	Magellan conducts outreach in a similar manner for providers and enrollees by including survey information in weekly updates/ newsletters and via provider meetings.
Was the method specified for calculating the response rate, and if so, was the method in accordance with industry standards?	--	✓	--	The method for calculating response rate was not specified in reviewed documentation. Per virtual discussions, Magellan includes all complete and partial response (surveys with at least two questions answered). Magellan also removes any providers who were unreachable from the response rate pool. In reviewed documentation, Magellan lists a "cooperation rate" but did not describe this further in discussions. The American Association of Public Opinion Research defines "response rates" and "cooperation rates" differently and it is not clear which approach Magellan uses.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
Was a plan included to conduct a non-response analysis?	--	✓	--	Per virtual discussions, Magellan has not conducted non-response analysis on this survey. The corporate survey team indicated this analysis has been completed for other surveys in the past.
Overall validation assessment: In the comments section, note any recommendations for improving the response strategy				Magellan can further clarify response rate calculations and strategies used to maximize response rates.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Worksheet 6.6. Quality Assurance Plan

Date of Quality Assurance Plan: None Provided. Magellan did not provide a quality assurance plan. Per virtual discussions, Magellan has internal, corporate policies which govern implementation of the provider satisfaction survey. However, corporate policies included general information about provider surveys and did not provide specific details about Wyoming CME's provider satisfaction survey.

Assess the quality assurance plan by indicating whether the following quality checks were included in the plan. Insert comments to explain "No" and "Not applicable" responses. (Note: The assessment of whether the plan was implemented appropriately is included in Worksheet 6.7.)

Question	Yes	No	NA	Comments
Sampling. Did the plan include a check to ensure the sample was constructed as specified in the sampling plan?	--	✓	--	Magellan did not provide a quality assurance plan. However, Magellan did describe, per virtual discussions, that the report of network provider (survey population) is pulled from Magellan's authorization and claims system and confirmed with the network team as well as the provider directory.
Locating. Did the plan include a check that initial contact was made for every sample member?	--	✓	--	Per virtual discussions, although Magellan does not conduct individual outreach, it does confirm that initial contact was made since the survey system, Qualtrics, tracks the status of each survey and whether the email was received, opened, undeliverable, etc.
Mail data collection. Were the following quality checks included in the plan? • Was the survey reviewed for respondent reading level (surveys should be written at a 6th grade reading level to ensure most respondents are able to read and understand the content) • Were specifications and procedures developed for formatting, reproducing, and distributing the survey questionnaire? • Were contents of the mailing packet, such as the cover letter and questionnaire, reviewed for accuracy, print smearing, fading, and misalignment? • Were the returned mail surveys data entry reviewed for accuracy?	--	--	✓	Not applicable – The survey is conducted electronically.
Telephone data collection. Were the following quality checks included in the plan?	--	--	✓	Not applicable – The survey is conducted electronically.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Question	Yes	No	NA	Comments
• Were interviewer training and telephone scripts reviewed for accuracy? • Were telephone interviews monitored to confirm that interviewers read questions verbatim and accurately captured responses?				
Web-based data collection. Did the plan include a check that the web-based instrument programming and content was tested for accuracy?	--	✓	--	Per virtual discussions, Magellan has an internal review process in which different teams review the survey to ensure proper functioning of skip patterns, logos, branding, content, etc.
Data quality controls. Did the plan include procedures to handle responses that fail edit checks, treatment of missing data, and determination of usable/complete surveys? (Note: The plan should establish a pre-determined number of questions that must be answered by the respondent to be considered a usable case.)	--	✓	--	Per virtual discussions, Magellan disregards missing data and adjusts the response result number for each question accordingly. To avoid provider frustration, Magellan does not require all questions to be answered. The survey itself also has data quality controls.
Overall validation assessment: In the comments section, note any recommendations for improving the quality assurance plan				Magellan should develop a quality assurance plan to govern survey quality.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Worksheet 6.7. Survey Implementation According to the Work Plan

Assess the implementation of the survey by answering the following questions. Insert comments to explain "No" and "Not applicable" responses.

Question	Yes	No	NA	Comments
Was the weekly data collection plan implemented as described in the work plan?	--	--	✓	Magellan did not provide a work plan.
If deviations from the data collection plan occurred, were the reasons for the deviations explained?	--	--	✓	Magellan did not provide a work plan.
Were quality assurance checks implemented as specified in the quality assurance plan (see Worksheet 6.6)? If deviations occurred, please explain in the Comments column • Was the sampling plan verified to ensure the sample was constructed as specified? • Was initial contact made for every sample member? • Were specified quality checks made in accordance with the data collection mode (mail, telephone, web-based, or mixed mode)? • Were procedures developed to handle responses that fail edit checks, treatment of missing data, and removal of surveys or data determined to be unusable?	--	--	✓	Magellan did not provide a work plan.
Overall validation assessment: In the comments section, note any recommendations for improving the implementation of the survey				Magellan should develop a work plan and assess whether the survey is implemented in accordance with the work plan.

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.

Worksheet 6.8. Survey Data Analysis and Final Report

Assess the data analysis and final report by answering the following questions. Insert comments to explain "No" and "Not applicable" responses.

Question	Yes	No	NA	Comments
Were post-processing procedures implemented to address the following: • Responses that failed edit checks • Missing data • Removal of surveys or data determined to be unusable	✓	--	--	Magellan has procedures in place to disregard missing data and remove unusable surveys.
Were weights created as appropriate for analyzing survey responses and generalizing results to the study population?	--	--	✓	Based on document review and virtual discussions, it is not clear if Magellan created weights to analyze survey responses.
Was a nonresponse analysis conducted to determine if survey respondents differ from respondents on key variables important to the findings?	--	✓	--	Per virtual discussions, Magellan has not conducted non-response analysis on this survey. The corporate survey team indicated this analysis has been completed for other surveys in the past.
Were survey data analyzed following the analysis plan laid out in the work plan?	--	--	✓	Magellan did not provide a work plan.
Did the final report include a comprehensive overview of survey purpose/objective, implementation, and substantive findings?	--	✓	--	There is not a final, standalone report describing the survey purpose, implementation, and findings. Magellan indicated the intention to develop a standalone report in the future.
Overall validation assessment: In the comments section, note any recommendations for improving the data analysis and final report				

END OF WORKSHEETS FOR PROTOCOL 6

Note: This worksheet is from CMS' EQR Protocols. All blue text represents the EQRO's findings and commentary.