Appendix A: Abbreviations and Acronyms

CANS	Child and Adolescent Needs and Strengths
CAPS	Claims Adjudication Payment System
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
CY	Calendar Year
DHCF	Division of Healthcare Financing
EDW	Enterprise Data Warehouse
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FCC	Family Care Coordinator
FEHR	Fidelity Electronic Health Records
FFS	Fee-For-Service
FSP	Family Support Partner
HFWA	High Fidelity Wraparound
HHS	U.S. Department of Health and Human Services
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
MCO	Managed Care Organization
MCP	Managed Care Plans
OOH	Out-of-Home
PAHP	Prepaid Ambulatory Health Plan
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PDSA	Plan Do Study Act
PHE	Public Health Emergency
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PMPM	Per-Member Per-Month
POC	Plan of Care
PRTF	Psychiatric Residential Treatment Facility
QAPI	Quality Assessment and Performance Improvement
QIA	Quality Improvement Activity
QIC	Quality Improvement Committee
RPO	Recovery Point Objective
RTO	Recovery Time Objective
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SFY	State Fiscal Year
SNCD	Strengths, Needs, and Culture Discovery
SOP	Standard Operating Procedure

SOW	Statement of Work
SPMI	Serious and Persistent Mental Illness
SQL	Structured Query Language
SSIS	SQL Server Integration Services
T-MSIS	Transformed Medicaid Statistical Information System
WDH	Wyoming Department of Health
WFI-EZ	Wraparound Fidelity Index-Short Form
YSP	Youth Support Partner

Appendix B: Status of SFY 2020 Recommendations

Table 1. Status of SFY 2020 Recommendations

#	SFY 2020 Recommendation	Responsibility	Findings	Comments
Protocol 1. Validation of Performance Improvement Projects				
1.	**Recommendation:** Update PIP documentation to include key elements and consistent information within a single document. Guidehouse recommends that Magellan include the following items for all PIPs in QIA forms: • A single concise, answerable aim statement that defines the improvement strategy, study population, and time period of the topic. • A written comprehensive data analysis plan that defines the goals for data analysis and tracking, roles and responsibilities of staff, data collection instruments, and timing / methods for data collection. A data analysis plan is helpful for Magellan to confirm that the data analysis method follows the prescribed procedures, ensures reliability and consistency in the data, facilitates future replication of the data, and clarifies processes for external validation. • Direct references to the PDSA rapid cycle approach and explanation for how Magellan leveraged the approach in barrier analysis and intervention development. • Direct references to strategies for assuring cultural competence and linguistic appropriateness within services. Additionally, PIP documentation should be comprehensive and include all relevant information within a single document. All sections of the PIP documentation should	Magellan	Fully Addressed	During SFY 2021, Magellan reported all Performance Improvement Project (PIP)-related data on individual Quality Improvement Activity (QIA) templates. Data in the documents is clearly identified and includes: • PIP development process • Aim statements • Target population • Sampling method • Data collection method and time frame; and • Comprehensive data tables

#	SFY 2020 Recommendation	Responsibility	Findings	Comments
	be fully completed once data analysis is finalized. Magellan should consult CMS EQR Protocols (dated October 2019) for additional guidance on comprehensive PIP documentation.			
2.	**Recommendation:** Align standards pursued by Magellan across business practices. Magellan appears to comply with 90-day internal timeframes for claims submission, but QIA forms for the Enrollment Initiative PIP imply that Magellan follows 12-month federal and State guidelines for claims submission. Magellan should align standards pursued across business practices and provide consistent messaging related to CME program operations. Since Magellan complies with 90-day requirements for claims submission, Magellan should communicate consistent timeframes for claims submission in QIA forms and other program documentation.	Magellan	Fully Addressed	Magellan has transitioned from using claims data for PIP reporting to using Electronic Health Records (EHRs). Data is collected from EHRs on a recurring basis.
Protocol 2. Validation of Performance Measures				
3.	**Recommendation:** Develop documentation describing the processes for manual (non-SQL) measure result creation. Magellan staff responsible for manual measure result creation have identified staff who can serve in a backup role as needed to generate measure results; however, Guidehouse recommends developing documentation to support acquisition of input data, calculation of numerator, denominator, and rate for the measures that are not generated via SQL. There may be an opportunity for	Magellan	Not Addressed	While the overall assessment found sufficient documentation for use of the Izenda query tool, and the three team members know how to perform the complete process, the team could benefit from having clear documentation for the final manual Excel steps describing the process from start to finish. Magellan shall ensure adequate documentation for the analytics team in the event of an emergency or staff change. This is an ongoing area of need for Magellan.

#	SFY 2020 Recommendation	Responsibility	Findings	Comments
	Magellan to automate portions of this process using Excel "functions" capabilities.			
4.	**Recommendation:** Specify the progress notes and dates for inclusion/exclusion in OP-04. Clarify the OP-04 numerator to count only those progress note records dated on or after the associated authorization application date. This will explicitly describe the exclusion of progress notes where an FCC may have a previous affiliation with an enrollee and essentially begins the contact process prior to the intended schedule as described by the measure.	WDH	N/A	New measures with different numerators and denominators were included in the updated 2021 SOW.
5.	**Recommendation:** Document calculation steps and perform monthly reconciliation of shared measure content. For measures OP-01 (numerator a1) and OP-25 (denominator), the measure owners and measure result creation teams should meet to discuss and document the criteria and calculation of the value describing number of enrolled providers. If Magellan determines these two measures are using the same definition, Guidehouse recommends reconciling the measure results each month to ensure each measure is reporting the same value. If the measures intend to report differing values for number of enrolled providers, Guidehouse recommends clarifying the description for each measure, so it is evident to all report recipients what type of count is displayed.	Magellan	N/A	New measures with different numerators and denominators were included in the updated 2021 SOW.

#	SFY 2020 Recommendation	Responsibility	Findings	Comments
6.	**Recommendation:** Document steps to validate provider ratio measure results. Following the recent departure of the subject matter expert for measure OP-08 regarding provider ratios, Guidehouse recommends documenting the validation process and highlighting any areas which may typically result in further review. Based on discussions with Magellan, the QIC reviews the results, so the documentation may focus on any information which may assist the measure creator in verifying initial results of the calculations and to assist the QIC in their final approval.	Magellan	Not Addressed	Guidehouse observed that unlike previous review periods, operational requirements were missing key performance goals during SFY 2021. Since performance goals are critical for monitoring program performance and are required for continuous quality improvement, missing goals poses a major risk for quality of care delivered to CME youth.
7.	**Recommendation:** Design processes to remediate current inconsistencies in reported measure results. Magellan should conduct additional rounds of data validation to align reported data. Guidehouse also recommends that Magellan utilize a consistent process to express measures for which there is no data.	Magellan	Partially Addressed	Magellan has not documented a formal process to review and remediate inconsistencies in data. Items with no data are listed in the Committee Data File as “No Data” or left blank.
8.	**Recommendation:** Review and revise critical incident reporting processes. WDH should clarify incident reporting requirements and Magellan’s roles and responsibilities regarding incident management. WDH should evaluate the measures included in the quarterly report to determine whether they capture all information necessary for ensuring the health and welfare of enrollees, in accordance with CMS guidance.	WDH	Fully Addressed	The updated 2021 SOW included a “Health and Welfare” section that defined the Contractor’s responsibility to prevent abuse, neglect, and exploitation. The SOW also outlined five metrics required to be reported to WDH on a quarterly basis.

#	SFY 2020 Recommendation	Responsibility	Findings	Comments
Protocol 3. Compliance with Medicaid Managed Care Regulations				
9.	**Recommendation:** Develop comprehensive quality assurance processes on committee data files and executive summaries. In discussion, Magellan outlined quality assurance and validation processes that relied primarily on internal discussion with workgroups and the QIC. Magellan should develop comprehensive quality assurance processes specifically for the Committee Data Files and Executive Summaries reported to WDH. Quality assurance processes should be documented and tracked as internal Magellan policy.	Magellan	Fully Addressed	Magellan provided a formal quality assurance corporate policy during the EQR document virtual discussion process.
10.	**Recommendation:** Add language to the SOW to reflect above requirements. Guidehouse recommends that WDH add and clarify language in the SOW regarding the following: • **Information Sharing of Assessment Activities**: WDH should design formal processes for information sharing once assessment activities are completed. This may include State access to Magellan's web portal where completed assessment forms are housed. • **Definitions of Managed Care Terminology**: WDH should include managed care definitions from Wyoming Administrative Rule in the SOW. • **Health Information Systems Reporting***:* WDH should clarify requirements for reporting information on appeals and denials of referrals to the State on a quarterly basis.	WDH	Partially Addressed	The 2021 SOW includes definitions for the managed care terms "significant change" and "effective date". The updated SOW also includes a requirement for Magellan to report information on appeals and denials to WDH on a quarterly basis. However, language identifying a formal process for Magellan to share the completion of assessment activities with WDH is not included in the SOW.

#	SFY 2020 Recommendation	Responsibility	Findings	Comments
11.	**Recommendation:** Clarify the purpose of OP-22 ("Complaints against Contractor") with Magellan and update performance measures accordingly. WDH should clarify the purpose of OP-22 with Magellan. Currently, Magellan reports provider complaints quarterly to WDH, but does not report enrollee grievances. Guidehouse recommends WDH clarify requirements for performance measure reporting to include enrollee grievances as part of WDH's monitoring efforts.	WDH	Fully Addressed	Magellan implemented a new SOW in 2021. In the updated SOW, "Complaints against Contractor" has been renamed "Enrollee Grievances and other Complaints" and divided into two requirements (Ops 8-32 and Ops8-33). Grievances are included in the measure and the requirement is reported quarterly to WDH.
12.	**Recommendation:** Confirm updated definitions of "grievance" and "complaint." Magellan provided internal policies which clarify definitions of "grievance" and "complaint." If WDH and Magellan are in agreement with the definitions, all other policies and external materials (e.g., provider and member handbooks) should use the updated definitions. Magellan should also specify the source of information reported as part of OP-22 (e.g., providers or enrollees).	Magellan	Fully Addressed	Magellan identifies grievances and complaints as the same in the updated 2021 SOW.
Protocol 4. Validation of Network Adequacy				
13.	**Recommendation:** Develop improved record-keeping practices to ensure practices are easily transferable between staff. Magellan would benefit from establishing improved record-keeping practices to support succession planning and staff transitions. It is important to ensure that more than one staff member has the knowledge and understanding needed to maintain consistent, accurate processes.	Magellan	Not Addressed	Magellan has continued to provide documents with inconsistent or incomplete information indicating ongoing record-keeping and reporting difficulties. Following the virtual EQR process, it is unclear whether Magellan maintains a consistent firm-wide data collection and analysis process.

#	SFY 2020 Recommendation	Responsibility	Findings	Comments
14.	**Recommendation:** Continue to regularly validate provider enrollment data. WDH has implemented 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. It is especially critical for WDH to continue to review and critique any data inconsistencies to confirm accurate record-keeping and consistent provider enrollment reconciliation efforts. Per discussions with WDH, Magellan and WDH continue to work together to confirm shared understanding of provider network data reconciliation efforts.	WDH	Partially Addressed	While Magellan provided corporate data assurance policies as part of the SFY 2021 EQR, data integrity has continued to be an issue during the review. WDH did not include reporting of distinct data elements, or a formal process for reviewing or reconcile data in the updated 2021 Statement of Work.
Protocol 6. Administration or Validation of Quality of Care Surveys				
15.	**Recommendation:** Develop documentation to fully describe survey administration and implementation procedures for the Provider Satisfaction Survey. Magellan would benefit from more clearly documenting survey administration and implementation procedures for the Provider Satisfaction Survey. Reviewed documentation describes corporate processes but does not adequately describe details relating to Wyoming's specific survey and processes. Documenting elements like project management details, survey timeframes, reporting requirements, and quality assurance procedures, for example, creates more structure and may improve Magellan's survey implementation processes	Magellan	N/A	Protocol not reviewed in SFY 2021.
16.	**Recommendation:** Develop a robust, documented strategic plan for maximizing response rates. Magellan indicates that "provider satisfaction surveys serve as the most direct measure of assessing the provider's satisfaction with the services and programs provided by Magellan." To best understand providers'	Magellan	N/A	Protocol not reviewed in SFY 2021.

#	SFY 2020 Recommendation	Responsibility	Findings	Comments
	perceptions and areas for improvement, increased participation is essential. The low response rates do not provide adequate representation of the provider network. Magellan should develop a robust, documented strategic plan for maximizing response rates. Magellan may choose to leverage existing communications, such as provider calls, to request feedback from providers regarding ease of access and barriers to completing the provider satisfaction survey. Magellan may also consider exploring provider incentives for survey completion as appropriate.			

Appendix C: EQR Protocol 1 – PIP Worksheets

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.)			✓	Topic selection was the result of reflection on FY17 performance for implementation of improvement programs in FY18. Available measures were vetted through a balanced scorecard measure. ***11/12/21:*** The Engagement and Implementation PIP is included in the 2021 SOW, and therefore is required by the State.
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.	✓			The strategy was built to address opportunity for improvement for providers identified in the Wyoming FY2017 Fourth Quarter report. Measures identified for improvement were engagement (>60 days), and implementation (>180 days). Magellan included specific input from both enrollees and providers in selecting this PIP topic.
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 listed the population served as "All WY CME enrolled youths". CME enrolled youths are Medicaid-covered youth (4-20 years of age) experiencing serious emotional disturbance/serious mental illness (SED/SMI).

Question	Yes	No	NA	Comments
1.5 Did the PIP topic align with priority areas identified by HHS and/or CMS?	✓			The Engagement and Implementation PIP aligns with CMS Aims and Priorities (i.e., *Strengthen Person and Family Engagement as Partners in their Care,* and *Promote Effective Communication and Coordination of Care).* Additionally, the PIP topic selection used the Triple Aim approach (adopted from the Institute of Medicine) to identify gaps in care and create efficiencies.
1.6 Overall assessment: In the comments section, note any recommendations for improving the PIP topic.				Magellan should include additional data and findings on the participant benefits of meeting engagement and implementation thresholds within PIP documentation.

Worksheet 1.2. Review the PIP Aim Statement

PIP Aim Statement(s):

1. Does the change in authorization process improve the percent of Wyoming Care Management Entity youth (ages 4-20 years old who were discharged during the measurement periods) and their families reach engagement threshold (>60 days) for SFY2021?

2. Does the change in authorization process improve the percent of Wyoming Care Management Entity youth (ages 4-20 years old who were discharged during the measurement periods) and their families reach implementation threshold (>180 days) for Standard Fiscal Year 2021?

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?	✓			The PIP aim statement identified enrollment and implementation as target measures, change in authorization process as the strategy, and SFY 2021 as the time period.
2.2 Did the PIP aim statement clearly specify the population for the PIP?	✓			The PIP population is identified as WY state Medicaid youth (aged (4 – 20 years old) discharged during the measurement period and their families.
2.3 Did the PIP aim statement clearly specify the time period for the PIP?	✓			The PIP aim statement clearly identified the time period as SFY 2021.
2.4 Was the PIP aim statement concise?	✓			The aim statements are two clear and concise sentences / questions.
2.5 Was the PIP aim statement answerable?	✓			The aim statements were both answerable, specifically focusing on improved fulfillment of engagement / implementation thresholds in the CME population.
2.6 Was the PIP aim statement measurable?	✓			The aim statement specifically focused on "improved percent" which is measurable year to year and quarter to quarter.
2.7 Overall assessment: In the comments section, note any recommendations for improving the PIP aim statement.				N/A

Worksheet 1.3. Review the Identified PIP Population

PIP Population All WY CME youths ages 4-20 years old discharged during the measurement period (SFY 2021).

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	✓			The population definition includes insured status, age, timeframe, and discharge date.
3.2 Was the entire MCP population included in the PIP?	✓			The entire MCP population is included in this PIP topic. The QIA form provided by Magellan lists population description as "All WY CME youths."
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.	✓			Data collection captured all enrollees to whom this PIP topic applies. Magellan specified that data is collected via the Fidelity EHR (FEHR) for all WY CME members.
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		✓		Magellan did not use sampling for this PIP topic.
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 Sampling was not Used for 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 – Magellan did not use sampling for this PIP topic.
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 – Magellan did not use sampling for this PIP topic.
4.3 Did the sample contain a sufficient number of enrollees taking into account non-response?			✓	N/A – Magellan did not use sampling for this PIP topic.
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 – Magellan did not use sampling for this PIP topic.
4.5 Were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field.			✓	N/A – Magellan did not use sampling for this PIP topic.
4.6 Overall assessment: In the comments section, note any recommendations for improving the sampling method.				N/A – Magellan did not use sampling for this PIP topic.

Worksheet 1.5. Review the Selected PIP Variables and Performance Measures

Selected PIP Variables and Performance Measures:

1. Engagement: percent of youth and families not reaching engagement threshold (>60 days)
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., 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 measures clearly identified engagement threshold (>60 days) and implementation threshold (>180 days) achievement during the 2021 SFY as the focus of the performance measure. Each measure identifies the percent of youth and families attaining the performance threshold for both engagement and implementation.
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?	✓			Engagement threshold and implementation threshold were identified as the aspects of care in question. ***11/12/21:*** Achieving full engagement and implementation is a key factor / principle of the HFWA program and is required for youth to obtain full benefit of the CME program.
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)?	✓			The measures are analyzed using claims data and EHR data (for 2021 only), which is available for all Medicaid 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		✓		PIP documentation did not identify current clinical knowledge or health services research that relates to full engagement or implementation in HFWA programs. However, enrollee and provider input were both considered in selection of this topic. ***11/12/21:*** While not academic research, Magellan utilized Wyoming-specific data found within CANS reports to inform the selection of this PIP topic.

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?	✓			The performance measures were viewed over a specified period of time (SFY 2021). The measures were compared to baseline measures and previous measurement years. Measures were not compared among MCPs because there is only one MCP.
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 performance 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 use existing measures to develop 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 measures include threshold performance but do not include a measurement of health or functional status. ***11/12/21:*** Achieving full engagement and implementation is a key factor / principle of the HFWA program and is required for youth to obtain full benefit of the CME program.

Question	Yes	No	NA	Comments
5.9 Did the measures include a strategy to ensure inter-rater reliability (if applicable)?		✓		In the data sources section, Magellan identified that they use both medical/treatment record and claims/encounter data for their analysis, however did not identify the data collections process as "Hybrid" (i.e., using both medical/treatment records and administrative records). ***Magellan:*** Can you classify the data collection methodology for this PIP? ***11/12/21:*** Magellan clarified that the data collection methodology of the Engagement and Implementation PIP is medical record / treatment record abstraction. Original documentation submitted for this PIP topic identified administrative data collection as the collection methodology. Magellan also identified that inter-rater reliability is assured through multiple rounds of review by data analysts.
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		✓		PIP documentation did not identify current clinical knowledge or health services research that relates to full engagement or implementation in HFWA programs. However, enrollee and provider input were both considered in selection of this topic. ***11/12/21:*** While not academic research, Magellan utilized Wyoming-specific data found within CANS reports to inform the selection of this PIP topic.
5.10 Overall assessment: In the comments section, note any recommendations for improving the selected PIP variables and performance measures.				Magellan should include additional data and findings on the participant benefits of meeting engagement and implementation thresholds within PIP documentation.

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?	✓			A detailed nine-step data pull process for the initiative was listed in PIP documentation.
6.2 Did the PIP design specify the frequency of data collection? If yes, what was the frequency (for example, semi-annually)?	✓			Data is collected on a monthly and quarterly basis.
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		✓		***11/12/21:*** Magellan clarified that the data collection methodology of the Engagement and Implementation PIP is medical record / treatment record abstraction. Original documentation submitted for this PIP topic identified administrative data collection as the collection methodology. Magellan also identified that inter-rater reliability is assured through multiple rounds of review by data analysts.
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)	✓			The following category of data are collected: • Member such as Youth ID, Youth Last Name, Youth First Name, and Medicaid Number • Enrollment such as the Discharge Date, Enrollment Status, Enrollment Status Start Date and Enrollment Status End Date • Plan of Care (POC) such as the Provider Name
6.5 Did the data collection plan link to the data analysis plan to ensure that appropriate data would be available for the PIP?		✓		The data analysis plan did not include details for how the EHR data will analyzed. ***11/12/21:*** Magellan confirmed that individual data analysts maintain personal data analysis plans, but no shared plan or operating procedure exists.
6.6 Did the data collection instruments allow for consistent and accurate data collection over the time periods studied?	✓			Data collection switched from claims data to EHR data in 2021.
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 was not collected for this PIP

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 include details on how EHR data will be analyzed for measuring progress on the PIP.

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?	✓			Data collection includes reviewing claims and encounters data. Claims and Encounters includes data from all patients.
6.10 If primary care data was used, did primary care providers submit encounter or utilization data for all encounters?			✓	N/A - PIP focused reviews claims/encounters data and EHR data (EHR data was only used in 2021)
6.11 If specialty care data was used, did specialty care providers submit encounter or utilization data for all encounters?			✓	N/A - PIP focused reviews claims/encounters data and EHR data (EHR data was only used in 2021)
6.12 If ancillary data was used, did ancillary service providers submit encounter or utilization data for all services provided?			✓	N/A - PIP focused reviews claims/encounters data and EHR data (EHR data was only used in 2021)
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 - PIP focused reviews claims/encounters data and EHR data (EHR data was only used in 2021)
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?		✓		A process to validate metrics for completeness and accuracy was not identified in the document. (EHR data was only used in 2021) ***11/12/21:*** Magellan confirmed that they conduct reviews once data reports for each PIP topic are generated. Magellan pursues a series of reviews to validate data matches.

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	✓			A data team including a Clinical Analyst, Senior Clinical Analyst, and a Senior Manager, Clinical Analysts were identified as collecting data. Relevant qualifications were not included in the description. However, it can be assumed that individuals

Question	Yes	No	NA	Comments
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				with these "Analyst" in their title have the relevant training and qualifications to conduct assessment of the EHR data.
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)		✓		Inter-rater and intra-rater reliability was not described in the document. ***11/12/21:*** Magellan confirmed that they conduct reviews once data reports for each PIP topic are generated. Magellan pursues a series of reviews to validate data matches.
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	✓			A detailed nine-step data pull process for the initiative was listed in PIP documentation.

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?	✓			In accordance with the data analysis plan, claims data was collected through enrollment/claims data. Data was collected via EHR beginning in 2021.
7.2 Did the analysis include baseline and repeat measurements of project outcomes?	✓			Data included baseline measures as well at three remeasurement periods for both Measure 1 and Measure 2.
7.3 Did the analysis assess the statistical significance of any differences between the initial and repeat measurements?		✓		The statistical significance of Measure 1 and Measure 2 were both measured using Fisher's Exact Test. Although the p-value for Measure #2 Remeasurement 3 in the document was listed as 0.000 (a highly significant value), the measure was listed in the QIA document as "ns" or non-significant. Additionally, Fisher's Exact Test was used to determine whether there is a statistically significant association between two categorical variables (i.e., two groups or categories). However, the Engagement and Implementation PIP measures determine whether there is a statistically significant relationship between group membership (i.e., opt-in and opt-out groups, categorical data) and "percent of youth and families not reaching engagement threshold" and "Percent of youth and families reaching implementation threshold", both of which are also numerical data. Magellan should explore using a different statistical test, such as t-tests, to correctly measure statistical significance for the PIP.
7.4 Did the analysis account for factors that may influence the comparability of initial and repeat measurements?		✓		Comparability was not discussed in the document. ***11/12/21:*** Magellan confirmed that they discuss factors that may influence validity quarterly, at minimum.
7.5 Did the analysis account for factors that may threaten the internal or external validity of the findings?		✓		Internal/external validity was not discussed in the document ***11/12/21:*** Magellan confirmed that they discuss factors that may influence validity quarterly, at minimum.
7.6 Did the PIP compare the results across multiple entities, such as different patient subgroups, provider sites, or MCPs?		✓		***11/12/21:*** Magellan clarified that comparison groups for the PIP topic include youth that didn't stay in program for 180 days vs. youth that

Question	Yes	No	NA	Comments
• 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				did (engaged vs. non engaged; implemented vs. non-implemented)
7.7 Were PIP results and findings presented in a concise and easily understood manner?	✓			PIP results and findings were presented in a clear and easy-to-read table. Results from Measure 1 and Measure 2 were organized into two separate tables with clear indication of the applicable measurement period.
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	✓			At the end of every remeasurement Magellan assesses the impact of the intervention.
7.9 Overall assessment: In the comments section, note any recommendations for improving the analysis and interpretation of PIP results				Magellan should include language addressing comparability and inter/external validity concerns within PIP documentation. Magellan should also review Data analysis methodology for applicability to available data.

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)?		✓		***11/12/21:*** Magellan confirmed that they used Monthly provider calls and information provided quarterly to the State) as evidence for the PIP.
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	✓			The strategy was built to address opportunity for improvement for providers identified in the Wyoming FY2017 Fourth Quarter report. Measures identified for improvement were engagement (>60 days), and implementation (>180 days).
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	✓			The document states that Magellan uses the PDSA practice to develop PIPs.

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

Question	Yes	No	NA	Comments
8.4 Was the strategy culturally and linguistically appropriate?[2]	✓			The document states: "No cultural or linguistic concerns were noted during the planning or intervention stages of this PIP during the baseline or re-measurement periods…There is a Cultural Competency workgroup that meets quarterly to review any cultural issues that might present barriers for Wyoming members in the program."
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)?	✓			Data was adjusted to exclude all enrolled members that are discharged with fewer than 60 days of HFWA.
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?	✓			At the end of every remeasurement Magellan assesses the impact of the intervention. An assessment of the Remeasurement 3 (SFY21) noted the ability of the program to exceed national engagement thresholds but to not meet the lower threshold set by the team and the marginal gains from the implementation initiative. The team discussed restarting a practice of "Letters of Education" to providers with low engagement and implementation scores.
8.7 Overall assessment: In the comments section, note any recommendations for improving the implementation strategies.				N/A

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

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?	✓			The Document states: "Baseline changes were made where there was improvement over the initial baseline. For the second measurement year, the baseline for Engagement did not change based on this rationale as the first measurement FY2019 was 16% (baseline 16%). For the second measurement year, the baseline for Implementation did change as the first measurement FY2019 was 62% (baseline 59%). The increase in baseline represents improvements expected towards a standard of excellence, defined as 10% for engagement and 80% for implementation. No baseline changes for 2021."
9.2 Was there any quantitative evidence of improvement in processes or outcomes of care?	✓			Both measures reported minimal changes from baseline but have yet to meet their respective goals after three years of the intervention. Measure 1 (goal 10%): The percent of youth and families not reaching engagement threshold at baseline was 16.43%. By 2021, the rate was 14.73%, a difference of only 1.7%. Measure 2 (goal 80%): The rate of Implementation increased from 58.90% a baseline to 64.21% in 2021, an increase of 5.31%.
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	✓			Although reported improvement has been minimal and below goals, the trend has continued to be favorable and reach towards the identified goals.
9.4 Is there statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention?	✓			Fisher's exact Test was used to test statistical significance. There was no statistical significance found for Measure 1. For Measure 2, there was a statistically significant

Question	Yes	No	NA	Comments
				difference between Remeasurement 2 (SFY 2020) and Remeasurement 3 (SFY 2021).
9.5 Was sustained improvement demonstrated through repeated measurements over time?		✓		Both measures have seen slight changes from baseline but have yet to meet their respective goals after three years of the intervention. Measure 1 (goal 10%): The percent of youth and families not reaching engagement threshold at baseline was 16.43%. By 2021, the rate was 14.73%, a difference of only 1.7%. Measure 2 (goal 80%): The rate of Implementation increased from 58.90% a baseline to 64.21% in 2021, an increase of 5.31%.
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	While PIP documentation was consistent with federal requirements, Engagement and Implementation thresholds did not meet respective goals for the period. The EQRO suggests considering format and design of other PIP documents as an example of improved reporting.

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

1. General PIP Information

Managed Care Plan (MCP) Name: Magellan

PIP Title: Engagement and Implementation Improvement

PIP Aim Statement:

- Does the change in authorization process improve the percent of Wyoming Care Management Entity youth (ages 4-20 years old who were discharged during the measurement period) and their families reach engagement threshold (>60 days) for Standard Fiscal Year 2021?
- Does the change in authorization process improve the percent of Wyoming Care Management Entity youth (ages 4-20 years old who were discharged during the measurement period) and their families reach implementation threshold (>180 days) for Standard Fiscal Year 2021?

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: Ages 4 – 20

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)

N/A

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. Technical assistance given on the new auth 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. Updated June 2019.
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, and reminder that past and current materials on website.
5. Provider newsletter included quarterly results
6. Talking points on these measures quarterly
7. Posting on Provider Website
8. Provider review of scorecard scores with network
9. Letter of education available if needed for high disengagement or low implementation. Updated process Jan 2019.
10. Scorecard quarter over quarter trending with QIC and EQIC quarterly.

11. Presentation of Provider Scorecard results in Monthly Provider Calls

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 2018 – August 2018	N=73; Rate= 16.43%	SFY 2021 ☐ Not applicable—PIP is in planning or implementation phase, results not available	N=190; Rate = 14.73%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Implementation: percent of youth and families reaching implementation threshold (>180 days)	May 2018 – August 2018	N=73; Rate= 58.90%	SFY 2021 ☐ Not applicable—PIP is in planning or implementation phase, results not available	N=190; Rate=64.21%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ 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): Third remeasurement

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:

While PIP documentation was consistent with federal requirements, Engagement and Implementation thresholds did not meet respective goals for the period.

The EQRO suggests considering format and design of other PIP documents as an example of improved reporting.

Please see individual worksheets for all recommendations for improvement.

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.)			✓	N/A - Topic is listed as required by the State.
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.			✓	N/A - Topic is listed as required by the State.
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 documentation listed the population served as "WY state Medicaid members (aged 4-20 years old) that were enrolled within the Psychiatric Residential Treatment Facility (PRTF) level of care".

Question	Yes	No	NA	Comments
1.5 Did the PIP topic align with priority areas identified by HHS and/or CMS?	✓			Although not specifically described as aligning with priority areas identified by CMS or HHS in the Rationale, the PIP aligns with HHS National Quality Strategy aims (*Healthy People / Healthy Communities*), and 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*). Additionally, the PIP topic selection topic was based on clinical priorities of the CME program that align with HHS / CMS goals. For example, the QIA form states that "…early engagement of the youth entering a higher level of care and the family in the High-Fidelity Wrap Around Program might provide an avenue to impact lengths of stay and readmissions to the PRTF level of care." This aligns with the HHS Triple Aim and encourages effective, safe treatment while managing costs.
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(s):

3. Will early engagement attempts with WY state Medicaid members (aged 4-20 years old) admitted to a PRTF level of care, (10/01/19 – 09/30/20) result in a decreased readmission rate (PRTF and acute inpatient settings)?

4. Will early engagement attempts with WY state Medicaid members (aged 4-20 years old) who opt in for the enrollment initiative have a decreased length of stay (LOS) during the initial PRTF stay compared to those members who opt-out of the program for the measurement timeframe of 10/01/19 – 09/30/20?

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?	✓			The aim statement identified early engagement of members as a method to decrease readmissions and length of stay, WY Medicaid members admitted to PRFT level of care as the population, and outlines a clear time frame for admission.
2.2 Did the PIP aim statement clearly specify the population for the PIP?	✓			The PIP population is identified as WY state Medicaid members aged (4 – 20 years old) admitted to PRTF level of care.
2.3 Did the PIP aim statement clearly specify the time period for the PIP?	✓			The time period of admission to PRTF level of care was identified as 10/01/19-09/30/20.
2.4 Was the PIP aim statement concise?	✓			The aim statements are two concise sentences.
2.5 Was the PIP aim statement answerable?	✓			The aim statements are answerable, "yes" / "no" questions, specifically focusing on decreased readmission rates and length of stay over the specified period of time.
2.6 Was the PIP aim statement measurable?	✓			The aim statement specifies measurable impact, specifically on decreased readmission rates and length of stay over the specified period of time.
2.7 Overall assessment: In the comments section, note any recommendations for improving the PIP aim statement.				N/A

Worksheet 1.3. Review the Identified PIP Population

PIP Population: All WY state Medicaid members (aged 4-20 years old) that were 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	✓			The population definition includes insured status, age, mandatory level of care, and the timeframe for treatment.
3.2 Was the entire MCP population included in the PIP?		✓		Only members that were enrolled in the PRTF level of care were included in the 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.	✓			Data was pulled from claim/encounter files that included all eligible members.
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		✓		Magellan did not use sampling for this PIP topic. The PIP documentation stated they used "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: N/A – Sampling was not used for Enrollment Initiative 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 – Sampling was not used for Enrollment Initiative 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 – Sampling was not used for Enrollment Initiative PIP
4.3 Did the sample contain a sufficient number of enrollees taking into account non-response?			✓	N/A – Sampling was not used for Enrollment Initiative 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 – Sampling was not used for Enrollment Initiative PIP
4.5 Were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field.			✓	N/A – Sampling was not used for Enrollment Initiative PIP
4.6 Overall assessment: In the comments section, note any recommendations for improving the sampling method.				N/A – Sampling was not used for Enrollment Initiative PIP

Worksheet 1.5. Review the Selected PIP Variables and Performance Measures

Selected PIP Variables and Performance Measures:

1. 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)

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., 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 measures clearly identified readmission at 30, 90, and 180 days and average length of stay to be the variables in question. Measures were compared to a baseline collection period from a year prior.
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?	✓			Readmissions and Length of Stay in inpatient facility settings were identified as the aspects of care in question. Since admission to an inpatient setting directly impacts an enrollee's access to home or community settings, this can be considered an important aspect to health / functional status. Once more, the PIP rationale cites the Magellan Health Services Children's Task Force study which found that "youth and adolescents who have extended stays in residential facilities may have difficulty applying the skills learned in treatment to the community setting." Therefore, identifying methods to limit length of stay and readmission has the potential to improve patient outcomes.
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)?	✓			The measures are analyzed using claims data, which is available for all Medicaid members and does not require additional resources for data collection.

Question	Yes	No	NA	Comments
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	✓			According to the rationale, shorter lengths of stay in residential facilities are more beneficial than longer stays. The rationale cites the Magellan Health Services Children's Task Force study which found that "youth and adolescents who have extended stays in residential facilities may have difficulty applying the skills learned in treatment to the community setting." Therefore, identifying methods to limit length of stay and readmission has the potential to improve patient outcomes. ***11/12/21:*** Magellan does not have more recent research references to include within the rationale of the study other than the Magellan Health Services Children's Task Force from 2007. However, Magellan stated that references are still accurate and highlight issues that remain within PRTF stays.
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?	✓			The performance measures were viewed over a specified period of time (i.e., 10/1/19-9/30/20). The measures were compared to baseline measures (collected 10/1/18-9/30/19). Measures were not compared among MCPs because there is only one MCP (Magellan Healthcare). Findings from the performance measures were used to determine referral processes used in the clinical process.
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 performance 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 use existing measures to develop this measure PIP.

Question	Yes	No	NA	Comments
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 measures included length of stay and readmissions, which can be considered reflective of changes in enrollee experiences with care. ***11/12/21:*** Magellan clarified that youth who have longer stays may experience difficulty re-integrating to community and may lose or lack skills to integrate successfully back into community when exiting PRTF setting. Magellan did not provide data to prove this item.
5.9 Did the measures include a strategy to ensure inter-rater reliability (if applicable)?			✓	N/A - Data was collected from claims/encounter files and EHRs and did not use inter-rater reliability.
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	✓			According to the rationale, shorter lengths of stay in residential facilities are more beneficial than longer stays. Therefore, identifying methods to limit length of stay and readmission has the potential to improve patient outcomes. ***11/12/21:*** Magellan clarified that youth who have longer stays may experience difficulty re-integrating to community and may lose or lack skills to integrate successfully back into community when exiting PRTF setting.
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?	✓			Data was collected via a programmed pull from claims/encounter files. Data was pulled annually for review and analysis and on a quarterly basis to monitor progress.
6.2 Did the PIP design specify the frequency of data collection? If yes, what was the frequency (for example, semi-annually)?	✓			Data was pulled annually for review and analysis and on a quarterly basis to monitor progress.
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	✓			Data was collected via a programmed pull from claims/encounter files.
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)	✓			**Measure 1**: Numerator – The number of unduplicated members ages 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 ages 4-20 who were discharged from a PRTF during the measurement period. **Measure 2**: 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?	✓			The data analysis plan is closely linked to the data collection plan with both depending heavily on the performance metrics.
6.6 Did the data collection instruments allow for consistent and accurate data collection over the time periods studied?	✓			Magellan reported no barriers to consistent and accurate data collection over the PIP time periods.

Question	Yes	No	NA	Comments
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 - This process did not include qualitative data collection.
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?	✓			Data collection included reviewing claims and encounters data mined from the Wyoming Cognos system. Claims and Encounters includes data from all patients.
6.10 If primary care data was used, did primary care providers submit encounter or utilization data for all encounters?			✓	N/A – Enrollment Initiative PIP focused on inpatient data.
6.11 If specialty care data was used, did specialty care providers submit encounter or utilization data for all encounters?			✓	N/A – Enrollment Initiative PIP focused on inpatient data.
6.12 If ancillary data was used, did ancillary service providers submit encounter or utilization data for all services provided?			✓	N/A – Enrollment Initiative PIP focused on inpatient data.
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 – Enrollment Initiative PIP focused on inpatient data.
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 – Enrollment Initiative PIP focused on inpatient data.

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	✓			Magellan reported that the data pull and SQL analysis for this PIP topic was conducted by a Senior Reporting Manager.
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 - Data was collected from claims/encounter files, not medical record review, and therefore did use inter-rater reliability.

Question	Yes	No	NA	Comments
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 - Data was collected from claims/encounter files, not through medical record review.

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?		✓		In accordance with the data analysis plan, claims data was collected through the Wyoming Cognos system, with the data for the members who elected to opt-in and the members who selected to opt out analyzed separately. Measure #1 ("Mean number of readmissions to a higher level of care (HLOC) (inpatient and/or PRTF) within 30/90/180 calendar days after discharge from PRTF for Enrollment Initiative members and opt-out youth") is described as a mean number in the QIA form (i.e., days); however, it is reported as a percentage. Additionally, the measure description lists three measurement periods (i.e., 30, 60, and 90 calendar days) but only reports one value. It is unclear which period aligns with the reported value.
7.2 Did the analysis include baseline and repeat measurements of project outcomes?	✓			Data was collected during the measurement period (10/1/19-9/30/20) was compared to data collected during the baseline period (10/1/18-9/30/19).
7.3 Did the analysis assess the statistical significance of any differences between the initial and repeat measurements?		✓		The statistical significance of Measure 1 and Measure 2 were both measured using Fisher's Exact Test. Neither were found to be statistically significant. However, Fisher's Exact Test is typically used to determine whether there is a statistically significant association between two categorical variables (i.e., two groups or categories). However, the Enrollment Initiative PIP measures determine whether there is a statistically significant relationship between group membership (i.e., opt-in and opt-out groups, categorical data) and "mean number of readmissions" and "average length of stay", both of which are also numerical data. Magellan should explore using different statistical tests, such as t-tests, to correctly measure statistical significance of improvement for this PIP.
7.4 Did the analysis account for factors that may influence the comparability of initial and repeat measurements?	✓			The data collection plan states that reliability of the data was taken into consideration and it was determined that there were no concerns or barriers related to data reliability.

Question	Yes	No	NA	Comments
7.5 Did the analysis account for factors that may threaten the internal or external validity of the findings?	✓			The data collection plan states that validity of the data was taken into consideration and it was determined that there were no concerns.
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	✓			The PIP analyzed the performance measures by comparing the performance of members who elected to opt-in and the members who selected to opt out of enrollment in the program.
7.7 Were PIP results and findings presented in a concise and easily understood manner?	✓			The data was organized in a clear, easy to read table. Results from Measure 1 and Measure 2 were separated into two separate tables.
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	✓			Through additional review, WY identified that the staff time needed to continue the initiative did not justify the limited membership gains from the program and decided to end the initiative 9/30/2020.
7.9 Overall assessment: In the comments section, note any recommendations for improving the analysis and interpretation of PIP results				Magellan should better align performance measure descriptions and data results reported in the QIA form. Magellan should also review data analysis methodology for applicability to available data.

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)?	✓			According to the Rationale, research shows that greatest benefits with residential stays occur from shorter stays, thus motivating the PIP's focus to minimize average length of stay and limit readmissions.
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	✓			Benefits of minimizing average length of stay and limiting readmissions listed in the rationale include significant improvement at discharge that is maintained at 12 months post-discharge.
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	✓			The rapid-cycle PDSA approach was clearly laid out in the Quality Improvement Form for this PIP via headers. The PDSA approach was explicitly named in the document and identified as the tool used to develop the plan of study for the project. **Describing each step of leveraging the rapid-cycle PDSA approach within PIP documentation was a marked improvement from previous review periods.**
8.4 Was the strategy culturally and linguistically appropriate?[4]	✓			The document states: "The [Quality Improvement Committee] work group assessed and did not identify barriers concerning cultural or linguistic issues with the planned strategies."

[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.

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)?	✓			As part of this PIP topic, Magellan excluded members that lost Medicaid eligibility at any point during the 180 days past the PRTF discharge date from the analysis. ***11/12/21:*** Magellan clarified that Medicaid enrollment is required to be included in the PIP. It is currently unclear what occurs if status is regained within the year.
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?	✓			Through additional review, WY identified that the staff time needed to continue the initiative did not justify the limited membership gains from the program and decided to end the initiative 9/30/2020.
8.7 Overall assessment: In the comments section, note any recommendations for improving the implementation strategies.				N/A

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 baseline and repeat measures: • **Measure 1:** 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) • **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
9.2 Was there any quantitative evidence of improvement in processes or outcomes of care?	✓			Data Results: • **Measure 1:** ○ Opt-in group: 41% had a readmission to a higher level of care post PRTF discharge ○ Opt-out group: 59% had readmission • **Measure 2:** ○ Opt in group: the average length of stay for the initial admission to PRTF was 77.4 days and the PRTF average length of stay per member for readmission after initial discharge was 113.1 days. ○ Opt – out group: the initial average length of stay was 86.6 days and the PRTF average length of stay for readmission after initial discharge was 71.0 days.
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	✓			The findings from the Intervention align with the findings from the research listed in the rationale (i.e. successful residential program stays were characterized by family and community involvement, addressing specific issues that lead to admission, and focusing on discharge planning)

Question	Yes	No	NA	Comments
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?	✓			The statistical significance of Measure 1 and Measure 2 were both measured using Fisher's Exact Test. Neither were found to be statistically significant.
9.5 Was sustained improvement demonstrated through repeated measurements over time?		✓		The intervention was only conducted twice (baseline and the measurement year). Magellan and WY CME determined that the impact was not large enough to continue implementing the initiative.
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	While Enrollment Initiative PIP design adhered to standards outlined by CMS, the PIP did not produce evidence of significant improvement and has been discontinued by the State and the Contractor.

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

1. General PIP Information

Managed Care Plan (MCP) Name: Magellan Healthcare
PIP Title: Enrollment Initiative Quality Improvement Activity
PIP Aim Statement: • Will early engagement attempts with WY state Medicaid members (aged 4-20 years old) admitted to a PRTF level of care, (10/01/19 – 09/30/20) result in a decrease readmission rate (PRTF and acute inpatient settings)? • Will early engagement attempts with WY state Medicaid members (aged 4-20 years old) who opt in for the enrollment initiative have a decreased length of stay (LOS) during the initial PRTF stay compared to those members who opt-out of the program for the measurement timeframe of 10/01/19 – 09/30/20?
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: Ages 4 – 20
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. 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. Motivational Interviewing specific to FSP and the Enrollment Initiative implemented
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) 12. Web-site posting about the Enrollment Initiative on the Provider Website 13. Provider Update communication sent on the Enrollment Initiative

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)	10/1/18 – 9/30/19	N= 18; Rate= 61%	10/1/19 – 9/30/20 ☐ Not applicable—PIP is in planning or implementation phase, results not available	N=39; Rate = 41%	☒ 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.	10/1/18 – 9/30/19	N=18; Rate=87.1	10/1/19 – 9/30/20 ☐ Not applicable—PIP is in planning or implementation phase, results not available	N=16; Rate=77.4	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
N/A			☐ 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):

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:

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.)			✓	N/A – The Minimum Contacts PIP topic is required in the 2021 Statement of Work with the Wyoming Department of Health.
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.			✓	N/A – The Minimum Contacts PIP topic is required in the 2021 Statement of Work with the Wyoming Department of Health.
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 listed the population served as "All WY CME enrolled youths". CME enrolled youths are Medicaid-covered youth (4-20 years of age) experiencing serious emotional disturbance/serious mental illness (SED/SMI)
1.5 Did the PIP topic align with priority areas identified by HHS and/or CMS?	✓			The Minimum Contact goals align with CMS Aims (i.e., *Better Care*) and Priorities (i.e., *Strengthen Person and Family Engagement as Partners in their Care,* and *Promote Effective Communication and Coordination of Care)*

Question	Yes	No	NA	Comments
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(s):

5. Will the use of education, training, and coaching, improve provider adherence to the minimum contact requirement to 100% of the time for the metric that all CME enrolled youths (with a full month of enrollment; ages 4-20 years old)/guardians/caregivers must be contacted at least two (2) times per month based on the family's preferred contact method by their HFWA provider during for calendar year 2021?

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?	✓			The aim statement clearly outlined the strategy (education, training, and coaching), population (Enrolled youths (with a full month of enrollment; ages 4-20 years old), and Time period (Calendar year 2021) for the PIP.
2.2 Did the PIP aim statement clearly specify the population for the PIP?	✓			The PIP aim statement clearly specified the population for the PIP, which included enrolled youths ages 4-20 years with a full month of enrollment during the time period.
2.3 Did the PIP aim statement clearly specify the time period for the PIP?	✓			The PIP aim statement clearly specified the time period for the PIP (calendar year 2021).
2.4 Was the PIP aim statement concise?	✓			The aim statement was a concise single sentence and only contained necessary information.
2.5 Was the PIP aim statement answerable?	✓			The aim statement was answerable and inquired whether providers are adhering 100% to the minimum contact requirements set forth by the CME program.
2.6 Was the PIP aim statement measurable?	✓			The aim statement was measurable and sought to determine compliance thresholds in comparison to 100% compliance to minimum contacts requirements.
2.7 Overall assessment: In the comments section, note any recommendations for improving the PIP aim statement.				N/A

Worksheet 1.3. Review the Identified PIP Population

PIP Population: All WY CME enrolled youths with a full month of enrollment, ages 4-20 during the 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		✓		Length of study was not specified in the PIP population description. The length of study was identified in other areas within the document (1/1/2021-12/31/2021)
3.2 Was the entire MCP population included in the PIP?	✓			The entire WY CME population is included in the Minimum Contacts 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.	✓			Data for the Minimum Contacts PIP is collected via EHR for all WY CME members
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		✓		Magellan did not use sampling for the Minimum Contacts PIP. Magellan stated they used "All eligible occurrences, no sampling used."
3.5 Overall assessment: In the comments section, note any recommendations for identifying the project population.				Magellan should specify length of study requirements for the population (e.g., 1/1/2021-12/31/2021).

Worksheet 1.4. Review the Sampling Method

Overview of Sampling Method Sampling was not Used for 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 – Magellan did not use sampling for the Minimum Contacts 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 – Magellan did not use sampling for the Minimum Contacts PIP.
4.3 Did the sample contain a sufficient number of enrollees taking into account non-response?			✓	N/A – Magellan did not use sampling for the Minimum Contacts 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 – Magellan did not use sampling for the Minimum Contacts PIP.
4.5 Were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field.			✓	N/A – Magellan did not use sampling for the Minimum Contacts 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. Rate of members/caregivers contacted at least two times per month based on the family's preferred contact type.

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	✓			The current performance measure includes a time-bound variable that can be used to measure performance and track improvement over time.
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?	✓			The impact of minimum contact requirements has not been established in PIP documentation. ***11/12/21:*** Magellan confirmed that meeting the minimum contacts requirements is critical for meeting HFWA program requirements and enabling youth to obtain full benefit from the CME program. As explained by Magellan, regular contacts between providers and families are critical for maintaining and tracking youths' goals and for assuring fidelity to the CME program.
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)?	✓			Compliance with minimum contact requirements is easily identified through the Fidelity EHR used by Magellan.

Question	Yes	No	NA	Comments
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 conducted a provider survey to identify barriers for FCCs and HFWA coaches to meet 100% adherence to minimum contact requirements. Identified Barriers include: • Lack of time / organization; • Youth not engaged in the program; • Member cancellations; • Families reluctant to meet, short contacts with families if the parent/child did not have updates; • Families not responsive to calls, texts, emails; • Decreased interaction with families when they begin to need less support and nearing time to leave the program; and • Families feeling overwhelmed by services
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?	✓			The measure is currently in the Baseline data collection process. However, monthly performance and an overall summary of meeting minimum contact requirements from 1/1/2021-6/30/2021 were collected and included in the Quality Improvement Form. The 2021 SOW update was based on lessons learned from a minimum contact PIP related to the prior SOW.
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 performance 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)?			✓	NA – The measure is based on a SOW requirement rather than clinical or health services research.

Question	Yes	No	NA	Comments
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		✓		Enrollees are free to ask questions or make comments on a Member Satisfaction Survey or on the Wyoming Member website. Feedback from enrollees on the minimum contact requirement are not included in the document.
5.9 Did the measures include a strategy to ensure inter-rater reliability (if applicable)?		✓		In the data sources section, Magellan identified that they use both medical/treatment record and other data for their analysis, however did not identify the data collections process as "Hybrid" (i.e., using both medical/treatment records and administrative records). ***11/12/21:*** Magellan classified data collection methodology as medical treatment records because the records are housed within EHR (both).
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	✓			***11/12/21:*** Magellan confirmed that meeting the minimum contacts requirements is critical for meeting HFWA program requirements and enabling youth to obtain full benefit from the CME program. As explained by Magellan, regular contacts between providers and families are critical for maintaining and tracking youths' goals and for assuring fidelity to the CME program. Therefore, the process measured can be considered "meaningfully associated with outcomes."
5.10 Overall assessment: In the comments section, note any recommendations for improving the selected PIP variables and performance measures.				Magellan should include data and / or evidence-based research on the clinical necessity / benefits of setting requirements for minimum contacts and a description for why minimum contacts are included in the SOW (if applicable).

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?	✓			The Minimum Contacts PIP documentation specified a detailed eight-step data pull process.
6.2 Did the PIP design specify the frequency of data collection? If yes, what was the frequency (for example, semi-annually)?	✓			The document states: "Data is collected monthly for trending and reporting purposes. PIP data is pulled annually for review and analysis for the performance improvement project."
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	✓			The PIP specified that data is collected from medical / treatment records (Fidelity Electronic Health Records).
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)	✓			The PIP identified data to be collected: • Member data, including Youth ID, Youth Name, Medicaid Number and Youth Age • Enrollment data, including Enrollment Status Start Date • Plan of Care (POC) data, including Facilitator Name and Provider Name • Service Note data, including Service Name.
6.5 Did the data collection plan link to the data analysis plan to ensure that appropriate data would be available for the PIP?		✓		The data collection plan did not include details for how the EHR data will be analyzed. ***11/12/21:*** Magellan confirmed that individual data analysts maintain personal data analysis plans, however no shared plan / SOP is maintained by Magellan.
6.6 Did the data collection instruments allow for consistent and accurate data collection over the time periods studied?	✓			Through leveraging Magellan's EHR, data collection instruments enable consistent and accurate data collection.

Question	Yes	No	NA	Comments
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 was not collected for this PIP
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 include details on how EHR data will be analyzed.

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 – PIP focused on EHR data
6.10 If primary care data was used, did primary care providers submit encounter or utilization data for all encounters?			✓	N/A – PIP focused on EHR data
6.11 If specialty care data was used, did specialty care providers submit encounter or utilization data for all encounters?			✓	N/A – PIP focused on EHR data
6.12 If ancillary data was used, did ancillary service providers submit encounter or utilization data for all services provided?			✓	N/A – PIP focused on EHR data
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 – PIP focused on EHR data
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?	✓			The document states: “Data is reviewed and verified by the Data Analyst monthly to ensure the information is complete and accurate…Additionally, the data is reviewed for anomalies in monthly trends and from one month’s run to another”

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	✓			A data analyst was identified as the individual who pulls data monthly, but no relevant qualifications were listed in the document. However, it can be assumed that individuals with these “Analyst” in their title have the relevant training and qualifications to conduct assessment of the EHR data.
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)		✓		In the data sources section, Magellan identified that they use both medical/treatment record and other data for their analysis, however did not identify the data collections process as “Hybrid” (i.e., using both medical/treatment records and administrative records) ***11/12/21:*** Magellan confirmed that they conduct reviews once data reports for each PIP topic are

Question	Yes	No	NA	Comments
				generated. Magellan pursues a series of reviews to validate data matches.
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	✓			The Minimum Contacts PIP documentation specified a detailed eight-step data pull process.

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?			✓	N/A – Baseline data collection still in progress. ***11/12/21:*** Magellan confirmed that individual data analysts maintain personal data analysis plans, however no shared plan / SOP is maintained by Magellan.
7.2 Did the analysis include baseline and repeat measurements of project outcomes?			✓	N/A – Baseline data collection still in progress.
7.3 Did the analysis assess the statistical significance of any differences between the initial and repeat measurements?	✓			Baseline data collection still in progress. However, the document states: "When the first remeasurement is completed, a statistical significance testing with Fisher's Exact Test will be used."
7.4 Did the analysis account for factors that may influence the comparability of initial and repeat measurements?	✓			The document states "There were no instances found that threatened the reliability or validity of the PIP"
7.5 Did the analysis account for factors that may threaten the internal or external validity of the findings?	✓			The document stated that the ongoing impact of the COVID-19 pandemic and providers still learning the new EHR system may impact the results from the first half of the year.
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	✓			Baseline data collection still in progress. Analysis plan did not mention comparing results across entities/groups. ***11/12/21:*** Magellan confirmed that the comparison groups encompassed members that met minimum contact requirements and those that did not meet requirements.
7.7 Were PIP results and findings presented in a concise and easily understood manner?	✓			Data is displayed in a clear and easy to understand table.
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			✓	N/A – Baseline data collection still in progress
7.9 Overall assessment: In the comments section, note any recommendations for improving the analysis and interpretation of PIP results				

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)?	✓			Since Minimum Contact requirements are an integral HFWA principle, the improvement strategy can be considered evidence-based.
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 provider survey to identify barriers for FCCs and HFWA coaches to meet 100% adherence to minimum contact requirements. Identified Barriers include: • Lack of time / organization; • Youth not engaged in the program; • Member cancellations; • Families reluctant to meet, short contacts with families if the parent/child did not have updates; • Families not responsive to calls, texts, emails; • Decreased interaction with families when they begin to need less support and nearing time to leave the program; and • Families feeling overwhelmed by services The Minimum Contacts PIP is designed to address the above barriers.

Question	Yes	No	NA	Comments
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	✓			Magellan identified the PDSA approach as the guideline used to develop this performance improvement project
8.4 Was the strategy culturally and linguistically appropriate?[6]	✓			Magellan assures cultural and linguistic competence for all strategies. The document states: "a Cultural Competency workgroup meets quarterly to review any cultural /linguistic issues that might present barriers for members in the program."
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)?	✓			FCC contact with youths and guardians / caregivers is only measured after one full month of enrollment in the WY CME Program.
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 – Baseline data collection still in progress
8.7 Overall assessment: In the comments section, note any recommendations for improving the implementation strategies.				Magellan should identify whether minimum contacts are an evidence-based practice and any benefits that may specifically apply to the covered population.

[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.

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 – Baseline data collection still in progress
9.2 Was there any quantitative evidence of improvement in processes or outcomes of care?			✓	N/A – Baseline data collection still in progress
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			✓	N/A – Baseline data collection still in progress
9.4 Is there statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention?			✓	N/A – Baseline data collection still in progress
9.5 Was sustained improvement demonstrated through repeated measurements over time?			✓	N/A – Baseline data collection still in progress
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 PIP is in baseline period, the EQRO cannot interpret PIP results or assess evidence of significant improvement. Magellan should include additional data and rationale supporting the impact of minimum contact requirements between youth / caregivers and providers in PIP documentation.

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

1. General PIP Information

Managed Care Plan (MCP) Name: Magellan
PIP Title: Improving Minimum Contact Engagement for Family Care Coordinators
PIP Aim Statement: Will the use of education, training, and coaching, improve provider adherence to the minimum contact requirement to 100% of the time for the metric that all CME enrolled youths (with a full month of enrollment; ages 4-20 years old)/guardians/caregivers must be contacted at least two (2) times per month based on the family's preferred contact method by their HFWA provider during for calendar year 2021.
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: ages 4 – 20
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) N/A
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. Development of Minimum Contact Report through the Electronic Health Record(EHR) for 2021 2. Review of minimum contact to determine how to assist specific providers with meeting minimum contact requirements 3. Provider communications concerning minimum contact expectations 4. Utilization of the Provider Scorecard with providers to raise awareness 5. Review overall network status on minimum contacts and reiterate minimum contact requirements during the Monthly Provider Calls 6. Magellan of Wyoming High Fidelity Wraparound Provider Requirements and Timelines posted to provider website as a reference for understanding minimum contact requirement timelines 7. 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

8. 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
9. Approved a back-up FCC when the primary FCC is unable to make the visits to the family
10. Approval of virtual contact through ZOOM/virtual platform

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 at least two times per month based on the family's preferred contact type.	1/1/21 – 12/31/21	N/A (Baseline data collection still in progress)	1/1/2021 – 6/30/21 (first half of baseline year) ☐ Not applicable—PIP is in planning or implementation phase, results not available	N=1,111 Rate=81.45%	☐ Yes ☐ No N/A – Baseline year	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
N/A			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
N/A			☐ 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):

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:

Since PIP is in baseline period, the EQRO cannot interpret PIP results or assess evidence of significant improvement.

Magellan should include additional data and rationale supporting the impact of minimum contact requirements between youth / caregivers and providers in PIP documentation.

Please see each worksheet for recommendations for improvement.

Appendix D: Additional Methodology for Protocol 2

Table 1 provides an example of a SOW operational requirement, the corresponding SOW performance measure, and the corresponding set of measures and goals. Table 2, 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.”

Instructions

Instructions for OPs Tool:

This is the review tool used by Reviewers to assess the Wyoming CME's compliance during SFY 2021 in accordance with the language from the SFY 2021 SOW. Reviewers have populated the following areas in the Contract Review tab:

No: The unique number assigned to the goal in the tool. Note that many operational requirements have more than one goal.

Category: The Category of the performance measure as stated in the contract.

Contract Section: The Contract Section (OP-Number) as stated in the contract. Above each operational requirements is the category for that section.

Contract 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. Reviewers developed a naming convention by adding letters to each OP (e.g., OP-01a) to differentiate between the OP's reported measures/goals.

Reported Measure/ Goal: Reported goals included in the Quarterly Reports, if available, or goals as identified by WDH.

Goal Threshold: Thresholds identified by Magellan in the Quarterly Reports.

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

Reported Barriers: Barriers included in the reviewed document, if available.

Reported Interventions: Interventions included in the reviewed document, if available.

Reviewer Comments: Any comments or concerns based on the review of the document.

Next Steps: Identification of next steps for review.

Review Findings: Reviewer's assessment of Magellan's compliance with the Contract Requirement. Review findings evaluate the answer to each review question.

Summary of SFY 21 Compliance with Operational Requirements

Overview

Number of OPs	54
Number of Goals	143

Level 1 Analysis - Does the supporting data meet the goal?

Compliance Result	% of Goals
Goal Met	15.4%
Goal Not Met	14.0%
Not Applicable	22.4%
Insufficient Data	48.3%
Total	100.0%

Level 2 Analysis - Are all goals for the performance measure met?

Compliance Result	% of Performance Measures
Yes	13.0%
No	22.2%
Not Applicable	22.2%
Insufficient Data	42.6%
Total	100.0%

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

Compliance Result	% of Goals
Yes	49.7%
Partially	1.4%
No	49.0%
Total	100.0%

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

Compliance Result	% of Performance Measures
Yes	44.4%
No	55.6%
Total	100.0%

Level 5 Analysis - Does the performance measure satisfy the contract requirement?

Compliance Result	% of Performance Measures
Yes	77.8%
Partially	20.4%
No	1.9%
Total	100.0%

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SFY21 Contract Review

#	Contract Section	Contract Requirement	Performance Measure	OP	Reported Measure/Goal	Goal Threshold	Findings for SFY 21					1. Does the supporting data meet the goal?	2. Are all goals for the performance measure met?	3. Does the goal address the performance measure?	4. Is the performance measure fully addressed by the goals?	5. Does the performance measure satisfy the contract requirement?
							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%	100%	100%	N/A	N/A	100%	Goal Met	No	Yes	Yes	Yes
2				OP01aR2	Rate of providers in network not meeting all requirements	0%	0%	0%	N/A	N/A	0%	Goal 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%	100%	N/A	N/A	100%	Goal Met		Yes		
4				OP01bR	Rate of providers completing annual recertification	100%	91%	83%	N/A	N/A	90%	Goal Not Met		Yes		
5				OP01cR	Rate of new providers completing initial provider training	100%	100%	100%	N/A	N/A	100%	Goal 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%	96%	97%	N/A	N/A	97%	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%	73%	N/A	N/A	77%	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%	64%	N/A	N/A	67%	Goal Not Met	No	Yes	Yes	Yes
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%	71%	63%	N/A	N/A	67%	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%	100%	99%	N/A	N/A	100%	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%	53%	59%	N/A	N/A	56%	Goal Not Met	No	Yes	Yes	Partially
12				OP07R2	Rate of enrollees enrolled with YSP	100%	8%	8%	N/A	N/A	8%	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%	97%	98%	N/A	N/A	98%	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%	100%	100%	N/A	N/A	100%	Goal Met		Yes		

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							Q1	Q2	Q3	Q4	Annual Total					
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%	65%	61%	N/A	N/A	63%	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%	69%	58%	N/A	N/A	63%	Goal Not Met		Yes		
17				OP09bR1	Rate of POCs in which services authorized and reflect participants' needs	100%	100%	100%	N/A	N/A	100%	Goal Met		Yes		
18				OP09bR2	Rate of POCs with participant/guardian signature affixed	100%	100%	100%	N/A	N/A	100%	Goal Met		Yes		
19				OP09bR3	Rate of POCs where services and supports are provided in type, scope, amt, duration, frequency	100%	68%	100%	N/A	N/A	85%	Goal Not Met		Yes		
20				OP09cR	Rate of POCs approved with verification of choice	100%	100%	100%	N/A	N/A	100%	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%	N/A	N/A	100%	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%	90%	79%	N/A	N/A	84%	Goal Not Met	No	Yes	Yes	Yes
23				OP10bR	Rate of enrollees contacted in person at least twice a month	95%	99%	94%	N/A	N/A	97%	Goal 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%	96%	98%	N/A	N/A	97%	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%	60%	61%	N/A	N/A	61%	Goal Not Met	No	Yes	Yes	Yes
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	23	11	N/A	N/A	34	Not Applicable	Not Applicable	Yes	Yes	No
27				OP13bR	Rate of enrollees disenrolled due to OOH placements	N/A	0%	0%	N/A	N/A	0%	Not Applicable		Yes		

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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%	94%	97%	N/A	N/A	95%	Goal Not Met	Yes	Yes	Yes	Yes
29				OP14bR	Rate of annual re-evaluations conducted prior to or on expiration date	N/A	82%	95%	N/A	N/A	89%	Not Applicable		Yes		
30				OP14cR1	Rate of OOH placements returned to community with new LOC evaluations	N/A	N/A	67%	N/A	N/A	86%	Not Applicable		Yes		
31				OP14cR2	Rate of OOH placements returned to community with new CASII evaluations	N/A	N/A	N/A	N/A	N/A	71%	Not Applicable		Yes		
32				OP14cR3	Rate of OOH placements returned to community with new LOC and CASII evaluations	N/A	N/A	N/A	N/A	N/A	57%	Not Applicable		Yes		
33				OP14dR	CASII/ ESCII status: Rate of enrollees with a valid CASII/ ESCII	100%	99%	99%	N/A	N/A	99%	Goal Not Met		Yes		
34				OP14eR	CANS status: Rate of enrollees with a valid CANS	100%	95%	98%	N/A	N/A	96%	Goal Not Met		Yes		
35				OP14fR	LOC attestation status: Rate of enrollees with a valid LOC attestation	100%	100%	100%	N/A	N/A	100%	Goal Met		Yes		
36				OP14gR	Rate of assessments completed by qualified evaluator	100%	100%	100%	N/A	N/A	100%	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	N/A	N/A	0	Not Applicable	Not Applicable	Yes	Yes	Partially
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%	N/A	N/A	100%	Goal Met	Not Applicable	Yes	Yes	Yes
39				OP16Q	Average turnaround time for referrals (days)	N/A	4	5	N/A	N/A	9	Not Applicable		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	604	495	N/A	N/A	1099	Not Applicable	Not Applicable	Yes	Yes	Yes
42				OP18bR	Rate of regions with staff member present	100%	100%	100%	N/A	N/A	100%	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%	97%	N/A	N/A	99%	Goal Not Met	No	Yes	No	Yes
44				OP19bR	Rate of extended standard auth decisions made within timeframe	100%	98%	85%	N/A	N/A	92%	Goal Not Met		Yes		
45				OP19cR	Rate of expedited auth decisions within timeframe	100%	N/A	N/A	N/A	N/A	N/A	Goal Met		Yes		
46				OP19dR	Rate of extended expedited auth decisions made within timeframe	100%	#DIV/0!	0%	N/A	N/A	0%	Goal Not Met		Yes		
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	3	3	N/A	N/A	6	Not Applicable	Not Applicable	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		

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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%	N/A	N/A	100%	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%	600%	100%	N/A	N/A	600%	Goal Met	Yes	Yes	Yes	Partially
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	25	27	N/A	N/A	52	Not Applicable	Not Applicable	Yes	No	Yes
54				OP24aR1	Rate of critical incidents followed up on	N/A	100%	100%	N/A	N/A	100%	Not Applicable		Yes		
55				OP24aR2	Rate of critical incidents that were addressed according to state statute	N/A	100%	100%	N/A	N/A	100%	Not Applicable		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%	N/A	N/A	100%	Goal Met	Yes	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
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	N/A	N/A	2	Not Applicable	Not Applicable	Yes	No	Yes
60				OP27b1Q	Number of attendees with family-based representation	N/A	626	392	N/A	N/A	1018	Not Applicable		Yes		
61				OP27b2Q	Number of attendees with State or local agency representation	N/A	29	20	N/A	N/A	49	Not Applicable		Yes		
62				OP27b3Q	Number of attendees with community-based org. representation	N/A	925	453	N/A	N/A	1378	Not Applicable		Yes		
63				OP27b4Q	Number of attendees with school representation	N/A	0	0	N/A	N/A	0	Not Applicable		Yes		
64				OP27b5Q	Number of attendees with informal resource representation	N/A	77	58	N/A	N/A	135	Not Applicable		Yes		
65				OP27b6Q	Number of attendees with child welfare/ juvenile stakeholder representation	N/A	0	0	N/A	N/A	0	Not Applicable		Yes		
66				OP27b7Q	Number of attendees with other representation	N/A	0	0	N/A	N/A	0	Not Applicable		Yes		

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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%	N/A	N/A	100%	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	7690	2571	N/A	N/A	10261	Not Applicable	Not Applicable	Yes	No	Partially
69				OP29bQ1	Total number of encounters sent to the State during the reporting period (date of submission)	N/A	8218	2607	N/A	N/A	10825	Not Applicable		Yes		
70				OP29aQ2	Total number of paid claim units processed by Magellan (date of adjudication)	N/A	24723	8261	N/A	N/A	32984	Not Applicable		Yes		
71				OP29bQ2	Total number of encounter units sent to the State during the reporting period (date of submission)	N/A	26997	8284	N/A	N/A	35281	Not Applicable		Yes		
72				OP29cR	Rate of claims submitted by providers within 90 days of service end date	95%	98%	92%	N/A	N/A	97%	Goal Met		Partially		
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	N/A	Goal Met	Yes	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	Not Applicable	Not Applicable	Yes	Yes	Yes
75	Ops 8-19	The Contractor must notify the Agency immediately and in writing of the following: Critical incidents may include any event that affects the health, safety, and welfare of an enrollee.	The Contractor must notify the Agency within two (2) business days of any critical incident event. Data showing compliance with this requirement shall be included in the quarterly data report.	Ops 8-19N	The Contractor shall notify the Agency within two (2) business days of any critical incident event.		N/A	N/A	24	12	36	Insufficient Data	Insufficient Data	No	No	Yes
76				Ops 8-19D	Data showing compliance with this requirement shall be included in the quarterly data report.		N/A	N/A	25	12	37	Insufficient Data		No		
77				Ops 8-19R	Calculated N/D		N/A	N/A	96%	100%	97%	Insufficient Data		No		
78	Ops 8-20	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) business days after receiving the complaint. Data showing compliance with this requirement shall be included in the quarterly data report.	Ops 8-20N	The Contractor must respond to any complaint received directly or by the Agency in regard to Contractor performance within five (5) business days after receiving the complaint.		N/A	N/A	2	No Data	2	Insufficient Data	Insufficient Data	No	No	Yes
79				Ops 8-20D	Data showing compliance with this requirement shall be included in the quarterly data report.		N/A	N/A	2	No Data	2	Insufficient Data		No		
80				Ops 8-20R	Calculated N/D		N/A	N/A	100%	0%	100%	Insufficient Data		No		
81	Ops 8-26	Provide enrollee grievance, appeal, and information about the right to a State fair hearings process to enrollees and designated representatives to voice expressions of dissatisfaction. This process shall be documented in the Policies and Procedures, Member Handbook, and Provider Handbook and communicated to enrollees and providers, as directed by the Agency. Enrollee grievances may be filed orally or in writing at any time. The Contractor must also ensure that individuals making decisions regarding enrollee grievances 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 enrollee grievance and appeal process.	An appeal must be filed by an enrollee within sixty (60) calendar days from the date on the adverse benefit determination notice. An enrollee may file a grievance with the CME at any time. The Contractor must present a proposed resolution to the issue reported within ninety (90) calendar days from the date the Contractor receives the enrollee grievance or appeal. If the Contractor's proposed resolution is not accepted by the individual or entity acting on their behalf, the Contractor has thirty (30) calendar days to review and respond to the enrollee grievance or appeal. After exhausting the enrollee grievance and appeal process with the Contractor, the enrollee must have no less than ninety (90) calendar days the date of the Contractor's final notice of resolution to request an Agency fair hearing. Contractor must resolve enrollee grievances and provide notice according to the enrollee's health condition, no more than ninety (90) calendar days from grievance receipt.	Ops 8-26N	An appeal must be filed by an enrollee within sixty (60) calendar days from the date on the adverse benefit determination notice.		N/A	N/A	No Data	No Data	0	Insufficient Data	Insufficient Data	No	No	Yes
82				Ops 8-26D	An enrollee may file a grievance with the CME at any time.		N/A	N/A	No Data	No Data	0	Insufficient Data		No		

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							Q1	Q2	Q3	Q4	Annual Total					
83				Ops 8-26R	Calculated N/D		N/A	N/A	0%	0%	#DIV/0!	Insufficient Data		No		
84	Ops 8-29	Provide a process for handling expedited resolutions of appeals, upon request of the enrollee.	Make a decision and send written notification to the requestor of the appeal review (an enrollee of their authorized representative such as the ordering and/or rendering provider) within seventy-two (72) hours of receipt of the initial verbal or written request for appeal review. 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 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	Ops 8-29N	Make a decision and send written notification to the requestor of the appeal review (an enrollee of their authorized representative such as the ordering and/or rendering provider) within seventy-two (72) hours of receipt of the initial verbal or written request for appeal review.		N/A	N/A	No Data	No Data	0	Insufficient Data	Insufficient Data	No	No	Yes
85				Ops 8-29D	# of Appeals		N/A	N/A	No Data	No Data	0	Insufficient Data		No		
86				Ops 8-29R	Calculated N/D		N/A	N/A	0%	0%	#DIV/0!	Insufficient Data		No		
87	Ops 8-30	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 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, the right and process 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. CME network providers do not have the right to file a grievance on behalf of themselves due to any adverse benefit determination regarding am enrollee they serve.	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. If the Contractor's review results in an adverse action, the Contractor must 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 mail the notice of adverse action notification at least ten (10) business days before the date of action, when the action is a termination, suspension, or reduction of previously authorized Medicaid covered services. If the Agency has facts indicating that action should be taken because of probable fraud by the enrollee, and the facts have been verified, if possible, through secondary sources, the Contractor must mail the notice of adverse action notification within five (5) business days prior to the date of action.	Ops 8-30N	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. 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.		N/A	N/A	No Data	No Data	0	Insufficient Data	Insufficient Data	No	No	Yes
88				Ops 8-30D	# of Appeals		N/A	N/A	No Data	No Data	0	Insufficient Data		No		
89				Ops 8-30R	Calculated N/D		N/A	N/A	0%	0%	#DIV/0!	Insufficient Data		No		
90	Ops 8-32	Provide a tracking and resolution model specific to the HFWA model, incorporating a child and family-centered approach for enrollee grievances and other complaints (instances of dissatisfaction that are not enrollee grievances). This model shall reflect a no-wrong door concept for enrollees to submit grievances and anyone else to submit a complaint.	Provide the enrollee or complainant with an acknowledgement of receipt of the grievance or compliant, within two (2) business days of receipt of the grievance or complaint. The acknowledgement shall include the timeframe for resolution.	Ops 8-32N	Provide the enrollee or complainant with an acknowledgement of receipt of the grievance or complaint, within two (2) business days of receipt of the grievance or complaint. The acknowledgement shall include the timeframe for resolution.		N/A	N/A	4	No Data	4	Insufficient Data	Insufficient Data	No	No	Yes
91				Ops 8-32D	# of Grievance/Complaints		N/A	N/A	4	No Data	4	Insufficient Data		No		
92				Ops 8-32R	Calculated N/D		N/A	N/A	100%	0%	100%	Insufficient Data		No		
93	Ops 8-33	The Contractor must send enrollee grievances and other complaints, received about the Contractor, to the Agency. Data showing compliance with this requirement shall be included in the Quarterly Report.	The Contractor must respond to enrollee grievances and other complaints, received directly or by the Agency in regard to Contractor performance, within five (5) business days after receiving the enrollee grievance or other complaint.	Ops 8-33N	The Contractor must respond to enrollee grievances and other complaints, received directly or by the Agency in regard to Contractor performance, within five (5) business days after receiving the enrollee grievance or other complaint.		N/A	N/A	2	No Data	2	Insufficient Data	Insufficient Data	No	No	Yes
94				Ops 8-33D	# of Grievance/Complaints		N/A	N/A	2	No Data	2	Insufficient Data		No		
95				Ops 8-33R	Calculated N/D		N/A	N/A	100%	0%	100%	Insufficient Data		No		
96	EM 9-3	Process all referrals received by the Contractor.	The Contractor must report on the number of children and youth referred, and turnaround time for referrals as part of the Quarterly Report.	EM 9-3N	Respond to any referral or request for enrollment within two (2) business days.		N/A	N/A	113	149	262	Insufficient Data	Insufficient Data	No	No	Yes
97				EM 9-3D	# of referrals		N/A	N/A	149	175	324	Insufficient Data		No		
98				EM 9-3R	Calculated N/D		N/A	N/A	76%	85%	81%	Insufficient Data		No		
99	EM 9-4	Assist families with the application or admission process for children and youth in accordance with the approved Policies and Procedures.	The Contractor must respond to enrollee grievances and other complaints, received directly or by the Agency in regard to Contractor performance, within five (5) business days after receiving the enrollee grievance or other complaint.	EM 9-4N	The Contractor must report on the number of children and youth referred, and turnaround		N/A	N/A	31	31	62	Insufficient Data	Insufficient Data	No	No	Yes
100				EM 9-4D	# of referrals		N/A	N/A	43	31	74	Insufficient Data		No		
101				EM 9-4R	Calculated N/D		N/A	N/A	72%	100%	84%	Insufficient Data		No		
102	EM 9-5	Process all applications in accordance with the approved Policies and Procedures once information is complete.	Process all enrollee applications within three (3) business days once application information is complete.	EM 9-5N	Process all enrollee applications within three (3) business days once application information is complete.		N/A	N/A	40	38	78	Insufficient Data	Insufficient Data	No	No	Yes
103				EM 9-5D	# of applications		N/A	N/A	42	38	80	Insufficient Data		No		
104				EM 9-5R	Calculated N/D		N/A	N/A	95%	100%	98%	Insufficient Data		No		

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							Q1	Q2	Q3	Q4	Annual Total					
105	EM 9-6	Triage all completed applications to the Agency that meet the Children's Mental Health Waiver (CMHW) criteria to the Agency for processing. Authorize providers upon receipt of Agency approval for services.	Send all CMHW referrals to the Agency within two (2) business days of discovery.	EM 9-6N	Send all CMHW referrals to the Agency within two (2) business days of discovery.		N/A	N/A	6	11	17	Insufficient Data	Insufficient Data	No	No	Yes
106				EM 9-6D	# of referrals		N/A	N/A	8	13	21	Insufficient Data		No		
107				EM 9-6R	Calculated N/D		N/A	N/A	75%	85%	81%	Insufficient Data		No		
108	EM 9-7	Notify the youth and/or the families of admission to the CME	Notify a youth and/or family of enrollment within two (2) business days of the final eligibility determination or date of the notification email from the Agency.	EM 9-7N	Notify a youth and/or family of enrollment within two (2) business days of the final eligibility determination or date of the notification email from the Agency.		N/A	N/A	9	32	41	Insufficient Data	Insufficient Data	No	No	Yes
109				EM 9-7D	# of new enrollees		N/A	N/A	10	35	45	Insufficient Data		No		
110				EM 9-7R	Calculated N/D		N/A	N/A	90%	91%	91%	Insufficient Data		No		
111	EM 9-9	Process client disenrollment if the enrollee meets any of the following criteria: A. All of the goals of the family/enrollee have been met; B. No evidence of POC in place or engagement with the family for care coordination; C. Lack of cooperation by family/enrollee in POC development, implementation, refusal to sign or abide by the POC, including the refusal of critical services; D. If the enrollee is no longer Medicaid eligible; E. The enrollee moves out of state; F. The enrollee ages out of program; G. The enrollee is incarcerated; H. Enrollment with an alternate State Waiver/ Program (DD Waiver); I. The enrollee is no longer financially eligible; J. The enrollee is no longer clinically eligible; K. The enrollee is determined eligible for any excluded program/population; L. The enrollee is in an out-of-home placement longer than one hundred eighty (180) calendar days; M. Family/enrollee's choice to terminate waiver services; or N. Death of participant. The Contractor may not request disenrollment because of a change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or 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).	Provide a thirty (30) calendar day advance notification to the enrollee and the enrollee's FCC prior to implementing a change in program eligibility and/or service amount, duration, or frequency. With exception of loss of Medicaid eligibility.	EM 9-9N	Provide a thirty (30) calendar day advance notification to the enrollee and the enrollee's FCC prior to implementing a change in program eligibility and/or service amount, duration, or frequency. With exception of loss of Medicaid eligibility.		N/A	N/A	0	40	40	Insufficient Data	Insufficient Data	No	No	Yes
112				EM 9-9D	# of 30 day advance notice		N/A	N/A	3	44	47	Insufficient Data		No		
113				EM 9-9R	Calculated N/D		N/A	N/A	0%	91%	85%	Insufficient Data		No		
114	EM 9-12	Review all evaluations, including the CASII and ECSII, for completeness by an appropriately qualified mental health professional (QMHP) or otherwise qualified evaluator according to Agency criteria. Escalate any concerns or incomplete evaluations to the State.	Review one hundred percent (100%) of all initial and re-evaluations.	EM 9-12N	Review one hundred percent (100%) of all initial and re-evaluations.		N/A	N/A	86	92	178	Insufficient Data	Insufficient Data	No	No	Yes
115				EM 9-12D	# of initials and evaluations		N/A	N/A	86	92	178	Insufficient Data		No		
116				EM 9-12R	Calculated N/D		N/A	N/A	100%	100%	100%	Insufficient Data		No		
117	EM 9-15	Provide a copy of the Member Handbook to all new enrollees and their guardians.	The Member Handbook may be in the form of an electronic copy if the enrollee or their guardian agrees to receive the information by email. Requested hard copies shall be mailed to the enrollee's mailing address.	EM 9-15N	Mailings/notifications		N/A	N/A	52	47	99	Insufficient Data	Insufficient Data	No	No	Yes
118				EM 9-15D	# of new enrollees		N/A	N/A	52	47	99	Insufficient Data		No		
119				EM 9-15R	Calculated N/D		N/A	N/A	100%	100%	100%	Insufficient Data		No		
120	EM 9-16	Ensure the FCC works with the enrollee, their family, and CFT at the start of the wraparound process to develop a Plan of Care (POC) based on the individual family and enrollee's needs, strengths and preferences. The FCC must collaborate with child and family serving agencies that are involved with the enrollee and his or her family. Each POC shall align with the HFWA phases and requirements, such as SNCD, and crisis planning. All POC's must include team member signatures, specifically youth (if age appropriate), family, and FCC at minimum.	All enrollees must have an FCC. A POC must be developed for each enrollee within forty-six (46) calendar days after enrollment.	EM 9-16N	# of POCs, all enrollees must have an FCC. A POC must be developed for each enrollee within forty-six (46) calendar days after enrollment.		N/A	N/A	39	36	75	Insufficient Data	Insufficient Data	No	No	Yes
121				EM 9-16D	# of enrollees		N/A	N/A	46	42	88	Insufficient Data		No		
122				EM 9-16R	Calculated N/D		N/A	N/A	85%	86%	85%	Insufficient Data		No		
123	EM 9-17	Authorize all POCs in the Contractor deployed system, addressing enrollee's assessed needs, health and safety risk factors, and personal goals. POCs shall be sufficient in service type, amount, duration, or scope to reasonably achieve the purpose for which services are furnished.	The Contractor must review and process one hundred percent (100%) of all POCs submitted.	EM 9-17N	# of POCs reviewed, the Contractor shall review and process one hundred percent (100%) of all POCs submitted.		N/A	N/A	184	202	386	Insufficient Data	Insufficient Data	No	No	Yes
124				EM 9-17D	# of POCs emailed		N/A	N/A	184	202	386	Insufficient Data		No		
125				EM 9-17R	Calculated N/D		N/A	N/A	100%	100%	100%	Insufficient Data		No		
126	EM 9-20	The FCC shall maintain regular contact with both the enrollee and his or her family or guardian based on the defined timeframes. The CFT is considered face-to-face contact.	The FCC shall contact both the youth, dependent upon age, and his/her caregiver at least two (2) times per month based on the family's preferred contact type	EM 9-20N	Minimum of two progress notes documenting FCC contacts per month for youth and/or caregiver		N/A	N/A	328	426	754	Insufficient Data	Insufficient Data	No	No	Yes
127				EM 9-20D	# of youths.		N/A	N/A	392	515	907	Insufficient Data		No		
128				EM 9-20R	Calculated N/D		N/A	N/A	84%	83%	83%	Insufficient Data		No		
129	EM 9-22	Conduct routine readiness assessments based on the pre-approved Transition Readiness Scale throughout the enrollment period to assess an enrollee's readiness to graduate from Wraparound.	Conduct transition readiness assessments every three (3) months of a child or youth's enrollment.	EM 9-22N	# of assessment within 3 months.		N/A	N/A	60	126	186	Insufficient Data	Insufficient Data	No	No	Yes
130				EM 9-22D	# of enrollees.		N/A	N/A	687	640	1327	Insufficient Data		No		
131				EM 9-22R	Calculated N/D		N/A	N/A	9%	20%	14%	Insufficient Data		No		

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							Q1	Q2	Q3	Q4	Annual Total					
132	EM 9-23	Ensure the FCC holds regularly scheduled CFTs and updates to the POC based on the needs of the enrollee and their family, in accordance to the Agency-defined timeframes.	The FCC must update the POC within the last thirty (30) calendar days of a ninety (90) day authorization period.	EM 9-23N	# of POCs that have been updated.		N/A	N/A	5	43	48	Insufficient Data	Insufficient Data	No	No	Yes
133				EM 9-23D	# of enrollees/POCs		N/A	N/A	18	43	61	Insufficient Data		No		
134				EM 9-23R	Calculated N/D		N/A	N/A	28%	100%	79%	Insufficient Data		No		
135	EM 9-24	Respite shall only be authorized for one enrollee per respite provider per instance at a time unless the CME reviews and approves additional youth. Exception may be made for sibling groups.	Respite is provided on a one to one ratio (one provider to one enrollee) unless otherwise approved by the CME.	EM 9-24N	Respite is provided on a one to one ratio (one provider to one enrollee) unless otherwise approved by the CME.		N/A	N/A	No Data	No Data	0	Insufficient Data	Insufficient Data	No	No	Yes
136				EM 9-24D	# with respite		N/A	N/A	No Data	No Data	0	Insufficient Data		No		
137				EM 9-24R	Calculated N/D		N/A	N/A	0%	0%	#DIV/0!	Insufficient Data		No		
138	EM 9-29	Prompt and oversee that families complete the Agency's WFI-EZ and prepare families to submit six months after enrollment.	The FCC shall prompt the enrollee and their family thirty (30) calendar days before the WFI-EZ assessment date. This shall be documented in the Contractor's deployed system.	EM 9-29N	The FCC shall prompt the enrollee and their family thirty (30) calendar days before the WFI-EZ assessment date. This shall be documented in the Contractor's deployed system.		N/A	N/A	11	8	19	Insufficient Data	Insufficient Data	No	No	Yes
139				EM 9-29D	# new enrollees		N/A	N/A	40	30	70	Insufficient Data		No		
140				EM 9-29R	Calculated N/D		N/A	N/A	28%	27%	27%	Insufficient Data		No		
141	PM 10-3	Timely follow up by the CME regarding interested provider inquiries to expedite the network provider onboarding process.	The receipt of the interested provider form to mailing of a CME provider application shall not exceed five (5) calendar days.	PM 10-3N	All providers shall complete and successful pass the certification process prior to providing any CME service.		N/A	N/A	236	213	449	Insufficient Data	Insufficient Data	No	No	Yes
142				PM 10-3D	Tier One Training shall be completed for each provider within ninety (90) calendar days of the start of the training for 95% of network providers.		N/A	N/A	236	213	449	Insufficient Data		No		
143				PM 10-3R	Calculated N/D		N/A	N/A	100%	100%	100%	Insufficient Data		No		

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

OP	Performance Measure Description	Q1	Q2	Q1-Q2 Total	Q3	Q4	Q3-Q4 Total
OP01aR1	Rate of providers in network meeting all requirements	100%	100%	100%	N/A	N/A	N/A
OP01aR2	Rate of providers in network not meeting all requirements	0%	0%	0%	N/A	N/A	N/A
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%	100%	N/A	N/A	N/A
OP01bR	Rate of providers completing annual recertification	91%	83%	90%	N/A	N/A	N/A
OP01cR	Rate of new providers completing initial provider training	100%	100%	100%	N/A	N/A	N/A
OP02R	Rate of enrollment notification letters sent within 2 business days of determination	96%	97%	97%	N/A	N/A	N/A
OP03R	Rate of SNCDs completed prior to initial CFT meeting	80%	73%	77%	N/A	N/A	N/A
OP04R	Rate of new referrals contacted by chosen FCC within 3 working days	69%	64%	67%	N/A	N/A	N/A
OP05R	Rate of enrollments with POCs developed within 46 days of enrollment	71%	63%	67%	N/A	N/A	N/A
OP06R	Rate of POCs with crisis plans	100%	99%	100%	N/A	N/A	N/A
OP07R1	Rate of enrollees enrolled with FSP	53%	59%	56%	N/A	N/A	N/A
OP07R2	Rate of enrollees enrolled with YSP	8%	8%	8%	N/A	N/A	N/A
OP08aR	Rate of FCC providers with <= 10 enrolled youth	97%	98%	98%	N/A	N/A	N/A
OP08bR	Rate of FSP/YSP providers with <= 10 enrolled youth under FSP and with <= 25 enrolled youth under YSP	100%	100%	100%	N/A	N/A	N/A
OP09aR1	Rate of CFT meetings held during the last 30 days (two weeks prior to 7/1/2019) of the authorization period	65%	61%	63%	N/A	N/A	N/A
OP09aR2	Rate of POCs completed during the last 30 days (two weeks prior to 7/1/2019) of the authorization period	69%	58%	63%	N/A	N/A	N/A
OP09bR1	Rate of POCs in which services authorized and reflect participants' needs	100%	100%	100%	N/A	N/A	N/A
OP09bR2	Rate of POCs with participant/guardian signature affixed	100%	100%	100%	N/A	N/A	N/A
OP09bR3	Rate of POCs where services and supports are provided in type, scope, amt, duration, frequency	68%	100%	85%	N/A	N/A	N/A
OP09cR	Rate of POCs approved with verification of choice	100%	100%	100%	N/A	N/A	N/A
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%	N/A	N/A	N/A
OP10aR	Rate of enrollees contacted by phone at least once a week	90%	79%	84%	N/A	N/A	N/A
OP10bR	Rate of enrollees contacted in person at least twice a month	99%	94%	97%	N/A	N/A	N/A
OP11R	Rate of enrollees with PCP documented	96%	98%	97%	N/A	N/A	N/A
OP12R	Rate of CFT meetings with invited formal supports	60%	61%	61%	N/A	N/A	N/A
OP13aQ	Number of enrollees in OOH placements	23	11	34	N/A	N/A	N/A
OP13bR	Rate of enrollees disenrolled due to OOH placements	0%	0%	0%	N/A	N/A	N/A
OP14aR	Rate of enrollees meeting all evaluation requirements (LOC, CASII, CANS) for enrollment	94%	97%	95%	N/A	N/A	N/A
OP14bR	Rate of annual re-evaluations conducted prior to or on expiration date	82%	95%	89%	N/A	N/A	N/A
OP14cR1	Rate of OOH placements returned to community with new LOC evaluations	N/A	67%	86%	N/A	N/A	N/A
OP14cR2	Rate of OOH placements returned to community with new CASII evaluations	N/A	N/A	71%	N/A	N/A	N/A
OP14cR3	Rate of OOH placements returned to community with new LOC and CASII evaluations	N/A	N/A	57%	N/A	N/A	N/A
OP14dR	CASII/ ESCII status: Rate of enrollees with a valid CASII/ ESCII	99%	99%	99%	N/A	N/A	N/A
OP14eR	CANS status: Rate of enrollees with a valid CANS	95%	98%	96%	N/A	N/A	N/A
OP14fR	LOC attestation status: Rate of enrollees with a valid LOC attestation	100%	100%	100%	N/A	N/A	N/A
OP14gR	Rate of assessments completed by qualified evaluator	100%	100%	100%	N/A	N/A	N/A
OP15Q	Number of consultations with Seattle Children's Hospital	0	0	0	N/A	N/A	N/A
OP16R	Rate of referrals responded to within 3 working days	100%	100%	100%	N/A	N/A	N/A

OP	Performance Measure Description	Q1	Q2	Q1-Q2 Total	Q3	Q4	Q3-Q4 Total
OP16Q	Average turnaround time for referrals (days)	4	5	9	N/A	N/A	N/A
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)	604	495	1099	N/A	N/A	N/A
OP18bR	Rate of regions with staff member present	100%	100%	100%	N/A	N/A	N/A
OP19aR	Rate of standard auth decisions within timeframe	100%	97%	99%	N/A	N/A	N/A
OP19bR	Rate of extended standard auth decisions made within timeframe	98%	85%	92%	N/A	N/A	N/A
OP19cR	Rate of expedited auth decisions within timeframe	N/A	N/A	N/A	N/A	N/A	N/A
OP19dR	Rate of extended expedited auth decisions made within timeframe	#DIV/0!	0.00%	0.00%	N/A	N/A	N/A
OP20aQ	Number of enrollees receiving flex funds	3	3	6	N/A	N/A	N/A
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	100%	100%	100%	N/A	N/A	N/A
OP22R	Rate of contractor complaint response timeliness	600%	100%	600%	N/A	N/A	N/A
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)	25	27	52	N/A	N/A	N/A
OP24aR1	Rate of critical incidents followed up on	100%	100%	100%	N/A	N/A	N/A
OP24aR2	Rate of critical incidents that were addressed according to state statute	100%	100%	100%	N/A	N/A	N/A
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%	N/A	N/A	N/A
OP26	Scalability (Annual as Appendix)	N/A	N/A	N/A	N/A	N/A	N/A
OP27aQ	Number of advisory council meetings	1	1	2	N/A	N/A	N/A
OP27b1Q	Number of attendees with family-based representation	626	392	1018	N/A	N/A	N/A
OP27b2Q	Number of attendees with State or local agency representation	29	20	49	N/A	N/A	N/A
OP27b3Q	Number of attendees with community-based org. representation	925	453	1378	N/A	N/A	N/A
OP27b4Q	Number of attendees with school representation	0	0	0	N/A	N/A	N/A
OP27b5Q	Number of attendees with informal resource representation	77	58	135	N/A	N/A	N/A
OP27b6Q	Number of attendees with child welfare/ juvenile stakeholder representation	0	0	0	N/A	N/A	N/A
OP27b7Q	Number of attendees with other representation	0	0	0	N/A	N/A	N/A
OP28R	Rate of referral to C Waiver within timeframe	100%	100%	100%	N/A	N/A	N/A
OP29aQ1	Total number of paid claims processed by Magellan (date of adjudication)	7690	2571	10261	N/A	N/A	N/A
OP29bQ1	Total number of encounters sent to the State during the reporting period (date of submission)	8218	2607	10825	N/A	N/A	N/A
OP29aQ2	Total number of paid claim units processed by Magellan (date of adjudication)	24723	8261	32984	N/A	N/A	N/A
OP29bQ2	Total number of encounter units sent to the State during the reporting period (date of submission)	26997	8284	35281	N/A	N/A	N/A
OP29cR	Rate of claims submitted by providers within 90 days of service end date	98%	92%	97%	N/A	N/A	N/A
OP30	Satisfaction Surveys (Annual as Appendix)	N/A	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
Critical Incidents							
Ops 8-19N	The Contractor shall notify the Agency within two (2) business days of any critical incident event.	N/A	N/A	N/A	24	12	36
Ops 8-19D	Data showing compliance with this requirement shall be included in the quarterly data report.	N/A	N/A	N/A	25	12	37
Ops 8-19R	Calculated N/D	N/A	N/A	N/A	96%	100%	97%
Complaints received about the Contractor							
Ops 8-20N	The Contractor must respond to any complaint received directly or by the Agency in regard to Contractor performance within five (5) business days after receiving the complaint.	N/A	N/A	N/A	2	No Data	2
Ops 8-20D	Data showing compliance with this requirement shall be included in the quarterly data report.	N/A	N/A	N/A	2	No Data	2
Ops 8-20R	Calculated N/D	N/A	N/A	N/A	100%	0%	100%

OP	Performance Measure Description	Q1	Q2	Q1-Q2 Total	Q3	Q4	Q3-Q4 Total
Enrollee grievance, appeal, and information about the right to a State fair hearings process							
Ops 8-26N	An appeal must be filed by an enrollee within sixty (60) calendar days from the date on the adverse benefit determination notice.	N/A	N/A	N/A	No Data	No Data	0
Ops 8-26D	An enrollee may file a grievance with the CME at any time.	N/A	N/A	N/A	No Data	No Data	0
Ops 8-26R	Calculated N/D	N/A	N/A	N/A	0%	0%	#DIV/0!
Handling expedited resolutions of appeals							
Ops 8-29N	Make a decision and send written notification to the requestor of the appeal review (an enrollee of their authorized representative such as the ordering and/or rendering provider) within seventy-two (72) hours of receipt of the initial verbal or written request for appeal review.	N/A	N/A	N/A	No Data	No Data	0
Ops 8-29D	# of Appeals	N/A	N/A	N/A	No Data	No Data	0
Ops 8-29R	Calculated N/D	N/A	N/A	N/A	0	0	#DIV/0!
Complaints, Appeals & Grievances							
Ops 8-30N	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. 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.	N/A	N/A	N/A	No Data	No Data	0
Ops 8-30D	# of Appeals	N/A	N/A	N/A	No Data	No Data	0
Ops 8-30R	Calculated N/D	N/A	N/A	N/A	0	0	#DIV/0!
Send enrollee grievances and other complaints							
Ops 8-32N	Provide the enrollee or complainant with an acknowledgement of receipt of the grievance or complaint, within two (2) business days of receipt of the grievance or complaint. The acknowledgement shall include the timeframe for resolution.	N/A	N/A	N/A	4	No Data	4
Ops 8-32D	# of Grievance/Complaints	N/A	N/A	N/A	4	No Data	4
Ops 8-32R	Calculated N/D	N/A	N/A	N/A	1	0	100%
Send enrollee grievances and other complaints							
Ops 8-33N	The Contractor must respond to enrollee grievances and other complaints, received directly or by the Agency in regard to Contractor performance, within five (5) business days after receiving the enrollee grievance or other complaint.	N/A	N/A	N/A	2	No Data	2
Ops 8-33D	# of Grievance/Complaints	N/A	N/A	N/A	2	No Data	2
Ops 8-33R	Calculated N/D	N/A	N/A	N/A	100%	0%	100%
Process all referrals received by the Contractor.							
EM 9-3N	Respond to any referral or request for enrollment within two (2) business days.	N/A	N/A	N/A	113	149	262
EM 9-3D	# of referrals	N/A	N/A	N/A	149	175	324
EM 9-3R	Calculated N/D	N/A	N/A	N/A	76%	85%	81%
Assist families with the application or admission process for children and youth							
EM 9-4N	The Contractor must report on the number of children and youth referred, and turnaround time for referrals as part of the Quarterly Report.	N/A	N/A	N/A	31	31	62
EM 9-4D	# of referrals	N/A	N/A	N/A	43	31	74
EM 9-4R	Calculated N/D	N/A	N/A	N/A	72%	100%	84%
Process all applications							
EM 9-5N	Process all enrollee applications within three (3) business days once application information is complete.	N/A	N/A	N/A	40	38	78
EM 9-5D	# of applications	N/A	N/A	N/A	42	38	80
EM 9-5R	Calculated N/D	N/A	N/A	N/A	95%	100%	98%

OP	Performance Measure Description	Q1	Q2	Q1-Q2 Total	Q3	Q4	Q3-Q4 Total
Completed applications for the Children's Mental Health Waiver (CMHW)							
EM 9-6N	Send all CMHW referrals to the Agency within two (2) business days of discovery.	N/A	N/A	N/A	6	11	17
EM 9-6D	# of referrals	N/A	N/A	N/A	8	13	21
EM 9-6R	Calculated N/D	N/A	N/A	N/A	75%	85%	81%
Youth and/or the families of admission to the CME							
EM 9-7N	Notify a youth and/or family of enrollment within two (2) business days of the final eligibility determination or date of the notification email from the Agency.	N/A	N/A	N/A	9	32	41
EM 9-7D	# of new enrollees	N/A	N/A	N/A	10	35	45
EM 9-7R	Calculated N/D	N/A	N/A	N/A	90%	91%	91%
Client disenrollment if the enrollee meets criteria							
EM 9-9N	Provide a thirty (30) calendar day advance notification to the enrollee and the enrollee's FCC prior to implementing a change in program eligibility and/or service amount, duration, or frequency. With exception of loss of Medicaid eligibility.	N/A	N/A	N/A	0	40	40
EM 9-9D	# of 30 day advance notice	N/A	N/A	N/A	3	44	47
EM 9-9R	Calculated N/D	N/A	N/A	N/A	0%	91%	85%
Review all evaluations, including the CASII and ECSII, for completeness							
EM 9-12N	Review one hundred percent (100%) of all initial and re-evaluations.	N/A	N/A	N/A	86	92	178
EM 9-12D	# of initials and evaluations	N/A	N/A	N/A	86	92	178
EM 9-12R	Calculated N/D	N/A	N/A	N/A	100%	100%	100%
Member Handbook to all new enrollees and their guardians.							
EM 9-15N	Mailings/notifications	N/A	N/A	N/A	52	47	99
EM 9-15D	# of new enrollees	N/A	N/A	N/A	52	47	99
EM 9-15R	Calculated N/D	N/A	N/A	N/A	100%	100%	100%
FCC & Plan of Care (POC)							
EM 9-16N	# of POCs, all enrollees must have an FCC. A POC must be developed for each enrollee within forty-six (46) calendar days after enrollment.	N/A	N/A	N/A	39	36	75
EM 9-16D	# of enrollees	N/A	N/A	N/A	46	42	88
EM 9-16R	Calculated N/D	N/A	N/A	N/A	85%	86%	85%
Authorize POCs							
EM 9-17N	# of POCs reviewed, the Contractor shall review and process one hundred percent (100%) of all POCs submitted.	N/A	N/A	N/A	184	202	386
EM 9-17D	# of POCs emailed	N/A	N/A	N/A	184	202	386
EM 9-17R	Calculated N/D	N/A	N/A	N/A	100%	100%	100%
FCC & Contact with Parent and Youth twice a month in a quarter							
EM 9-20N	Minimum of two progress notes documenting FCC contacts per month for youth and/or caregiver	N/A	N/A	N/A	328	426	754
EM 9-20D	# of youths.	N/A	N/A	N/A	392	515	907
EM 9-20R	Calculated N/D	N/A	N/A	N/A	84%	83%	83%
Routine readiness assessments based on the pre-approved Transition Readiness Scale							
EM 9-22N	# of assessment within 3 months.	N/A	N/A	N/A	60	126	186
EM 9-22D	# of enrollees.	N/A	N/A	N/A	687	640	1327
EM 9-22R	Calculated N/D	N/A	N/A	N/A	9%	20%	14%
FCC holds regularly scheduled CFTs and updates to the POC							
EM 9-23N	# of POCs that have been updated.	N/A	N/A	N/A	5	43	48
EM 9-23D	# of enrollees/POCs	N/A	N/A	N/A	18	43	61
EM 9-23R	Calculated N/D	N/A	N/A	N/A	28%	100%	79%

OP	Performance Measure Description	Q1	Q2	Q1-Q2 Total	Q3	Q4	Q3-Q4 Total
Respite shall only be authorized for one enrollee per respite provider per instance at a time unless the CME reviews and approves additional youth. Exception may be made for sibling groups.							
EM 9-24N	Respite is provided on a one to one ratio (one provider to one enrollee) unless otherwise approved by the CME.	N/A	N/A	N/A	No Data	No Data	0
EM 9-24D	# with respite	N/A	N/A	N/A	No Data	No Data	0
EM 9-24R	Calculated N/D	N/A	N/A	N/A	0	0	#DIV/0!
Prompt and oversee that families complete the Agency's WFI-EZ and prepare families to submit six months after enrollment.							
EM 9-29N	The FCC shall prompt the enrollee and their family thirty (30) calendar days before the WFI-EZ assessment date. This shall be documented in the Contractor's deployed system.	N/A	N/A	N/A	11	8	19
EM 9-29D	# new enrollees	N/A	N/A	N/A	40	30	70
EM 9-29R	Calculated N/D	N/A	N/A	N/A	28%	27%	27%
Conduct initial provider training and certification as an FCC, FSP, YSP, or respite provider prior to being activated to provide CME service.							
PM 10-3N	All providers shall complete and successful pass the certification process prior to providing any CME service.	N/A	N/A	N/A	236	213	449
PM 10-3D	Tier One Training shall be completed for each provider within ninety (90) calendar days of the start of the training for 95% of network providers.	N/A	N/A	N/A	236	213	449
PM 10-3R	Calculated N/D	N/A	N/A	N/A	100%	100%	100%
Out-of-Home (OOH) Placements							
OUT 13-1N	# of enrolled in OOH	N/A	N/A	N/A	6	8	N/A
OUT 13-1D	# of youth enrolled with the CME Contractor.	N/A	N/A	N/A	229	213	N/A
OUT 13-1R	Calculated N/D	N/A	N/A	N/A	0.026200873	0.037558685	N/A
Decreased Length of Stay (LOS) for Inpatient and Residential Treatment admissions for youth enrolled in the CME							
OUT 13-2_1	Average LOS for CME enrolled youth in OOH placement	N/A	N/A	N/A	144	317	N/A
OUT 13-2_2	# of youth enrolled with the CME Contractor.	N/A	N/A	N/A	229	213	N/A
Recidivism							
OUT 13-3N	# of youth enrolled in HLOC	N/A	N/A	N/A	6	22	N/A
OUT 13-3D	# of youth enrolled with the CME Contractor.	N/A	N/A	N/A	229	213	N/A
OUT 13-3R	Calculated N/D	N/A	N/A	N/A	0.026200873	0.103286385	N/A
Recidivism (LOC) at six (6) months post CME graduation							
OUT 13-4N	# of graduated youth admitted to HLOC w/in 6mths.	N/A	N/A	N/A	0	1	N/A
OUT 13-4D	# of youth graduated from the CME.	N/A	N/A	N/A	24	25	N/A
OUT 13-4R	Calculated N/D	N/A	N/A	N/A	0%	4%	N/A
Primary Care Practitioner Access (EPSDT)							
OUT 13-5N	# of CME enrolled youth with an identified Primary Care Practitioner.	N/A	N/A	N/A	35	27	N/A
OUT 13-5D	# of youth enrolled in the CME.	N/A	N/A	N/A	229	213	N/A
OUT 13-5R	Calculated N/D	N/A	N/A	N/A	15%	13%	N/A
Cost Savings							
OUT 13-6N	total Medicaid cost (WYCME)	N/A	N/A	N/A	1066090.59	1288647.2	N/A
OUT 13-6D	# of youth enrolled in CME 6+ months	N/A	N/A	N/A	229	213	N/A
OUT 13-6A	Average cost of CME youth (for 6 months)	N/A	N/A	N/A	5005.120141	5753	N/A
OUT 13-6RON	Total Medicaid cost (other)	N/A	N/A	N/A	$ 1,302,342.33	$ 1,625,212	N/A
OUT 13-6ROD	# of non-HFWA youths w PRTF	N/A	N/A	N/A	56	65	N/A
OUT 13-6ROA	Average cost of PRTF youth (for 6 months)	N/A	N/A	N/A	23256.11304	25003	N/A
Fidelity to the high fidelity wraparound (HFWA) Model							
OUT 13-7N	The Contractor shall report fidelity to the HFWA model as measured by the Wraparound Fidelity Index (WFI-EZ)	N/A	N/A	N/A	0	0	N/A
OUT 13-7D	relative to 72%	N/A	N/A	N/A	80%	79%	N/A

OP	Performance Measure Description	Q1	Q2	Q1-Q2 Total	Q3	Q4	Q3-Q4 Total
Fidelity to the high fidelity wraparound (HFWA) Model							
OUT 13-8	The Contractor shall report the number of WFI-EZ surveys received to capture a valid and representative sample of the experiences of enrollees served.	N/A	N/A	N/A	17	23	N/A

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Appendix F. Outcome Measures Review Tool

Outcomes Tool

No	2021 SOW Section	Outcome Name - SFY 2021	Outcome Requirement - SFY 2021	Outcome Performance Measure - SFY 2021	Outcome Performance Penalty - SFY 2021	Q1	Q2	Q3	Q4	Status of Goal	Findings and Comments
1	OUT 13-1	Out-of-Home (OOH) Placements	The Contractor must, report the number of OOH placements of Contractor youth OOH=Out of Home (PRTF, or Acute Psychiatric Stabilization)	Report quarterly for the previous quarter the Denominator - number of youth enrolled with the CME Contractor and the Numerator – number of CME 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: 231 %: 5	N: 12 D: 213 %: 6	N: 6 D: 229 %: 2.6	N: 8 D: 213 %: 3.8	Meets Requirement	Magellan reported the number and percent of OOH placements on a quarterly basis.
2	OUT 13-2	Decreased Length of Stay (LOS) for Inpatient and Residential Treatment admissions for youth enrolled in the CME.	The Contractor must report the overall length of stays for inpatient psychiatric treatment (PRTF and Acute Psychiatric Stabilization) for youth enrolled in the CME.	Report quarterly for the previous quarter the Average LOS for CME enrolled youth 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)	N/A	N/A	ALOS: 144 days CME Enrolled Youth: 229	ALOS: 317 days CME Enrolled Youth: 213	Partially Meets Requirement	Magellan reported the average length of stay for PRTF and AIP on a quarterly basis. However, the data reported by Magellan does not appear to align. For Q1 of the review period, Magellan reported ALOS of 10 days for AIP and 34 days for PRTF. Q2 data reported similar figures. However, Magellan reported ALOS of 144 days in Q3 and 317 days in Q4.
3	OUT 13-3	Recidivism	The Contractor must 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 = PRTF level of care	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: 8 D: 231 %: 3	N: 9 D: 213 %: 4	N: 6 D: 229 %: 2.6	N: 22 D: 213 %: 10.3	Meets Requirement	Magellan reported the number of youth who moved to a higher level of care on a quarterly basis.
4	OUT 13-4	Recidivism (LOC) at six (6) months post CME graduation	The Contractor must report recidivism of youth served by the Contractor and who graduated from the CME program as having met goals, who are moving from a lower LOC to a higher LOC within six (6) months of graduation from the CME.	Report annually quarterly on the previous quarter in the following fiscal year no earlier than the end of the third quarter to assure any higher LOC claims are available for inclusion, the Denominator - number of youth graduated from the CME and the Numerator - number of graduated youth moved to a higher level of care (PRTF) 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 annual period (following year)	N/A	N/A	N: 0 D: 24 %: 0	N: 1 D: 25 %: 4	Partially Meets Requirement	Magellan did not report data on recidivism for Q1 or Q2 of the review period.
5	OUT 13-5	Primary Care Practitioner Access (EPSDT)	The Contractor must report the number of CME enrolled youth who have an identified Primary Care Practitioner.	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 identified Primary Care Practitioner.	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: 17 D: 231 %: 7	N: 11 D: 213 %: 5	N: 35 D: 229 %: 15.3	N: 27 D: 213 %: 12.7	Meets Requirement	Magellan reported on EPSDT Compliance / PCP identification across the review period. *NOTE: Q1 and Q2 data reported on EPSDT visits, and not number of enrolled youth with an identified PCP.*

Appendix F. Outcome Measures Review Tool

No	2021 SOW Section	Outcome Name - SFY 2021	Outcome Requirement - SFY 2021	Outcome Performance Measure - SFY 2021	Outcome Performance Penalty - SFY 2021	Q1	Q2	Q3	Q4	Status of Goal	Findings and Comments
6	OUT 13-6	Cost Savings (Healthcare Costs)	The Contractor must report healthcare costs to Medicaid for the CME enrolled youth.	Average total Medicaid healthcare costs per CME enrolled youth as compared to the total Medicaid costs for the target eligible population of non-CME enrolled youth with PRTF 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 annual reporting period (following year)	Avg. cost of CME youth (6 mo.): $4,910 Avg. cost of PRTF youth (6 mo.): $20,529	Avg. cost of CME youth (6 mo.): $5,005 Avg. cost of PRTF youth (6 mo.): $23,256	Avg. cost of CME youth (6 mo.): $5,005 Avg. cost of PRTF youth (6 mo.): $23,256	Avg. cost of CME youth (6 mo.): $5,753 Avg. cost of PRTF youth (6 mo.): $25,003	Meets Requirement	Magellan reported average cost of CME youth and average cost of PRTF youth on a quarterly basis.
7	OUT 13-7	Fidelity to the high fidelity wraparound (HFWA) Model	The Contractor must 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 baseline 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)	82.0%	73.1%	80.2%	78.6%	Meets Requirement	Magellan reported fidelity to the HFWA model as measured by the Wraparound Fidelity Index (WFI-EZ) on a monthly basis.
8	OUT 13-8		The Contractor must report the number of WFI-EZ surveys received to capture a valid and representative sample of the experiences of enrollees served.	Report quarterly the number of WFI-EZ surveys received during the quarterly period compared to the same quarter in the previous year.	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by one quarter of one percent (0.25%) and the decreased PMPM will continue until the next reporting period (following quarter)	# of Surveys (average): 42	# of Surveys (average): 30	# of Surveys: 17	# of Surveys: 23	Meets Requirement	Magellan reported the number of WFI-EZ surveys administered on a monthly basis.
9	OUT 13-9	Family and Youth Participation at State-level Advisory Committees	The Contractor must work with Agency to identify and invite family and youth to participate on State-level Advisory Committees.	Report quarterly for the previous quarter the Denominator - number of state-level Advisory 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%). The decreased PMPM will continue until the next reporting period (following quarter)	N/A	N/A	N/A	N/A	Does Not Meet Requirement	For Q1-Q2, Magellan reported Advisory Board Family Participation for OUT-10. However, this measure was based on number of attendees representing families, over total number of attendees. Additionally, the data file provided by Magellan reported erroneous numerators and denominators for OUT-10. For Q3-Q4, Magellan did not report on Advisory Board participation.
10	OUT 13-10	Family and Youth Participation in Communities	The Contractor must 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%). The decreased PMPM will continue until the next reporting period (following quarter)	N/A	N/A	N/A	N/A	Does Not Meet Requirement	Magellan did not report on Family and Youth Participation in Communities across all quarters.

External Quality Review (EQR) Protocol 3 Compliance Tool

#	Federal regulation source(s)	New or Existing	Medicaid/CHIP agency policy/ regulation information needed to determine MCP compliance	SFY2021 Amended Contract	Documents Reviewed	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)	Existing Requirement	•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. 13]	Magellan CME Quality Annual Program Evaluation 7.1.2020-12.31.2020 Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	9.24.2021: According to the **Annual Program Evaluation,** CME had adequate resources to serve to serve WY CME membership and meet the needs of the program (pg. 5) In Section 11 (Benefit Plan and Covered Services) of **Chapter 47 of Wyoming's Department of Health Administrative Rules**, patient to provider ratios are listed (pg. 9): (i)A ratio of no more than one (1) FCC for a total of ten (10) persons (1:10) being served by that FCC regardless of the referral source; (ii) A ratio of no more than one (1) Family Support Partner (FSP) for a total of ten (10) persons (1:10) being served by that FSP regardless of the referral source; (iii) A ratio of no more than one (1) Youth Support Partner (YSP) for a total of twenty-five (25) persons (1:25) being served by that YSP regardless of the referral source; 11.17.2021: Magellan completes a quarterly report sent to the state which indicates the number of enrollees and providers at that time. Magellan also shares information on a weekly basis on providers that are going in and coming out. There currently are two levels of care: youth support and respite. Respite is currently under-utilized so there are no issues with capacity. Youth services is limited to a certain age range. Enrollees can age out so this LOC requires closer monitoring.	Fully Met
2		Existing Requirement	•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. 14]	WY CME Provider List Clinical	9.24.2021: **Provider List:** Magellan provided an Excel-based provider listing of all active CME providers, including group and solo providers. Data include NPI, email, and physical addresses. Provider Directory also included on the **Magellan website**: https://www.magellanofwyoming.com/youth-and-families/find-a-provider/. Magellan provides the directory in machine-readable format (XML) and states that the directory is updated "every day".	Fully Met
3		Existing Requirement	•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 service requirements. 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. 13]	WY_CME_Map_FamCare WY_CME_Map_FamSupport WY_CME_Map_Respite WY_CME_Map_YouthSupport WY CME Provider List Clinical - June 25, 2021 Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	9.24.2021: Magellan provided **CME Geo-Maps** demonstrating the placement of CME resources throughout the state, including placement of providers and members. Magellan provided a **Provider List** of all active providers, including group and solo providers. Data includes NPI, email, addresses, point of contact etc. **Chapter 47 of Wyoming's Department of Health Administrative Rules** outlines the Availability and accessibility of services required for the CME Program (Section 9; pg. 7-9) Magellan did not provide a map of referral and subsequent enrollment patterns (analysis is part of Contractor's performance evaluation). 10.25.2021: Within the first **Committee Data File** covering July 2020 - December 2020, Magellan reports on performance measure D8 "Percentage of approved plans of care that confirm via signature or another method that the youth and/or guardian had choice of HCBS services and choice of provider offered" and demonstrates 100% compliance for all months throughout this period. 11.17.2021: Providers are determined to be geographically accessible through the geographic mapping that is conducted as part of the quarterly report. This mapping shows the distribution of provider type across the state. Providers meet families according to family presence so if accommodations are needed, providers will meet them accordingly. If accessibility issues are identified, the quality and compliance team would conduct an investigation to rectify the issue.	Partially Met
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	Existing Requirement	•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. 13] 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. 14] 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. 12]	Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	9.24.2021: **Chapter 47 of Wyoming's Department of Health Administrative Rules** outline the agency's standards for timely enrollee access to care and services required of Medicaid/CHIP and MCPs. Standards are outlined in Section 9 (Availability of Services/Accessibility), and Section 10 (Individualized Plan of Care) (pg. 7-9) The Wyoming Department of Health's Administrative Rules for Medicaid were not included in the documents shared by Magellan (link: https://rules.wyo.gov/Search.aspx?mode=1) 11.17.2021: Magellan's contract with Wyoming is Monday - Friday 8am - 5pm. Magellan staff are available during those hours. Additionally, Magellan supports 24/7 call center. Provider hours vary according to families' preferences. In the review period, Magellan has not received any grievances or appeals related to provider network hours. A variety of data fields are collected in EHR/ Committee Data Files to determine that care and services are rendered to CME enrollees in a timely manner. A Provider Education Team meets weekly to address concerns and discuss corrective action plans. A letter to a provider may be sent to request an explanation and a plan to remedy timeliness issues.	Fully Met

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	Existing Requirement	•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. 14]	2021 WY Member Handbook 2021 Provider Handbook - Complete	9.24.2021: According to the **Member Handbook**, part of developing the Plan of Care is assessing an enrollee's cultural needs (pg. 15); Listed in the Member's Rights and Responsibilities is the right to "Learn about treatment in a way that respects your culture" (pg. 27) The **Provider Handbook** includes a section titled "Cultural Competency" that outlines the roles Providers and Magellan play in providing culturally competent care (pg. 44) A small number of providers speak Spanish. Handbooks are available in Spanish. Translation services are also available for enrollees upon request. Call center staff have access to EHR and can see what interpretation services members need. Providers are expected to assist families who have difficulty understanding the materials that have been provided. Resources include the website and the Youth and Family Guide. The current contract requires all public facing materials to be written at a 8th grade reading level. Inherently because of the program, Magellan aims to use family friendly language. Magellan follows federal regulations on providing reasonable accommodations when possible. Turnaround got meeting accommodations depends on vendors. Magellan offers alternative solutions to help in the interim (e.g., TTY) All providers receive training and must demonstrate cultural competency as part of the HFWA process.	Fully Met
6		Existing Requirement	•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. 14] 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. 14]	2021 Provider Handbook - Complete Network Development Plan Calendar Year 2021 Final Draft 11.13.2020	9.24.2021: The **Provider Handbook** includes a section titled "Cultural Competency" that outlines the role and responsibilities Magellan has in providing culturally competent care to enrollees (pg. 44) The **Network Development Plan** includes data on the racial and ethnic identity of enrollees, outcome measures, utilization and special needs populations. Additionally, Magellan's annual reporting for Contract Year SFY 2021 included reporting of demographic data, outcomes measures, utilization, and data on special needs populations relevant to the CME program. **Appendix AD of the Annual Report** includes the CME's Race and Disparity Report 2021. The disparity analysis tracks race of WY CME Youth vs. FidelityEHR and State Medicaid and makes recommendations for the program to remediate disparities and improve access to the program. The Network plan did not report measures related to racial/ethnic disparities in in timely access, coverage, and authorization of care to WY. Annual trainings are conducting and all staff must complete a module on cultural competency. Providers must demonstrate a certain level of competency. Monitoring occurs at the corporate and local level. Monitoring most commonly occurs through document review and tracking of annual trainings and recertification. Cultural competency is core to operation and part of the HFWA process. Magellan supports internal cultural competency committees.	Fully Met
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	Existing Requirement	•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 "provide a process for assisting families in identifying a Primary Care Physician (PCP) when the enrollee or family chooses. Document in the enrollee's health record." [SOW pg. 64] The Contractor must report the number of CME enrolled youth who have an identified Primary Care Practitioner. The Contractor must 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 identified Primary Care Practitioner. [SOW pg. 81]	Clinical Manual 2020	9.24.2021: In the **Clinical Manual,** part of the Provider Requirements and Timelines is to identify "if the family has a primary care provider (PCP = doctor) and discuss the benefits" (pg. 43) 10.25.2021: Within the first **Committee Data File** covering July 2020 - December 2020, Magellan reports on performance measure G6 "The percentage of participants who have identified a Primary Care Provider (PCP) by submission of their first plan of care for authorization" and demonstrates high compliance (>93% compliance) for all months within this period. Within the final **Committee Data File** covering January 2021 - June 2021, Magellan reports on OUT 13-5 "Primary Care Practitioner Access (EPSDT) which measures the percent of CME enrolled youth with an identified Primary Care Practitioner. For this measure, Magellan reports 15.3% for Q3 and 12.7% for Q4. 11.17.2021: As part of the enrollment process, Family Care Coordinators are encouraged to select PCP's in their communities. FCC develop robust teams including medical staff/ PCP. These teams have access to general case information and on a routine basis are able to have conversations with FCC throughout the HFWA process. If a family does not elect to have a team, Magellan does not take additional steps to mandate the relationship in the plan. PCP information is available in EHRs and Magellan can pull reports, note trends, and target outreach to PCPs. Magellan does not keep a list of PCPs to send out to enrollees.	Partially Met
8		Existing Requirement	•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 must 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. 12]	Magellan CME Quality Annual Program Evaluation 7.1.2020-12.31.2020 WY_CME_Map_FamCare WY_CME_Map_FamSupport WY_CME_Map_Respite WY_CME_Map_YouthSupport	9.24.2021: In the **Quality Annual Program Evaluation** for SFY 2021, Magellan states that "any potential service gaps in the delivery system are reviewed and plans developed to expand the network accordingly in conjunction with membership growth." Generally, Magellan's provider network adequacy efforts appear to mirror membership growth as required by the SOW. Across the review period, Magellan reported membership and provider counts. Magellan also provided **WY CME Geo-Maps** demonstrating the locations of FCCs, Family Support, Youth Support, and Respite Providers.	Fully 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	Existing Requirement	The state's requirements regarding the obligation to and methods by which an MCP must: •a) 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. 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. 17]	2021 WY Member Handbook 2021 Provider Handbook - Complete	9.24.2021: The **Member Handbook** identifies the Family Care Coordinator as "A Family Care Coordinator is a person who is trained to coordinate the High Fidelity Wraparound process, support the family and team and is responsible for all documents Magellan needs to keep High Fidelity Wraparound in place." (pg. 11) The **Provider Handbook** outlines requirements of the Family Care Coordinator including coordinating services, recording enrollee utilization or services, and documenting enrollee progress towards goals from the Plan of care (pg. 26-29) 11.17.2021: Monitoring compliance of enrollee rights to service availability, coordination, and continuity of care is conducted through a review of EHR – A specific tab for monitoring OOH placement is used. Clinical reviewer would see tab and this would drive service coordination. A second opinion is driven by FCC. Such concerns wouldn't necessarily bubble up to CME program level. If it did escalate, would fall under POC review process. Clinical eligibility assessment – if there were a LOC / CASII assessment submitted that indicated the youth did not continue to meet LOC requirement for enrollment, team would have the option to conduct an additional assessment. If a youth requires HLOC, Magellan would conduct a review process and discuss additional alternatives. Enrollees can work with FCC to determine potential placement in other waivers. Magellan uses same coordination of care across all CME services.	Fully Met
10		Existing Requirement	•b) **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. 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. 17]	2021 Provider Handbook - Complete	9.24.2021: The **Provider Handbook** outlines requirements of the Family Care Coordinator (pg. 26-29) including coordinating services between settings: "The Family Care Coordinator will communicate within defined timelines for any inpatient or other out-of-home placements" In addition, the Handbook outlines requirements for coordinating services with other services provided by community and social supports: "The Family Care Coordinator shall work with the family to schedule and document all team meetings and invite the entire team." 10.25.2021: Within the final **Committee Data File** covering January 2021 - June 2021, Magellan reports on EM 9-20 "FCC & Contact with Parent and Youth twice a month in a quarter" which measures the percent of enrollees with a minimum of two progress notes documenting FCC contacts per month for youth and/or caregiver out of the total number of youths. Magellan reported 83.7% compliance for Q3 and 82.7% compliance for Q4. Additionally, Magellan reports on EM 9-23 "FCC holds regularly scheduled CFTs and updates to the POCs" which is measured by dividing the number of PCOs that have been updated by the total number of enrollees/ POCs. Magellan reported 27.8% compliance in Q3 and 100% compliance in Q4.	Fully Met
11		Existing Requirement	•c) **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 enrollee, their family, and CFT at the start of the wraparound process to develop a Plan of Care (POC) based on the individual family and enrollee's needs, strengths and preferences. The FCC must collaborate with child and family serving agencies that are involved with the enrollee and his or her family. Each POC shall align with the HFWA phases and requirements, such as SNCD, and crisis planning. All POC's must include team member signatures, specifically youth (if age appropriate), family, and FCC at minimum. [SOW pg. 62]	Clinical Manual 2020	9.24.2021: The **Clinical Manual** outlines the timeline for engagement with new enrollees. The timeline provided in the manual states that by Day 28, the FCC must gather info to complete the SNCD and other needed tests and surveys (pg. 43) 10.25.2021: Within the first **Committee Data File** covering July 2020 - December 2020, Magellan reports on the performance measure D1 "Percent of POC that reflect participant's assessed needs, risks, and personal goals as detailed in the clinical eligibility assessments, or any other applicable evaluation provided to the CFT " and demonstrates 100% compliance for all months within the period. Within the final **Committee Data File** covering January 2021 - June 2021, Magellan reports on EM 9-16 "FCC & Plan of Care (POC)" which is measured as follows: Numerator - "Number of POCs, all enrollees must have an FCC. A POC must be developed for each enrollee within forty-six calendar days after enrollment." Denominator - "Number of enrollees". Magellan reports 84.8% compliance in Q3 and 85.7% in Q4.	Fully Met
12		Existing Requirement	•d) 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	Once the assessment is complete, the family and youth or their Family Care Coordinator will provide a completed copy of the assessment and score to the Contractor. The youth/family or their Family Care Coordinator must also provide clinical documentation from a qualified mental health professional that confirms the presence of an Axis 1 diagnosis, validating that the youth meets the federal qualifying criteria for a serious emotional disturbance (SED) or serious mental illness (SMI). The youth/family may also provide appropriate authority for the evaluator to send the assessment results directly to the Contractor. The submission of these components to the Contractor will serve as confirmation of the medical eligibility component required for enrollment. The Contractor is prohibited from discriminating against individuals eligible under the medical eligibility criteria on the basis of health status or need for health care services. The Contractor must maintain copies of the assessments and documentation for State review during periodic quality assurance audits. Once a youth is enrolled, the youth may begin receiving CME services provided by the Contractor's provider network. [SOW pg. 57-58]	2021 Provider Handbook - Complete Clinical Manual 2020	9.24.2021: Reviewed documents did not mention whether results are shared with the State of other MCPs for the purpose of non-duplication of assessment.	Partially Met
13		Existing Requirement	•e) 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. 17]	2021 Provider Handbook - Complete	9.24.2021: The **Provider Handbook** outlines requirements of the Family Care Coordinator. The Handbook states that "It is the provider's responsibility to maintaining all member records for a minimum of six years. Providers may be asked to produce those records for auditing purposes" (pg. 29)	Fully Met

14		Existing Requirement	•f) **Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with applicable privacy requirements**	Adhere to applicable State and federal laws, rules, regulations, guidelines, policies, and procedures relating to information systems, information systems security and privacy, physical security, PHI confidentiality and privacy. Zero percent (0%) out of compliance. If the system is out of compliance, a mitigation plan to regain compliance is due to the agency within ten (10) business days with mitigation to be complete and testing to be complete in timeframe defined in the mitigation plan. The Contractor will assume all liabilities including any incurred cost to the Department for the violation of applicable State and Federal laws, rules, regulations, guidelines, policies, and procedures relating to information systems, information systems security and privacy, physical security, PHI confidentiality and privacy. [SOW pg. 85] The Contractor must provide multiple layers of external and internal security that provides administrative, physical, and technical means to protect sensitive or confidential information used in performing the responsibilities and duties set forth in this SOW [SOW pg. 34]	2021 Provider Handbook - Complete	9.24.2021: The **Provider Handbook** outlines requirements of the Family Care Coordinator. The Handbook states that "The Family Care Coordinator must demonstrate all coordination of care activities protect each enrollee's privacy in accordance with the privacy requirements at 45 CFR, parts 160 and 164, subparts A and E, to the extent that they are applicable" (pg. 26) 11.17.2021: Compliance Committee Meeting meets monthly to review policy and changes in protocol. Staff has been diligent on PHI and disclosure issues and conduct refresher trainings or coaching with individual staff depending on what the issue is. Different icons on email are used to indicate the level of security/ sensitivity categories for exchanging PHI internally (e.g. "Secure" is included in the subject line). Magellan also conducts annual HIPAA training. Phishing emails are also sent out internally to test staff.	Fully Met
15	**Additional coordination and continuity of care requirements: LTSS** **Medicaid**: 42 C.F.R. § 438.208: Coordination and continuity of care	Existing Requirement	•Methods used by the Medicaid/CHIP agency to identify to the MCP enrollees who need LTSS.	None	Not Applicable	Not Applicable	Not Applicable
16	**CHIP:** 42 C.F.R. § 457.1230(c): Coordination and continuity of care	Existing Requirement	•Whether the MCP is required to meet identification, assessment, and treatment planning requirements for dually-enrolled beneficiaries.	None	Not Applicable	Not Applicable	Not Applicable
17		Existing Requirement	•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	Not Applicable	Not Applicable
18		Existing Requirement	•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. 20]	Quality Improvement Program Policy pgs. 5-6 WY CME Quality Issues Management Procedure WY CME QI_WorkPlan Final 7.1.2020-12.31.2020 Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	9.24.2021: **Quality Improvement Program Policy** outlines requirements for QAPI Program and related PIPs. **Quality Issues Management Procedure** outlines the process to identify underperforming metrics or areas of concern **Chapter 47 of Wyoming's Department of Health Administrative Rules** outline the agency's standards for quality review and utilization standards. Standards are outlined in Section 12 (Quality Reporting) (pg. 12) The Wyoming Department of Health's Administrative Rules for Medicaid were not included in the documents shared by Magellan (link: https://rules.wyo.gov/Search.aspx?mode=1)	Fully Met
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	Existing Requirement	•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. 20]	Clinical Manual 2020 (HFWA Program Enrollment and Disenrollment: Policy and Standards) Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	9.24.2021: The **Clinical Manual** states that youth are received through referral from youth funded through Wyoming Medicaid B Waiver or C Waiver, from a Family Care Coordinator (FCC)/Agency, or youth's guardian. Youth are then assessed to determine if they meet Clinical Eligibility; the process is outlined in the Clinical Manual (pg. 366). **Chapter 47 of Wyoming's Department of Health Administrative Rules for Medicaid** outline the agency's standards for CME Eligibility and the Participant Application and Enrollment Process. Standards are outlined in Section 5 (Eligibility) and Section 6 (Participant Application and Enrollment Process) (pg. 3-5) The Wyoming Department of Health's Administrative Rules for Medicaid were not included in the documents shared by Magellan (link: https://rules.wyo.gov/Search.aspx?mode=1)	Fully Met
20		Existing Requirement	•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. 20]	Clinical Manual 2020 2021 Provider Manual Handbook - Complete 2021 WY Member Handbook Chapter 1: Definitions Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	9.24.2021: The **Clinical Manual** outlines an assessment for determining youth clinical eligibility for the program (pg. 366); The Manual also outlines the process through which FCCs develop a Plan of Care for each member (pg. 44-46) The **Provider Manual** outlines criteria enrollees must meet to be eligible for the program (pg. 43) and the initial assessment process (Appendix A); Outlines process through which the provider team builds and revisits Plan of Care for the enrollee (Appendix A) **Member Handbook** outlines the HFWA phases to build an enrollee care plan (pg. 15-18) The State definition of special health care needs was not provided by Magellan or in the reviewed State Medicaid documents.	Fully Met
21		Existing Requirement	•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. 20]	Not Applicable	Not Applicable	Not Applicable
22		Existing Requirement	•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.	The Contractor must include mechanisms to assess the quality and appropriateness of care coordination furnished to enrollees with special health care needs. [SOW pg. 20]	Not Applicable	Not Applicable	Not Applicable

23		Existing Requirement	•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.	The Contractor must include mechanisms to assess the quality and appropriateness of care coordination furnished to enrollees with special health care needs. [SOW pg. 20]	2021 Provider Manual Handbook - Complete Clinical Manual 2020	9.24.2021: The **Provider Manual** outlines the process through which the provider team builds and revisits Plan of Care for the enrollee (Appendix A) The **Clinical Manual** outlines the process through which FCCs develop a Plan of Care for each member (pg. 44-46)	Fully Met
24		Existing Requirement	•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. 20]	WY CME QI_WorkPlan Final 7.1.2020-12.31.2020 Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	**9.24.2021: Magellan's Work Plan** states quality indicators, goals, and outcomes of the goals (pg. 20-21): Positively influencing Health and Well-being, including youth/member safety: 1.Monitor care through Critical Incident Reporting and the Wyoming Clinical (WYClinical) authorization to determine if any member safety concerns exist. 2. Increase the volume of members enrolled in the CME that can benefit from HFWA services. Enhancing Service and the Experience of Care: 3. Meet or exceed the national mean for member and family satisfaction results through monitoring of the Wraparound Fidelity Index, Short Form (WFI EZ). 4. Stabilize and increase volume, including service array representation of the network HFWA providers to improve adequacy across regions. Meeting and exceeding contractual, and regulatory requirements: 5. Maintain compliance with contractual requirements 6. Successful implementation and ongoing monitoring of the Enrollment Pilot Project to identify, prioritize, and pursue opportunities to improve processes by recognizing operational issues or efficiencies. **Chapter 47 of Wyoming's Department of Health Administrative Rules for Medicaid** outline the agency's standards for Quality Reporting. Included in Section 12 (Quality Reporting) (pg. 9) The Wyoming Department of Health's Administrative Rules for Medicaid were not included in the documents shared by Magellan (link: https://rules.wyo.gov/Search.aspx?mode=1)	Fully Met
25	**Disenrollment** **Medicaid**: 42 C.F.R. § 438.56: Disenrollment: Requirements and limitations **CHIP:** 42 C.F.R. § 457.1212: Disenrollment	Existing Requirement	•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 some of the 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. 10]	Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	9.24.2021: **Chapter 47 of Wyoming's Department of Health Administrative Rules** lists the reasons the MCP can request disenrollment including (Section 7; pg. 6): (i) The youth is no longer Medicaid eligible; (ii) The youth moves out of the State; (iii) The youth ages out of the program; (iv) The youth is incarcerated; (v) The youth is no longer financially eligible; (vi) The youth is no longer clinically eligible; (vii) The youth is determined eligible for any excluded program/population pursuant to Section 4; (viii) The youth is in out-of-home placement longer than one hundred eighty(180) days; (ix) The youth needs related services (for example a cesarean section and tubal ligation) to be performed at the same time; not all related services are available within the network; and the youth's Primary Care Provider (PCP) or another provider determines that receiving the services separately would subject the youth to unnecessary risk; or (x) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the youth's specific health care needs. 10.25.2021: Within the final **Committee Data File** covering January 2021 - June 2021, Magellan reports on EM 9-9 "Client disenrollment if the enrollee meets criteria" which is measured as follows: Numerator - "Provide a thirty (30) calendar day advance notification to the enrollee and the enrollee's FCC prior to implementing a change in program eligibility and/or service amount, duration, or frequency. With exception of loss of Medicaid eligibility", Denominator - "Number of 30 day advance notice". Magellan reported 0% for Q3 and 90.9% for Q4. 11.17.2021: The disenrollment process begins when the EHR is triggered by FCC actions. Upon disenrollment, the guardian receives an automated disenrollment notification. As part of the disenrollment process, a transition meeting takes place to go through the crisis plan with the family and understand where supports have stepped down. As part of the discharge planning process, documents are also given to the family. Magellan must process disenrollment and turn over to the state within 7 days.	Fully Met
26		Existing Requirement	•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 must 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. 10]	Clinical Manual 2020 (HFWA Program Enrollment and Disenrollment: Policy and Standards)	9.24.2021: The **Clinical Manual** states that disenrollment requests by Magellan will be reviewed and approved by the State (pg. 369)	Fully Met
27		Existing Requirement	**•Whether the state chooses to limit disenrollment.**	Disenrollment requested by the enrollee may occur for cause at any time. The enrollee (or his or her representative) must submit an oral or written request to the Contractor requesting disenrollment. [SOW pg. 10]	Clinical Manual 2020 (HFWA Program Enrollment and Disenrollment: Policy and Standards) Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	9.24.2021: The documents reviewed did not report a limit on disenrollment.	Fully Met
28		Existing Requirement	**•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. 10] The Contractor must 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. 10]	Clinical Manual 2020 (HFWA Program Enrollment and Disenrollment: Policy and Standards) Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	9.24.2021: The **Clinical Manual** states (pg. 369) : 1. Disenrollment requested by the enrollee may occur at any time. 2. A youth or guardian may request disenrollment for any reason. **Chapter 47 of Wyoming's Department of Health Administrative Rules** states (pg. 5 & 7): (b) A youth and his or her family may choose to disenroll at any time pursuant to Section 7 of this Chapter. (b) A participant may voluntarily disenroll from the CME without cause at any time	Fully Met

29		Existing Requirement	•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. 10] 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. 10]	Clinical Manual 2020 (HFWA Program Enrollment and Disenrollment: Policy and Standards)	9.24.2021: The **Clinical Manual** states that Magellan may approve disenrollment requests by or on behalf an enrollee (pg. 369)	Fully Met
30		Existing Requirement	•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.		Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	9.24.2021: **Chapter 47 of Wyoming's Department of Health Administrative Rules** states (pg. 8): (b) An enrollee may appeal their loss of eligibility pursuant to the grievance process outlined in Section 22 of this Rule	Fully Met
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): 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	Existing Requirement	•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 Contractor must review one hundred percent (100%) of all plans of care submitted and report this information to the Agency quarterly. The Contractor must 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 must submit data to the Agency annually showing remediation for individual problems related to the plan of care. [SOW pg. 18]	Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	9.24.2021: **Chapter 47 of Wyoming's Department of Health Administrative Rules** Outlines State Requirements for Availability of Services/Accessibility (Section 9) and Benefit Plan and Covered Services (Section 11) The first **Committee Data File** provided by Magellan (for the SOW covering July - December 2020), Magellan largely met requirements related to Plans of Care, especially requirements for inclusion of crisis plans; POC reflection of member needs; and POC approval. However, for POC timeliness requirements (OP-05 -- "Rate of enrollments with POCs developed within 46 days of enrollment"), Magellan showed only 60% compliance in August 2020, and only 56% compliance in November 2020. Additionally, in EM 9-17, the Final **Committee Data File** provided for Q4 2021 shows that Magellan fully complied with requirements to review and process 100% of POCs throughout the review period. 11.17.2021: All services provided and authorized are provided as listed in the plan of care. Reviewer authorizes services. Upon enrollment, providers connect with youth and family. If the youth is in crisis, providers create a band aid plan until the team has a chance to make a plan of development and a formal crisis plan (created within the first 46 days of enrollment) The Crisis plan is included in the plan of care (POC is required for all enrollees). Clinical Manual describes the process for notifying the requesting provider and enrollee of a decision to deny, limit, or discontinue authorization of services. Magellan has a process for letters to alert providers and enrollees.	Fully Met
32		Existing Requirement	•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 PA/UM process will require the Contractor to implement a service authorization review process and. 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, CANS and any other information deemed necessary to determine service authorization. [SOW pg. 43]	Chapter 1: Definitions	9.24.2021: **Chapter 1 of Wyoming's Department of Health Administrative Rules** defines medical necessity as "A determination that a health service is required to diagnose, treat, cure or prevent an illness, injury or disease which has been diagnosed or is reasonably suspected to relieve pain or to improve and preserve health and be essential to life." Limitations for the designation are listed in the document (pg. 19) 11.17.2021: All CME services require pre-authorization.	Fully Met
33		Existing Requirement	•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. 16]	Medicaid SA Determination - CO.MCD.244	**9.24.2021: Medicaid SA Determination**: The policy outlines the Authorization and Standard UM Service Authorization Review Process (pg. 3) 11.17.2021: Timeframes for processing standard and expedited requests for service authorization are as follows: •Standard: 14 calendar days to process completed requests (all required documentation is accompanied by request = completed) •Expedited: 72 hours The Committee Data File has measures related to these timeframes. Magellan reports data to conduct ongoing monitoring. Magellan makes auth determinations based on requests from providers -- Magellan examines documentation regarding scope, frequency, and services. Magellan reviews POC updates, review documentation submitted to Magellan for concurrent review. The nature of requests can be inconsistent based on family needs. Magellan does not deny authorization. However, services can be non-authorized if documentation is complete or if a child loses Medicaid. Non-authorizations are issued by clinical reviewers who review all documentation. 11.22.2021: Magellan was mostly compliant with contract requirements for authorization decisions. During the first half of the review period (7/1/2020 - 12/31/2020), Magellan reported compliance of >95% for each month for OP-19A (Rate of standard auth decisions within timeframe). However, in December 2020, Magellan reported only 62% compliance with OP-19B (Rate of extended standard auth decisions made within timeframe).	Partially Met
34		Existing Requirement	•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.	No mention of drugs or medication in the document	Medicaid SA Determination - CO.MCD.244 Medicaid SA Determination - CO.MCD.244 HFWA.AA	9.24.2021: **Medicaid SA Determination**: The policy outlines notice requirements for outpatient drugs (pg. 7) 11.17.2021: Medicaid SA Determination Addendum Attachment: States that the Notice Requirements for Outpatient Drugs does not apply to WY HFWA business	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	Existing Requirement	· 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. 11]	Member Enrollee Rights and Responsibilities Policy	9.24.2021: **Rights and Responsibilities Policy:** According to the policy, Magellan provides required information to enrollees and requires network providers to inform enrollees and their legal guardians of rights and responsibilities (pg. 2-3) 10.25.2021: Additionally, in the final **Committee Data File** covering January 2021- June 2021, Magellan reports on EM 9-15 "Member Handbook to all new enrollees and their guardians" which is calculated by dividing the number of mailings/ notifications by the total number of new enrollees. Magellan reported 100% compliance with this measure for all months in the period. 11.17.2021: Magellan provides enrollees automated enrollment and disenrollment letters. Family/ Stakeholder Newsletter is mailed monthly and contains resources on the referral process, articles on cultural sensitivity/ competency, and upcoming events. Information is disseminated via US mail/ postcards. Enrollees will also receive notice of updates to the enrollee handbook. Magellan gives written notice of termination of a contracted provider to enrollees who receive care from the terminated provider. This information is tracked via the EHR.	Fully Met
36		Existing Requirement	· 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	Policy Glossary and Terms 01-2021 Chapter 1: Definitions Chapter 10: Pharmaceutical Services Chapter 26: Covered Services	9.24.2021: **Chapter 1 of Wyoming's Department of Health Administrative Rules** includes definitions for the following terms: copayment; durable medical equipment; hospital outpatients care ("outpatient hospital services"); medically necessary; plan ("plan of care"); preauthorization ("Prior Authorized"); provider; and skilled nursing care ("Skilled nursing service") **Chapter 10 of Wyoming's Department of Health Administrative Rules** includes definitions for the following terms: prescription drug **Chapter 26 of Wyoming's Department of Health Administrative Rules** includes definitions for the following terms: emergency services ("emergency hospital services"); habilitation services ("habilitative services"); Hospice Services; physician services; rehabilitative services State definitions do not include the terms: appeal; emergency medical condition; emergency medical transportation; emergency room care; excluded services; grievance; habilitation devices; health insurance; home health care; hospitalization; network; non-participating providers; participating provider; premium; prescription coverage; primary care physician; primary care provider; rehabilitation devices; specialist; urgent care **Policy Glossary:** Magellan's Policy Glossary is an extensive list of terms including: durable medical equipment, emergency medical transportation, emergency room care, habilitation services and devices, health insurance, home health care, hospitalization, hospital outpatient care, physician services, plan, preauthorization, premium, prescription drugs, primary care physician, primary care provider, rehabilitation services and devices, skilled nursing care, specialist and urgent care; Glossary was not included in the documents shared by Magagula for Protocol 3 (the link to the Policy Glossary was found on multiped pages in the Clinical Manual)	Fully Met
37		Existing Requirement	· 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. 11]	2021 WY Member Handbook 2021 WY Member Handbook-Spanish 2019-2020 Member Handbook - Final Notice of Action-Non-Authorization - 2020-2021 WY CME Enrollee appeal Response Letter Final 2020-2021_ Clinical Manual 2020	**9.24.2021: Member Handbook** includes: 1. Member rights and responsibilities. 2. Covered services. 3. Procedures to follow if a clinical emergency occurs. 4. Confidentiality, its scope and its limits. 5. Ensure current medications are updated in the Plan of Care as needed, include updates when medication changes are made and communication with the primary care physician, other relevant healthcare providers and Magellan. 6. Choice of Provider **Clinical Manual** includes example Notices: Application Authentication Notice (B-Waiver and C-Waiver), Assessment Authentication Notice, C-Waiver Assessment Authentication Notice, and Advanced Notice of Disenrollment, Transition of Care Letter, Clinical Nonauthorization Letter 11.17.2021: A small number of providers speak Spanish. Handbooks are available in Spanish. Translation services are also available for enrollees upon request. Call center staff have access to EHR and can see what interpretation services members need. Enrollee primary language is determined at onboarding/ initial content. Information is inputted in the EHR.	Fully Met
38		Existing Requirement	· 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. [SOW pg. 11] The Contractor must 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. [SOW pg. 12]	Clinical Manual 2020	9.24.2021: The statement of work, included in the **Clinical Manual**, states the that Spanish is the prevalent non-English language in WY (pg. 18) The **Provider Handbook** provides accessibility contact information from Magellan, including TTY lines. However, it is unclear if the Provider Handbook is provided in multiple languages and formats. The **Provider Handbook** also appears to offer providers guidance with accessing interpreter services, if necessary to provide services to an enrollee. The Handbook lists Magellan's responsibility to "Assist providers in locating interpreters for our members when requested by the member or when requested by the provider." (pg. 44)	Fully Met

39		Existing Requirement	· Policies relevant to written material language and format, for example, policies relevant to inclusion of taglines.	The Contractor must 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. 12]	Member Enrollee Rights and Responsibilities Policy	**9.24.2021: Rights and Responsibilities Policy:** Standards for Enrollee Written materials are listed in the policy (pg. 3) A. All enrollee written materials must be provided using easily understandable language and format. B. The font size cannot be smaller than 12 points. C. Written material must be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency. D. Written material must include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 point. E. Written material that is considered a significant publication (including individual member letters) must include the notice of nondiscrimination and the language access taglines. These notice and tagline requirements are outlined in the Nondiscrimination and Language Access policy. Some accounts may require that all written materials contain the notice and taglines.	Fully Met
40		Existing Requirement	· Any interpretation services that the Medicaid/CHIP agency makes available to enrollees.	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. 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. 12]	Member Enrollee Rights and Responsibilities Policy 2021 WY Member Handbook Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	**9.24.2021: Rights and Responsibilities Policy:** Interpretation and translation services are provided at no additional cost to enrollees. Services provided to Enrollees are outlined in the rights and responsibilities policy (pg. 4-5) **Member Handbook:** Instructions for members to access interpretations services are included in the Member Handbook (pg. 7) **Chapter 47 of Wyoming's Department of Health Administrative Rules:** "E. Written material that is considered a significant publication (including individual member letters) must include the notice of nondiscrimination and the language access taglines. These notice and tagline requirements are outlined in the Nondiscrimination and Language Access policy. Some accounts may require that all written materials contain the notice and taglines." (pg. 16)	Fully Met
41		Existing Requirement	· 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. 11]	Member Enrollee Rights and Responsibilities Policy Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	**9.24.2021: Rights and Responsibilities Policy:** According to the policy, Magellan provides enrollee with Enrollee rights and responsibilities at their first appointment (pg. 3) **Chapter 47 of Wyoming's Department of Health Administrative Rules:** "(i) HFWA Youth and Family Handbooks issued to those automatically referred to the CME. Handbooks shall outline all Federal information requirements and include any additional HFWA educational material that may be helpful to families when being assessed for enrollment." (pg. 15)	Fully Met
42		Existing Requirement	· 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. 11]	2021 WY Member Handbook Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	**9.24.2021: Member Handbook** includes language explaining grievance and appeal process (pg. 30-33) **Chapter 47 of Wyoming's Department of Health Administrative Rules:** The CME rules include a section titled "Grievance and Complaints" (Section 22) that outlines the grievance process for the CME program (pg. 16)	Fully Met
43		Existing Requirement	· 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.	Provide continuous enrollee benefits if the enrollee files a request for an appeal within sixty (60) calendar days from the adverse action notification. Benefits shall 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 State policies, the costs of the enrollee's continued benefits. The Contractor must pay for disputed services if the decision to deny, limit or delay services was overturned.[SOW pg. 48]	Medicaid Adverse Benefit Determination Appeal	9.24.2021: The **Medicaid Adverse Benefit Determination policy** states that Magellan will continue to provide benefits for a service while an appeal or state fair hearing is pending. The Policy also outlines the circumstances in which benefit continuance would occur. 11.17.2021: Magellan reviews and either accepts or rejects the plan of care. Clinical reviewer notifies family and providers on the reasoning for rejections. This must occur within 14 days (standard) or, for expedited needs, within 3 days.	Fully Met
44		Existing Requirement	· Any content required by the state for the enrollee handbook that is not covered in 42 CFR 438.10(g).	None	Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	9.24.2021: Could not identify additional state requirements	Fully Met
45		Existing Requirement	· 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 will have mechanisms in place to help enrollees and potential enrollees understand the requirements and benefits of their plan and provide such information in a manner and format that may be easily understood and is readily accessible. The Contractor is required to provide each enrollee notice of any significant change in the information specified in the enrollee handbook at least thirty (30) days before the intended effective date of the change. The Contractor is also required to have policies that highlight enrollee's rights, including their right to participate in decisions regarding his/her healthcare, refuse treatment, be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, and request a copy of medical records and to have these record amended or corrected, when necessary. Each enrollee is free to exercise his or her rights without the Contractor or its network providers treating the enrollee adversely. [SOW pg. 11]	Member Enrollee Rights and Responsibilities Policy 2021 WY Member Handbook 2021 Provider Handbook - Complete Clinical Manual 2020 Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	11.17.2021: A definition of "significant change' is provided in the Wyoming State Medicaid Managed Care Quality Strategy: WDH defines "significant change" as a modification in the Medicaid program or managed care plans' operations that would materially affect service delivery or receipt of benefits, including adjustments in services, benefits, geographic service area, payments, eligible populations, or other circumstances which impact delivery or measurement of the quality of services as determined by the State. Significant change may include, but is not limited to: •Addition or removal of service offerings and benefits offered to managed care plan enrollees; •System-wide changes in the composition, frequency, or amount of payments made to the provider network delivering services to enrollees; •New or amended federal and/or State regulations which impact programmatic operations. (PJ)	Fully Met

46		Existing Requirement	· 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 required to provide each enrollee notice of any significant change in the information specified in the enrollee handbook at least thirty (30) days before the intended effective date of the change**. The Contractor is also required to have policies that highlight enrollee's rights, including their right to participate in decisions regarding his/her healthcare, refuse treatment, be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, and request a copy of medical records and to have these record amended or corrected, when necessary. Each enrollee is free to exercise his or her rights without the Contractor or its network providers treating the enrollee adversely. [SOW pg. 11] The Contractor shall have staff available using an 800 number 24 hours a day/365 days a year to respond to enrollee calls. Interpreter services are available for the hearing impaired and for non-English speakers [SOW pg. 12]	Member Enrollee Rights and Responsibilities Policy	**9.24.2021: Member Enrollee Rights and Responsibilities Policy:** Enrollee rights as required in the SOW are outlined in the policy 11.17.2021: Guardians can access enrollee medical records maintained by Magellan through a family portal.	Fully Met
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	Existing Requirement	•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: C. Treatment options [SOW pg. 11-12]	Member Enrollee Rights and Responsibilities Policy	**9.24.2021: Member Enrollee Rights and Responsibilities Policy** states "For a counseling or referral service that the customer and/or Magellan does not cover because of moral or religious objections, MCO and/or Magellan must inform enrollees that the service is not covered by the MCO and how they can obtain information from the State about how to access the services." (pg. 6) No specific identification of any moral or religious objections to provide care 11.17.2021: Magellan has a process for providers to identify if other services outside of CME are needed (e.g., hospitalization). As soon as Magellan is aware that a higher level of care for enrollees is needed, a clinical team will conduct service coordination. Contacts at Optum and DFS will reach out as needed.	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 **CHIP:** 42 C.F.R. § 457.1220: Enrollee rights	Existing Requirement	•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.	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. 11]	Member Enrollee Rights and Responsibilities Policy	**9.24.2021: Member Enrollee Rights and Responsibilities Policy** states "Each enrollee has the right to receive written information on advanced directives and their rights under State law." (pg. 5) 11.17.2021: Family choice is a high fidelity wraparound principle. As part of the HFWA process, providers are trained on consulting families and include families in meetings and decision making. Staff are trained on enrollee's rights and responsibilities and must complete trainings within the first 20/60 days, including a training on the Member's Rights and Responsibilities Document. Compliance is monitored via an EHR review. Magellan leverages an online training system through Rise (software). Modules are assigned to providers and must achieve an 80%. There are 14 modules total as part of initial training. Topic areas include services they are providing, steps to complete work, quality, WY court systems, addressing abuse, neglect, and exploitation. Providers are not allowed to restrain the enrollees; if that were to happen, would be brought up to the state, a critical incident report would be filed and would work together to determine next steps	Fully Met
49		Existing Requirement	•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	Member Enrollee Rights and Responsibilities Policy	**9.24.2021: Member Enrollee Rights and Responsibilities Policy** states "For a counseling or referral service that the customer and/or Magellan does not cover because of moral or religious objections, MCO and/or Magellan must inform enrollees that the service is not covered by the MCO and how they can obtain information from the State about how to access the services." (pg. 6) No specific identification of any moral or religious objections to fulfilling advance directives	Fully Met
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	Existing Requirement	•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	Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules Chapter 18: Medicaid Eligibility Chapter 16: Medicaid Program Integrity	9.24.2021: Could not identify enrollee rights with which the state Medicaid Agency requires. 11.17.2021: Magellan has a compliance officer associated with the contract to review corporate compliance. This includes compliance with enrollees' rights. Providers at the time of enrollment are tasked with explaining to patients their rights and responsibilities. Documents are also presented to enrollees and signed at enrollment. Corporate structures are also in place.	Fully Met

51	**Provider Selection** **Medicaid**: 42 C.F.R. § 438.214: Provider selection **CHIP**: 42 C.F.R. § 457.1233(a): Provider selection	Existing Requirement	•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. 13]	Wraparound Solutions - 2021 Provider Agreements 2021 Provider Handbook - Complete Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	9.24.2021: As part of the **Provider Agreements**, Magellan outlined required Credentialing and Recredentialed procedures for providers (pg. 3) According to the **Provider Handbook**, providers must notify Magellan of changes to information reviewed during the credentialling process including (pg. 32): o Licensure or certification, including state licensing board actions on your license, o Board certification(s), o Hospital privileges, o Insurance coverage, o New information regarding pending or settled malpractice actions. The **Provider Handbook** also outlines a Network Provider training and recertification that providers must adhere to (pg. 22-24) and the provider must be enrolled in Medicaid (pg. 73) **Chapter 47 of Wyoming's Department of Health Administrative Rules:** Includes Provider Training and Certification Requirements (Section 18, pg. 11-15) 10.25.2021: In the first **Committee Data File** covering July 2020 - December 2020, Magellan reports on performance measure C1 "Percentage of waiver providers that meet all initial provider credentialing and qualification requirements" and C2 "Percentage of waiver providers that meet all ongoing provider credentialing and qualification requirements". Magellan reports high compliance (>99%) for all months within this period. 11.17.2021: Providers complete applications which are sent to corporate supports for review to ensure that providers meet all requirements. Once all elements are verified, the application is approved. Providers must successfully apply for Medicaid to get through initial stages. Providers recertify every year. During the process team ensures that they have completed annual trainings on HIPAA, cultural competency, Crisis plans, safety plans, and plans of care. Magellan monitors provider network Medicaid eligibility loss. In the given review periods, no providers were removed due to loss in Medicaid eligibility. Denials of provider participation can be due to quality of care issues, FBI background check or registry concerns, and instances of abuse/crimes.	Fully Met
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	Existing Requirement	•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.	[Language removed from SOW]	Social Tecknowledgy FidelityEHR - MH CS 14660 executed	9.24.2021: According to the **Master Services Agreement**, Magellan can review and audit FIDELITYEHR's compliance with the MSA annually.	Fully Met
53	**Practice Guidelines** **Medicaid:** 42 C.F.R. § 438.236: Practice guidelines **CHIP:** 42 C.F.R. § 457.1233(c): Practice guidelines	Existing Requirement	•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. 14]	Clinical Manual 2020 WY CME QI_WorkPlan Final 7.1.2020-12.31.2020 2021 Provider Handbook- Complete	9.24.2021: Could not identify "practice guidelines" within documents shared by Magellan or in the Medicaid Administrative Rules 11.17.2021: Guidelines are developed from state and federal requirement, contract with the state, SOW; Practice guidelines are based on HFWA guidelines/principles. Magellan ensures that policy and procedures align with the principles of WY and then comes up with strategic plan to meet goals and contractual requirements. The Contract drives Magellan's priorities and the HFWA principles and SOW drives strategic planning. Magellan also gathers feedback enrollees via survey and receive provider feedback via monthly provider calls. The Compliance Committee and Network Strategy Committee take the necessary information and funnel it into actionable steps. Enrollees are given a 30-day notice of changes and provide notice and provide update. Monthly QIC meetings and monthly provider education group meetings are used to align the QAPI program and the practice guidelines adoption process. When Magellan determines updates to practice guidelines are needed, the committee will review the requested changes to ensure that updates do not infringe on contractual agreements in place. The Compliance Committee conducts a Policy and Procedure review. The Leadership Team then determines whether an alert must be sent out. Appropriate steps and trainings would then be conducted. Magellan conducts surveys (WFI-EZ, Member satisfaction, Annual Surveys Provider Surveys) to obtain feedback on enrollee perceptions about the availability of provider services. The Quality Improvement Committee meets quarterly and focus groups and phone calls occur on an ad-hoc basis. Concerns can be raised through the grievance process. Enrollees can email or call Magellan any time. All guidelines related to utilization management are guided by the contract and are consistent with other practice guidelines. Magellan works with the State to conceptualize how to develop guidelines for HFWA.	Fully Met
54	**Health information systems** **Medicaid:** 42 C.F.R. § 438.242 **CHIP**: 42 C.F.R. § 457.1233(d):	Existing Requirement	· 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. 9]	2021 WY CME Program Description Final iSeries Uptime - Prev. 12 Months - June21 Mid-Range Development Systems - June21 Mid-Range Production Systems - June21 Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules Waiting for missing Fidelity HER Business Continuity Plan Information System document	9.24.2021: According to the **Master Services Agreemen**t, Magellan can review and audit FIDELITYEHR's compliance with the MSA once annually Did not find other information clarifying state-required health information system assessments or past assessments 11.17.2021: Examples of practice guidelines adopted include: 1.EHR – All activities moved from paper to electronic which helped streamline data gathering and collection and gave providers/members additional access to information. 2.Training – All provider training is now available online. This changed how Magellan collects and tracks data. All went into effect in 2021	Fully Met

55		Existing Requirement	· State specifications for data on enrollee and provider characteristics that must be collected by the MCP.	The Agency has established a comprehensive list of performance measures. The performance measures provide information on process; health status/outcomes; access/availability of care; use of service/utilization; health plan stability/financial/cost of care; health plan/provider characteristics; and beneficiary characteristics. [SOW pg. 9]	Clinical Manual 2020 (Enrollments) WY CME QI_WorkPlan Final 7.1.2020-12.31.2020	9.24.2021: The **Clinical Manual** includes extensive information on the client data collected during the initial onboarding process (pg. 147-160) **Work Plan** includes list of QI measures tracked by Magellan including measures applicable to both enrollees and providers 11.17.2021: Types of data collected varies, ranging from demographics of youth and family and providers, diagnosis, utilization management, and enrollee management. Systems are set up to easily create reports that can be shared with the state and other appropriate stakeholders.	Fully Met
56		Existing Requirement	· 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	2021 WY CME Program Description Final iSeries Uptime - Prev. 12 Months - June21 Mid-Range Development Systems - June21 Mid-Range Production Systems - June21 Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules Waiting for missing Fidelity HER Business Continuity Plan Information System document	9.24.2021: According to the **Master Services Agreement**, Magellan can review and audit FIDELITYEHR's compliance with the MSA once annually Did not find other information clarifying state-required health information system assessments or past assessments	Fully Met
57		Existing Requirement	· 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 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. 14] [Language on MMIS and monthly tracking UM data were removed from SOW]	2021 WY CME Program Description Final iSeries Uptime - Prev. 12 Months - June21 Mid-Range Development Systems - June21 Mid-Range Production Systems - June21	**Chapter 47 of Wyoming's Department of Health Administrative Rules** included guidelines to ensure that enrollee encounter data was submitted to the state: Section 15 (Provider Record keeping and Data Collection): "For the purposes of data collection, the Medicaid Management Information System shall capture all eligibility data as well as claims and encounter data" (pg. 10) Review of the state Medicaid Administrative rules did not reveal specifications for how the MCP should collect data elements for electronic transmission of data, transmit data on provider and enrollee characteristics, or how to ensure data collected from providers is complete 11.22.2021: Issues regarding Magellan's data quality assurance and control process were discussed in live review. Magellan shared policies and procedures for quality control on 11/19.	Partially Met
58		Existing Requirement	· Specifications for submitting encounter data to the Medicaid/CHIP agency in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format.	Magellan PMPM claims will be submitted to the Agency in standardized Accredited Standards Committee (ASC) X12N 837 format, the ASC X12N 835 format, and EDI 270/271 Eligibility Benefit Inquiry and Response formats, as appropriate. [SOW pg. 30]	Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	**9.24.2021: Chapter 47 of Wyoming's Department of Health Administrative Rules** included guidelines to ensure that enrollee encounter data was submitted to the state: Section 15 (Provider Record keeping and Data Collection): "For the purposes of data collection, the Medicaid Management Information System shall capture all eligibility data as well as claims and encounter data" (pg. 10) In reviewed documents, could not identify process for submitting encounter data	Fully Met
59		Existing Requirement	· Make all collected data available to the state and upon request to CMS.	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. 9]	Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	**9.24.2021: Chapter 47 of Wyoming's Department of Health Administrative Rules** included guidelines to ensure that enrollee encounter data was submitted to the state: Section 15 (Provider Record keeping and Data Collection): "For the purposes of data collection, the Medicaid Management Information System shall capture all eligibility data as well as claims and encounter data" (pg. 10) In reviewed documents, could not identify process for sharing data with the state 11.17.2021: Systems are set up to easily create reports that can be shared with the state and other appropriate stakeholders.	Fully Met
60		Existing Requirement	· 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 Contract also establishes expectation around continuous quality improvement that includes participating in the development of measures of performance and collecting and reporting baseline data on identified performance indicators, and development and implementation of improvement plans. Measures must be designed with the goal of maintaining quality of services, controlling costs and are consist with its responsibilities to enrollees. The results are reported to the Agency and the Agency discusses the findings and identifies opportunities for improvements. In addition, this information aids in the assessment of the effectiveness of the quality improvement process. The data from all sources is analyzed for compliance. The identified aspects are integrated into the implementation of continuous quality improvement processes. The findings will be included in the Contractor's performance evaluation. The Agency will require the Contractor to undergo annual, external independent reviews of the quality, timeliness, and access to the services covered under this contractual agreement. [SOW pg. 9-10]	Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	**9.24.2021: Chapter 47 of Wyoming's Department of Health Administrative Rules** included guidelines to ensure that enrollee encounter data was submitted to the state: Section 15 (Provider Record keeping and Data Collection): "For the purposes of data collection, the Medicaid Management Information System shall capture all eligibility data as well as claims and encounter data" (pg. 10) Section 10 (Quality Reporting): (a) The Department shall perform, at minimum, quarterly monitoring of the CME 1915(b) waiver program's impact, access, and quality to ensure access to adequate services where medically necessary. (i) The Department shall establish standards of quality for CME adherence, including, but not limited to, plan assurances on network adequacy. (ii) The Department shall deem the CME in compliance with standards as long as the accrediting agency maintains standards as required by the Department. (pg.10)	Fully Met
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	Existing Requirement	•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	WY CME QI_WorkPlan Final 7.1.2020-12.31.2020 2021 WY CME Program Description Final	9.24.2021: Documents did not contain language requesting an exemption from national performance measures or PIPs	Fully Met
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	Existing Requirement	· 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. 20]	Magellan CME Quality Annual Program Evaluation 7.1.2020-12.31.2020	9.24.2021: In the **Quality Annual Program Evaluation**, Magellan identified two Performance Improvement Projects: Improving minimum contact engagement for Family Care Coordinators, and Engagement and Implementation Improvement (pg. 17-23) 11,17.2021: Magellan conducts a member satisfaction survey on access and availability. The most recent survey yielded the following results: 92% of enrollees are satisfied with their provider, 86.7% are satisfied with meeting locations, 100% are satisfied with time of meetings, and 87% indicated that providers were respectful of language-related needs. Magellan educates providers if there are specific concerns or challenges. The provider scorecard ensures that providers are engaging families. Magellan captures metrics and trending issues identified. With minimum contacts, if providers are not meeting targets or are trending to not meet targets, Magellan will reach out to the provider to identify potential barriers. There are currently no compliance thresholds set by the state. The Clinical Team monitors issues relating to timeliness of access to care. If issues are identified, the clinical team will call/email the provider. If issues persist and are ongoing, the clinical team will contact the education team. Training is used to promote cultural competency and a cultural competency workgroup meets quarterly to provide specific learning opportunities for staff. Disparity reports are also conducted to identify trends or concerns and develop remediation strategies. For instances, there was an undercount of the Native American population and in response, Magellan was able to get a provider on the reservation to provide services. Provider complaint information is considered during the re-credentialing process. Data from EHRs is pulled and checked for trends to identify compliance issues. Data is important to quarterly and annual reports to identify strengths or areas to improve upon. Magellan also identifies whether there is data needed to share with providers on how to improve their performance either in one on one settings or in a group setting.	Fully Met
63		Existing Requirement	· The state's specifications for how the MCP should identify, measure and report performance measures required per paragraph (c) 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. 20]	Quality Improvement Program Policy	9.24.2021: The **QI Program Policy** includes a descripting of required documentation, including a Quality Improvement Program Description, an Annual Quality Work Plan, and an Annual Evaluation Review of the state Medicaid Administrative rules did not reveal specifications for how the MCP should measure and report performance measures	Fully Met
64		Existing Requirement	· 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. 20]	WY CME Quality Issues Management procedure_ Magellan CME Quality Annual Program Evaluation 7.1.2020-12.31.2020	9.24.2021: The CME Quality Annual Program Evaluation Describes the process Magellan uses to Evaluate over- and/or under-utilization (pg. 36): "Magellan has processes in place to monitor for under or over utilization on a continuing basis to facilitate the timely identification of any trends suggestive of under-utilization or over-utilization Magellan monitors the number of enrollments, encounters, authorizations, 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 since the implementation of this contract. Situations that might impact utilization such as seasonal variability, changes in the provider network and external factors (such as natural disasters, cultural events etc.) are considered as well. If extremes in utilization are detected, the Clinical, Network and Quality team work together to review the possible causes and address any root causes. The complete annual analysis of over and underutilization will be provided in the 2021 program evaluation." Review of the state Medicaid Administrative Rules did not reveal specifications for how the MCP should measure and report performance measures. 11.17.2021: Magellan does not have any gaps in data. Magellan has access to all the data needed to conduct any analysis we need; Areas for improvement include: access to services and other quality metrics. FCC is mandated so it can't be under or over utilized. Magellan uses documentation from providers, EHR, claims to Medicaid to track over and under utilization. Magellan is not getting requests for Respite services. Magellan uses "anecdotal tracking" of utilization patterns. The PHE has impacted this process substantially.	Fully Met
65		Existing Requirement	· 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. 20]	Quality Improvement Program Policy Magellan CME Quality Annual Program Evaluation 7.1.2020-12.31.2020 Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	9.24.2021: The **Quality Improvement Program Policy** outlines state requirements for the Quality Assessment to assess the quality and appropriateness of care (pg. 5) The **Annual Quality Evaluation** outlines Magellan's process to monitor quality of service (pg. 10) and member access to appropriate care/services (pf. 13) **Chapter 47 of Wyoming's Department of Health Administrative Rules**: Quality Reporting guidelines are outlines in Section 12 (Quality Reporting, pg. 9-10)	Fully Met
66		Existing Requirement	· 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.	Not Applicable	Not Applicable	10.25.2021: In the first **Committee Data File** covering July 2020 - December 2020, Magellan reports on performance measure D3 "Number and percent of services delivered according to the type specified in the plan ", D4 "Number and percent of services delivered according to the amount specified in the plan", D5 "Number and percent of services delivered according to the frequency specified in the plan", D6 "Number and percent of services delivered according to the scope authorized in the plan of care", and D7 "Number and percent of services delivered according to the duration authorized in the plan of care". Compliance percentages for each of these performance measures ranged from 53% to 100% for each of the months in this period.	Fully Met

67		Existing Requirement	· 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	Not Applicable	Not Applicable	10.25.2021: In the first **Committee Data File** covering July 2020 - December 2020, Magellan reports on the following performance measures: G1 The percentage of incidents regarding abuse, neglect, exploitation and unexplained death that were addressed according to both the state statute and the approved waiver G2 The percentage of waiver participants (or families/legal guardians) who received training and education on how to identify and report abuse, neglect, exploitation and unexplained death G3 Percentage of critical incidents that resulted in PAHP contractor follow up, provider corrective action plans, sanctions, or other disciplinary action G4 The percent of critical incident where the root cause was identified (Related to QOC) In the final **Committee Data File** covering January 2021 - June 2021, Magellan reports on Ops 8-19 "Critical Incidents" which measures compliance with the following requirement: "The Contractor shall notify the Agency within two (2) business days of any critical incident event". Magellan reported 96% compliance in Q3 and 100% compliance in Q4. 11.17.2021: Providers are on the frontline and report on critical incidents. They are trained on reporting. Critical incidents are discussed during monthly calls. Having a good crisis plan in place helps to prevent the critical incidents. Monitoring occurs through the clinical team to make sure that the plan of care and crisis pan help enrollees avoid critical incidents. If critical incidents do increase, Magellan looks back at the crisis plans to see what works and what doesn't work and see if there is a training issue related to providers. Generally Magellan works with the family to identify effective strategies.	Fully Met
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	Existing Requirement	· Information on the standard performance measures identified by the state.	The Agency has established a comprehensive list of performance measures. The performance measures provide information on process; health status/outcomes; access/availability of care; use of service/utilization; health plan stability/financial/cost of care; health plan/provider characteristics; and beneficiary characteristics. [SOW pg. 9]	Network Development Plan Calendar Year 2021 Final Draft 11.13.2020 WY CME QI_WorkPlan Final 7.1.2020-12.31.2020	9.24.2021: According to the **Network Development Plan**, WY CME reports quarterly on a list of performance indicators and compares performance to national care and service delivery systems of Magellan. Additional expanded performance data set based on contractual and customer requirements is also reported at established intervals (pg. 21) **Quality Work Plan:** Performance Indicators and outcomes are listed (pg. 8-11)	Fully Met
69		Existing Requirement	· 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.	Not Applicable	Not Applicable	Not Applicable	Fully Met
70		Existing Requirement	· 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. 9]	Magellan CME Quality Annual Program Evaluation 7.1.2020-12.31.2020 Quality Improvement Program Policy	9.24.2021: The **CME Quality Annual Program Evaluation** states: "The WY CME collects data from multiple sources to support quality improvement activities. The data is used to measure performance against established goals, objectives and performance indicators as outlined in the QI Work Plan." (pg. 17) **Quality Improvement Policy** states: "The MCO/SBU/Operational Unit will annually Submit to the State data, specified by the State, which enables the State to calculate the MCO/SBU/Operational Unit performance using the standard measures identified by the State" (pg. 5-6)	Fully Met
71	**Performance improvement projects** **Medicaid:** 42 C.F.R. § 438.330(d) and **CHIP**: 42 C.F.R. § 457.1240(b)	Existing Requirement	· 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. 20]	Quality Improvement Program Policy	**9.24.2021: Quality Improvement Policy** outlines state requirements for Performance Improvement Projects and for program review by the state (pg. 6) 11.17.2021: Magellan works closely with state to address whatever needs they have. Magellan recently implemented the enrollment initiative PIP. The SOW outlines expectations for PIPs.	Fully Met
72		Existing Requirement	· 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. 20]	Quality Improvement Program Policy	**9.24.2021: Quality Improvement Policy** outlines state requirements for Performance Improvement Projects and for program review by the state. It states: " The MCO/SBU/Operational Unit reports the status and results of each project conducted to the State as requested, but not less than once per year." (pg. 6)	Fully Met
73		Existing Requirement	Information on if the state permits an MCP exclusively serving dual eligible 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	Not Applicable	Not Applicable	Not Applicable

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	Existing Requirement	•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. 20]	Quality Improvement Program Policy	**9.24.2021: Quality Improvement Policy** outlines state requirements for Performance Improvement Projects and for program review by the state. It states: "The MCO/SBU/Operational Unit will submit, for review, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each PCCM entity" (pg. 6) 11.17.2021: Magellan conducts an annual QI program evaluation that is similar to the WY program evaluation. This evaluation examines accomplishments, improvements, key metrics, grievances and appeals, provider network, and overall performance for the year. Magellan achieved timely delivery of all required documents to the state and reported successful contract implementation, successful training for EHRs to transition to the platform, successful integration of online training and increased training/provider completed trainings with scores above the national average, and no critical incidents that threaten compliance. Magellan seeks to continue to improve the following areas: increase providers in network, enrollment, making sure family/youths are being seen adequately, maintain compliance with current metrics. This evaluation is required by the state and is included in the annual report for the State. Quarterly reports are also submitted to the State. Magellan collaborates with the State to make sure youth/family receive the services they need. Magellan also supports weekly meetings with the State in a very collaborative relationship. Magellan provides data through the committee data file and report on grievances and appeals and critical incidents. Clinical teams will make sure risks and issues are resolved and crisis plans are updated.	Fully Met
Grievance System							
75	**Grievance Systems** **Medicaid**: 42 C.F.R. § 438.228: Grievance and appeal systems	Existing Requirement	•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. [SOW pg. 16]	Medicaid Enrollee Grievances WY CME Enrollee Appeal Response Letter Final 2020-2021_ Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	**9.24.2021:** WY CME Enrollee Appeal Response Letter: Magellan (the MCP) provides notice of resolution for appeals. Included in the notice is an explanation of the Grievance and Appeals process and notification of the enrollee's right to request a State Fair Hearing. (pg. 4-5) Chapter 47 of Wyoming's Department of Health Administrative Rules: "Notice of the CME's grievance procedure shall be sent to enrollees once the Department informs the CME of the youth's eligibility as a program enrollee" (pg. 15) The Final Committee Data File covering January - June 2021 states a requirement of Magellan to provide a 30 calendar day advance notification to the enrollee and the enrollee's FCC prior to changes in program eligibility and/or service amount, duration, or frequency (Ops 8-30). Magellan did not provide data for the period for Ops 8-30. 10.25.2021: Magellan also reports on Ops 8-26 "Enrollee grievance, appeal, and information about the right to a State fair hearings process". An appeal must be filed by an enrollee within sixty (60) calendar days from the date on the adverse benefit determination notice. An enrollee may file with the CME at any time. Magellan did not provide data for the period for Ops 8-26. Numerator and denominator are poorly defined.	Fully Met
76	**General requirements** **Medicaid:** 42 C.F.R. § 438.402: General requirements **CHIP:** 42 C.F.R. § 457.1260: Grievance system	Existing Requirement	· Information on: · Whether enrollees are required or permitted to file a grievance with either the state or the MCP, or both	None	Medicaid Enrollee Grievances Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	**9.24.2021: Medicaid Enrollee Grievances:** Magellan's Enrollee Grievance Policy states that enrollees have the right to submit a grievance with the MCO (pg. 4) **Chapter 47 of Wyoming's Department of Health Administrative Rules: "**The CME shall have a system in place for enrollees or providers acting on behalf of enrollees to access a grievance process, an appeal process, and access to the Department's fair hearing system." (pg.15)	Fully Met
77		Existing Requirement	· 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. 15]	Medicaid Enrollee Grievances Medicaid Adverse Benefit Determination Appeal	**9.24.2021: Medicaid Enrollee Grievances:** Magellan's Enrollee Grievance Policy states that an Authorized representative can request a grievance on an enrollee's behalf (pg. 3); the grievance policy does not include providers **Medicaid Adverse Benefit Determination Appeal:** 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" (pg. 3) 10.25.2021: In the Final **Committee Data File** covering January - June 2021, Magellan reports on Ops-30 which states that "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." Since no appeals occurred during the review period, Magellan did not report any data regarding appeals timeframes in the **Committee Data Files**. 11.17.2021: Providers are allowed to request expedited appeals on behalf of an employee with the member's written approval.	Fully Met
78		Existing Requirement	Whether state offers external medical review.	None	Medicaid Adverse Benefit Determination Appeal	**9.24.2021: Medicaid Adverse Benefit Determination Appeal:** Policy states the State (WY) may offer external medical review for an Adverse Benefit Determination Appeal if the following conditions are met (pg. 13): 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.	Fully Met

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	Existing Requirement	•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. 16]	Clinical Manual 2020 (HFWA Clinical Nonauthorization Process Document)	**9.24.2021: Clinical Manual**: In alignment with the SOW, the HFWA Clinical Nonauthorization Process Document states that service authorization requests must be reviewed within 14 days (pg. 214); Mailing written notice to enrollees is mentioned on infographics (pg. 217-220) but no timeframe is given. Magellan reported requirements related to standard and extended auth decisions in the Committee Data File covering July - December 2020. Specifically, Magellan was highly compliant with authorization timeframe requirements (>95% for all months within period), with the exception of the rate of extended standard auth decisions made within timeframe (OP-19), for which Magellan reported 62% compliance in December 2020.	Partially Met
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	Existing Requirement	•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...Grievances filed only with the Contractor may be filed 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. 15]	Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules Medicaid Adverse Benefit Determination Appeal	9.24.2021: State requirements for grievances and appeals do not differ from the requirements and programs laid out in **Chapter 47 of Wyoming's Department of Health Administrative Rules** or in the **Medicaid Adverse Benefit Determination Appeal** document	Fully Met
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	Existing Requirement	· 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. 15]	Medicaid Enrollee Grievances Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	**9.24.2021: Medicaid Enrollee Grievances:** Policy states that the investigation and response to grievance must not exceed 90 day timeframe (pg. 6) **Chapter 47 of Wyoming's Department of Health Administrative Rules** Outlines in Section 22 (Grievance and Complaints) the standard timeframes for the grievance and appeals process (pg. 15): (ii) The CME's grievance and one-level appeal process must adhere to the timeframes specified in 42 C.F.R. §438.400 and §438.424. (iii) An enrollee has sixty (60) calendar days from the date on the adverse action notice to file an oral or written request (iv) The CME shall acknowledge in writing, via certified mail, the receipt of a written or oral grievance or complaint within five (5) working days of receipt; (v) The CME shall prepare and present a proposed resolution to the complaint within forty-five (45) calendar days from the date the CME receives the grievance. If the CME's proposed resolution is not accepted by the enrollee or entity acting on behalf of the enrollee they may file a request for continuation of benefits within ten (10) calendar days of receipt of the proposed resolution or the intended effective date of the adverse action notification, whichever is later. The CME has thirty (30) calendar days to review and respond to the appeal. 10.25.2021: In the Final **Committee Data File** covering January - June 2021, Magellan reports on Ops 8-32 which states that Magellan must "Provide the enrollee or complainant with an acknowledgement of receipt of the grievance or complaint, within two (2) business days of receipt of the grievance or complaint. The acknowledgement shall include the timeframe for resolution". Magellan reported 100% compliance for Q3 and no data for Q4. Additionally, Magellan reports on Ops 8-33 which states that the "Contractor must respond to enrollee grievances and other complaints, received directly or by the Agency in regard to Contractor performance, within five (5) business days after receiving the enrollee grievance or other complaint". Magellan reported 100% compliance with Q3 and no data for Q4. 11.17.2021: Annual reports include an analysis of grievances and appeals. Grievance and appeals records are retained for 10 years. The appeals process requires a written notice. Enrollees have 60 days to file and appeal and can request standard or expedited. If expedited, there is a 72 hour timeframe. Members can always request to extend benefits throughout this process.	Fully Met
82		Existing Requirement	· 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. 15]	Medicaid Enrollee Grievances Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	**9.24.2021: Medicaid Enrollee Grievances:** Document states that Magellan adheres to state established guidelines including resolving and providing written notice of disposition of grievance within 90 days (pg. 4) **Chapter 47** states: "The CME shall acknowledge in writing, via certified mail, the receipt of a written or oral grievance or complaint within five (5) working days of receipt" (pg. 15) The **Committee Data File** provided for January - June 2021 does not report all timeframes required in the SOW. In Ops-32 and 33, the updated Committee Data File includes reporting on acknowledgement of grievances or complaints (2 business days) and Contractor response to grievances (5 business days). The updated Committee Data File does not include reporting on grievance resolution as specified in the SOW.	Fully Met

83		Existing Requirement	· 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. 15]	Medicaid Adverse Benefit Determination Appeal Medicaid Enrollee Grievances	**9.24.2021: Medicaid Enrollee Grievances:** Magellan's Enrollee Grievance Policy states that an Authorized representative can request a grievance on an enrollee's behalf (pg. 3); the grievance policy does not include providers **Medicaid Adverse Benefit Determination Appeal:** 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 (pg. 3) 10.25.2021: The Final Committee Data File covering January - June 2021, Magellan reports on Ops-30 which states that "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."	Fully Met
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	Existing Requirement	None	An oral notice of appeal or an oral inquiry seeking to appeal an adverse action must be treated as an appeal, 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**. 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. 15 -16]	Clinical Manual 2020 Medicaid Adverse Benefit Determination Appeal	9.24.2021: The expedited Appeal process is described in the **Clinical Manual** (pg. 373): "An expedited appeal is filed when you or your doctor believe waiting 30 calendar days for a decision could harm your health. We have 3 working days after we receive your appeal request to make a decision. If you ask for an expedited appeal without support from your provider, we will decide if the request meets the requirements. If not, your request will be decided within 30 calendar days." The Process is also outlines in the **Adverse Benefit Determination** document in the "Adverse Benefit Determination Appeal Review Process: Expedited Appeal Review" Section (pg. 8-10) 10.25.2021: In the Final **Committee Data File** covering January - June 2021, Magellan monitors Ops 8-29 "Handling expedited resolution of appeals" in which Magellan must " Make a decision and send written notification to the requestor of the appeal review (an enrollee of their authorized representative such as the ordering and/or rendering provider) within seventy-two (72) hours of receipt of the initial verbal or written request for appeal review." Since Magellan did not report any appeals for the review period, Magellan did not report any data in **Committee Data Files**. 11.17.2021: Magellan notifies enrollees of denials of a request for expedited resolution via a written letter.	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	Existing Requirement	· 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. 15] d. The written notice must be in a format and language that meets the requirements of 42 C.F.R. 438.10 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. 15] 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. 16]	Medicaid Enrollee Grievances	9.24.2021: **The Medicaid Enrollee Grievances** Document has signatures which show that the description of the MCP's grievance system was approved internally by Magellan. However, the document does not show approval from contacts at the State. (pg. 1) The **Committee Data File** provided for January - June 2021 does not report on the all timeframes required in the SOW. In Ops-32 and 33, the updated Committee Data File includes reporting on acknowledgement of grievances or complaints (2 business days) and Contractor response to grievances (5 business days). The updated Committee Data File does not include reporting on grievance resolution as specified in the SOW.	Fully Met
86		Existing Requirement	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.	[Language removed from SOW]	Medicaid Enrollee Grievances	9.24.2021: **The Medicaid Enrollee Grievances** Document has signatures which show that the description of the MCP's grievance system was approved internally by Magellan. However, the document does not show approval from contacts at the State. (pg. 1)	Fully Met
87	**Recordkeeping requirements** **Medicaid:** 42 C.F.R. § 438.416: Recordkeeping requirements **CHIP:** 42 C.F.R. § 457.1260: Grievance system	Existing Requirement	•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. 15]	WY CME Appeal Information 7.1.20-6.30.21 WYCME Member Grievances 7.1.2020 - 6.30.2020	9.24.2021: **WY CME Appeals Information:** Magellan did not have any appeal requests from 7/1/2020 to 6/30/2021 **WY CME Member Grievances:** Magellan reported 10 Grievances filed from 7/1/2020 to 6/30/2021. All were resolved.	Fully 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 hearing are pending (Note: This requirement does not apply to CHIP)	Existing Requirement	· 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 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. 17]	Medicaid Adverse Benefit Determination Appeal Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	9.24.2021: **Medicaid Adverse Benefit Determination Appeal**: The policy states that continuation of benefits pending a trial or state fair hearing are in accordance with 42 C.F.R. § 420 (pg. 12) **Chapter 47 of Wyoming's Department of Health Administrative Rules** states: "The CME's grievance and one-level appeal process must adhere to the timeframes specified in 42 C.F.R. §438.400 and §438.424" (Section 22; pg. 15)	Fully Met
89		Existing Requirement	· 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	Medicaid Adverse Benefit Determination Appeal WY CME Appeal Information 7.1.20-6.30.21	9.24.2021: **Medicaid Adverse Benefit Determination Appeal:** The policy states that the MCO maintains a record of appeals that contains, at a minimum (pg. 13-14): 1. A general description of the reason for the appeal; 2. The date received; 3. The date of each review or, if applicable, review meeting; 4. Resolution at each level of the appeal, if applicable; 5. Date of resolution at each level, if applicable; and 6. Name of the covered person for whom the appeal was filed. **WY CME Appeal Information 7.1.20-6.30.21:** Magellan did not have any appeals between 7/1/2020 and 6/30/2021.	Fully Met
90		Existing Requirement	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. [SOW pg. 17]	Medicaid Adverse Benefit Determination Appeal	9.24.2021: **Medicaid Adverse Benefit Determination Appeal:** The policy states that at the final resolution of an appeal or state fair hearing, Magellan may recover costs of services furnished to the enrollee (pg. 13)	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	Existing Requirement	•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. 17]	Medicaid Adverse Benefit Determination Appeal	9.24.2021: **Medicaid Adverse Benefit Determination Appeal:** The policy states "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) **SOW** states that the Contractor (Magellan) must pay if an adverse decision is overturned, but the Adverse Benefit Determination Appeal policy document does not clarify whether the State or Magellan is responsible for payment. Is the state or Magellan responsible to pay for the services? Recommendation is to clarify which entity pays for services in the Adverse Benefit Determination Appeal policy document.	Fully Met

Wyoming CME - EQR Network Adequacy Tool

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2021 Contract Language	Does Contract Language Reflect CFR?	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. 13]	Yes	9.14.2021: The **CME Quality Annual Program Evaluation** states that providers are re-certified annually, and that "all providers must comply with the Magellan certification process and meet the state and regulatory requirements". Magellan provided the Recertification Policy via **Process Document - Recertification Policy**, however, the version appears to be incomplete and in draft form. However, Magellan provides additional information on certification / re-certification in the **Provider Handbook**: Certification: *"To be eligible to provide High Fidelity Wraparound services, Magellan network providers are required to successfully complete the qualification and certification process prior to being accepted as a network provider. Our High Fidelity Wraparound coaching staff is the primary source for competency requirements needed for certification. We verify and certify providers in accordance with the criteria required under Wyoming's 1915(B) and (C) Children's Mental Health Waivers and developed with the Wyoming Department of Health. "* Recertification: *"Magellan High Fidelity Wraparound providers are required to undergo annual recertification. Recertification is a year-long process that includes evaluation of provider performance in the Magellan network, including, but not limited to, coordination of care, service and outcomes, member service and adherence to Magellan policies and procedures. If Providers are identified as not rendering High Fidelity Wraparound services there will be education and interventions that may include a continuum from education to a hold on new referrals to a referral to the Magellan Quality Improvement Team. Providers will need to work with a coach to create a Professional Development Plan for the recertification process, complete continuing education hours, send documentation to the coach for scoring, and have a passing score on the tracking sheet requirements."* The **Provider Handbook** specifically outlines provider and Contractor responsibilities in provider certification and re-certification processes.	1. Complete
§ 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 must 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. 14].	Yes	9.14.2021: In the **Quality Annual Program Evaluation for SFY 2021**, Magellan states that "any potential service gaps in the delivery system are reviewed and plans developed to expand the network accordingly in conjunction with membership growth." Generally, Magellan's provider network adequacy efforts appear to mirror membership growth as required by the SOW. Across the review period, Magellan reported membership and provider counts: •212 enrollees, 74 providers in July 2020; •233 enrollees, 84 providers in December 2020; and •199 enrollees, 69 providers in June 2021 Once more, Magellan largely met provider ratio requirements during applicable reporting months (>96% compliance for all months during 2020 within the review period). However, at the end of SFY 2021, Magellan's provider network may be insufficient to meet member demand, as active providers fell sharply in 2021. With approximately 200 enrollees as of June 2021, the provider network may be hard-pressed to provide services across CME membership. Magellan also provided **geo-maps** of providers and members for each HFWA service, including FCC, FSP, YSP, and Respite. Magellan has providers throughout all regions of Wyoming -- including, the Southeast, Southwest, Northeast, Northwest, and Central regions. However, while FCC, FSP, YSP, and Respite providers served all regions of the state during the review period, total provider counts offered via geo-mapping are duplicative across service areas and include cross-certified providers. The EQRO is unable to determine regional, non-duplicative provider counts from the geo-mapping provided for FCC, FSP, YSP, or Respite providers, which is needed to make determinations on timely access, coordination/continuity of care, and coverage. 11.15.2021: Magellan confirmed that unduplicated provider counts are not provided via geo-mapping. Maps show catchment area of each provider, which creates a duplicate provider count. Magellan also discussed diminished provider counts for YSP and Respite services. Magellan offered that services are under-utilized due to natural supports, lack of awareness of service by FCCs, and lack of sufficiently trained providers. Magellan also provides an analysis of provider demographics in the **Quality Annual Program Evaluation** to ensure the network of providers is sufficient and appropriate to meet needs of enrollees. The analysis found that all providers spoke English, while four providers were bi-lingual in Spanish and one provider was bi-lingual in Arabic	1. Complete
(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:	N/A			
2a	(i)	Primary care, adult and pediatric.	Not applicable.	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.	Not applicable.
2c	(iii)	Behavioral health (mental health and substance use disorder), adult and pediatric.	Not applicable.	Not applicable	Not applicable.	Not applicable.
2d	(iv)	Specialist, adult and pediatric.	Not applicable.	Not applicable	Not applicable.	Not applicable.
2e	(v)	Hospital.	Not applicable.	Not applicable	Not applicable.	Not applicable.
2f	(vi)	Pharmacy.	Not applicable.	Not applicable	Not applicable.	Not applicable.
2g	(vii)	Pediatric dental.	Not applicable.	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.	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	Not applicable. This program not does include LTSS.	Not applicable.
3b	(ii)	Network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services.	Not applicable.	Not applicable	Not applicable. This program not does include LTSS.	Not applicable.

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2021 Contract Language	Does Contract Language Reflect CFR?	Findings from CME Documentation	Compliance Status
4	(b)(3)	*Scope of network adequacy standards*. Network standards established in accordance with paragraphs (b)(1) and (2) of this section must include all geographic areas covered by the managed care program or, if applicable, the contract between the State and the MCO, PIHP or PAHP. States are permitted to have varying standards for the same provider type based on geographic areas.	The Contractor must serve all approved regions 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. 22] 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. 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. The Contractor must provide notification to the Agency when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the HFWA program, including the termination of the provider agreement with the Contractor. [SOW pg. 13] 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 service requirements. 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. 13]	Yes	9.14.2021: In the **Quality Annual Program Evaluation for SFY 2021,** Magellan states that "any potential service gaps in the delivery system are reviewed and plans developed to expand the network accordingly in conjunction with membership growth." Generally, Magellan's provider network adequacy efforts appear to mirror membership growth as required by the SOW. Across the review period, Magellan reported membership and provider counts: •212 enrollees, 74 providers in July 2020; •233 enrollees, 84 providers in December 2020; and •199 enrollees, 69 providers in June 2021 Once more, Magellan largely met provider ratio requirements during applicable reporting months (>96% compliance for all months during 2020 within the review period). However, at the end of SFY 2021, Magellan's provider network may be insufficient to meet member demand, as active providers fell sharply in 2021. With approximately 200 enrollees as of June 2021, the provider network may be hard-pressed to provide services across CME membership. Magellan also provided **geo-maps** of providers and members for each HFWA service, including FCC, FSP, YSP, and Respite. Magellan has providers throughout all regions of Wyoming -- including, the Southeast, Southwest, Northeast, Northwest, and Central regions. However, while FCC, FSP, YSP, and Respite providers served all regions of the state during the review period, total provider counts offered via geo-mapping are duplicative across service areas and include cross-certified providers. The EQRO is unable to determine regional, non-duplicative provider counts from the geo-mapping provided for FCC, FSP, YSP, or Respite providers, which is needed to make determinations on timely access, coordination/continuity of care, and coverage. 11.15.2021: Magellan confirmed that unduplicated provider counts are not provided via geo-mapping. Maps show catchment area of each provider, which creates a duplicate provider count. Magellan also discussed diminished provider counts for YSP and Respite services. Magellan offered that services are under-utilized due to natural supports, lack of awareness of service by FCCs, and lack of sufficiently trained providers. Magellan also provides an analysis of provider demographics in the Quality Annual Program Evaluation to ensure the network of providers is sufficient and appropriate to meet needs of enrollees. The analysis found that all providers spoke English, while four providers were bi-lingual in Spanish and one provider was bi-lingual in Arabic.	1. Complete
(c) Development of network adequacy standards.						
5	(c)(1)	States developing network adequacy standards consistent with paragraph (b)(1) of this section must consider, at a minimum, the following elements:				
5a	(i)	The anticipated Medicaid enrollment.	The Agency reserves the right to add additional populations to the Contractor's target population. Should the Agency elect to add a group to the Contractor's target population, the parties must agree in writing and negotiate a payment methodology for the population in good faith. All contracted rates must be certified by the Agency and any updates to the Contract must be approved by CMS. Any changes to this Contract will be reflected in an approved and fully executed Contract Amendment. Each youth must meet minimum score criteria for the Contractor to enroll. The Contractor must conduct outreach in accordance with the approved Stakeholder Engagement and Outreach Plan to encourage participation for eligible children and youth. The Contractor must submit outreach materials to the Agency for review and approval prior to distribution. Outreach shall refrain from any door-to-door, telephone, e-mail, texting, or other cold-call marketing activities directly to children and youth that isn't generated from a referral. The Contractor must not seek to influence enrollment in any way, such as in conjunction with the sale or offering of any private insurance. [SOW pg. 57] The Contractor must promptly notify the Agency when it receives any information related to a change in an enrollee's circumstances that may affect the enrollee's eligibility including changes in the enrollee's residence or the death of the enrollee. The Contractor must submit an updated list of enrolled youths to the Agency as deemed necessary to effectively manage the enrollment and eligibility process. The Contractor will be able to utilize existing tools to help support this process, including the 270/271 Transaction Set, eligibility registries, and Medicaid Provider Agreements. This list will help the Agency determine any changes to eligibility and help mitigate enrollment discrepancies between the Agency and the Contractor. [SOW pg. 58]	Yes	9.14.2021: Magellan conducts significant outreach efforts via numerous outlets to increase referrals. The **Network Development Plan**, in part, specifies these efforts, including the Enrollment Initiative and targeted outreach initiatives to the Wind River Reservation. Additionally, the **CME Quality Annual Program Evaluation** includes information on stakeholder engagement within the program. The Evaluation states that: *Effective stakeholder communication management begins with knowing the players and understanding their needs. Magellan has identified internal and external stakeholders and will continue to expand these lists as community outreach efforts expand.* *External Stakeholders include the following:* *- Healthcare providers* *- HFWA team in Wyoming* *- Primary care providers (PCP)* *- Youth and their families/Family Voice and Choice* *- Community-based organizations such as faith-based organizations; Wyoming 211; Family focused organizations* *- Legal and court community* *- Schools/Wyoming Department of Education* *- Local government*	1. Complete
5b	(ii)	The expected utilization of services.	The Agency does not require the Contractor to contract with more providers than necessary to meet the needs of its enrollees and in consideration of the number of enrollees and expected utilization of services, and the number of providers that have met ratio requirements. The Contractor must provide notification to the Agency when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the HFWA program, including the termination of the provider agreement with the Contractor. [SOW pg. 13] The Contractor must 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. 14-15] Utilization management data can be used to monitor program integrity, free choice of provider, marketing, enrollee enrollment/disenrollment, timely access, coordination and continuity of care, quality of care and coverage/authorization. Data is utilized to indicate opportunities for improvement and to assess compliance with utilization policies and procedures at the provider and Contractor level. This information is primarily used for provider and enrollee monitoring. The analysis is reported to the Agency. The Agency discusses the findings to identify opportunities from improvement and, if areas of improvement are noted, the Contract works with the specific provider noted or incorporates the identified aspects into the implementation of performance measures. The findings are included in the Contractor's performance evaluation. [SOW pg.	Yes	9.14.2021 The Contractor provides utilization management data to the Agency quarterly and annually via **Committee Data Files** and the **FY 2021 Annual Report.** Additionally, the **Network Development Plan** includes analysis of utilization management data provided by Magellan, which tracks enrollment, authorizations, and encounter claims for each CME service (FCC, FSP, YSP, Respite).	1. Complete

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2021 Contract Language	Does Contract Language Reflect CFR?	Findings from CME Documentation	Compliance Status
5c	(iii)	The characteristics and health care needs of specific Medicaid populations covered in the MCO, PIHP, and PAHP contract.	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. The Contractor must include mechanisms to assess the quality and appropriateness of care coordination furnished to enrollees with special health care needs. [SOW pg. 20] 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. 18] The Contractor must develop a strong network of providers to deliver services reflective of goals and objectives of the CME program. The Contractor must continue to monitor the CME provider network and scale its provider network to meet the needs and required service capacity for enrolled youth. The Contractor must provide a comprehensive and flexible provider training program as agreed to in the approved Training Plan Deliverable that reflects HFWA training requirements to assist providers in meeting initial and continuing certification requirements. This training program shall include online and on-demand training options to help providers fulfill CME program requirements. [SOW pg. 66]	Yes	9.14.2021: Magellan outlines an extensive training plan in **Final Training Plan 2021**. Magellan outlines their approach for conducting all initial, ad hoc training and refresh training, as well as re-certification of providers on an annual basis and training on the foundations of HFWA. In the plan, Magellan states that all trainings are made available online. The **Provider Handbook** includes additional information on provider training programs, including individual modules for provider certification and process for provider re-certification. In the **WY CME Executive Summary 2021 Annual Report**, Magellan reported that 100% of the provider network remained trained and certified in HFWA. 11.15.2021: Magellan delivers provider trainings via the Rise Training Platform.	1. Complete
5d	(iv)	The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services.	The provider network must be sufficient to provide adequate access to all services covered under the contractual agreement for all enrollees, including those with limited English proficiency or physical or mental disabilities. The Contractor will also demonstrate that they have complied with availability and accessibility of service requirements. 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. 13] The Contractor must 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. 14]	Yes	9.14.2021: In the **Quality Annual Program Evaluation for SFY 2021**, Magellan states that "any potential service gaps in the delivery system are reviewed and plans developed to expand the network accordingly in conjunction with membership growth." Generally, Magellan's provider network adequacy efforts appear to mirror membership growth as required by the SOW. Across the review period, Magellan reported membership and provider counts: •212 enrollees, 74 providers in July 2020; •233 enrollees, 84 providers in December 2020; and •199 enrollees, 69 providers in June 2021 Once more, Magellan largely met provider ratio requirements during applicable reporting months (>96% compliance for all months during 2020 within the review period). However, at the end of SFY 2021, Magellan's provider network may be insufficient to meet member demand, as active providers fell sharply in 2021. With approximately 200 enrollees as of June 2021, the provider network may be hard-pressed to provide services across CME membership. Magellan also provided **geo-maps** of providers and members for each HFWA service, including FCC, FSP, YSP, and Respite. Magellan has providers throughout all regions of Wyoming -- including, the Southeast, Southwest, Northeast, Northwest, and Central regions. However, while FCC, FSP, YSP, and Respite providers served all regions of the state during the review period, total provider counts offered via geo-mapping are duplicative across service areas and include cross-certified providers. The EQRO is unable to determine regional, non-duplicative provider counts from the geo-mapping provided for FCC, FSP, YSP, or Respite providers, which is needed to make determinations on timely access, coordination/continuity of care, and coverage. 11.15.2021: Magellan confirmed that unduplicated provider counts are not provided via geo-mapping. Maps show catchment area of each provider, which creates a duplicate provider count. Magellan also discussed diminished provider counts for YSP and Respite services. Magellan offered that services are under-utilized due to natural supports, lack of awareness of service by FCCs, and lack of sufficiently trained providers. Magellan also provides an analysis of provider demographics in the **Quality Annual Program Evaluation** to ensure the network of providers is sufficient and appropriate to meet needs of enrollees. The analysis found that all providers spoke English, while four providers were bi-lingual in Spanish and one provider was bi-lingual in Arabic.	1. Complete
5e	(v)	The numbers of network providers who are not accepting new Medicaid patients.	No pertinent language from the SOW.	No	N/A	3. Not Applicable
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 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 service requirements. 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. 13] The Contractor must 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. 14]	Yes	9.14.2021: In the **Quality Annual Program Evaluation for SFY 2021,** Magellan states that "any potential service gaps in the delivery system are reviewed and plans developed to expand the network accordingly in conjunction with membership growth." Generally, Magellan's provider network adequacy efforts appear to mirror membership growth as required by the SOW. Across the review period, Magellan reported membership and provider counts: •212 enrollees, 74 providers in July 2020; •233 enrollees, 84 providers in December 2020; and •199 enrollees, 69 providers in June 2021 Once more, Magellan largely met provider ratio requirements during applicable reporting months (>96% compliance for all months during 2020 within the review period). However, at the end of SFY 2021, Magellan's provider network may be insufficient to meet member demand, as active providers fell sharply in 2021. With approximately 200 enrollees as of June 2021, the provider network may be hard-pressed to provide services across CME membership. Magellan also provided **geo-maps** of providers and members for each HFWA service, including FCC, FSP, YSP, and Respite. Magellan has providers throughout all regions of Wyoming -- including, the Southeast, Southwest, Northeast, Northwest, and Central regions. However, while FCC, FSP, YSP, and Respite providers served all regions of the state during the review period, total provider counts offered via geo-mapping are duplicative across service areas and include cross-certified providers. The EQRO is unable to determine regional, non-duplicative provider counts from the geo-mapping provided for FCC, FSP, YSP, or Respite providers, which is needed to make determinations on timely access, coordination/continuity of care, and coverage. 11.15.2021: Magellan confirmed that unduplicated provider counts are not provided via geo-mapping. Maps show catchment area of each provider, which creates a duplicate provider count. Magellan also discussed diminished provider counts for YSP and Respite services. Magellan offered that services are under-utilized due to natural supports, lack of awareness of service by FCCs, and lack of sufficiently trained providers. Magellan also provides an analysis of provider demographics in the Quality Annual Program Evaluation to ensure the network of providers is sufficient and appropriate to meet needs of enrollees. The analysis found that all providers spoke English, while four providers were bi-lingual in Spanish and one provider was bi-lingual in Arabic.	1. Complete

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2021 Contract Language	Does Contract Language Reflect CFR?	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 service requirements. 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. [pg. 13] 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. 14]	Yes	9.14.2021: Magellan outlines criteria for providing services with cultural competency in the **Provider Handbook**. Specifically, Magellan's cultural competence policy: *Magellan staff is trained in cultural diversity and sensitivity in order to refer members to providers appropriate to their needs and preferences. Magellan also provides cultural competency training, technical assistance and online resources to help providers enhance their provision of high quality, culturally appropriate services. Magellan continually assesses network composition by actively recruiting, developing, retaining and monitoring a diverse provider network compatible with the member population.* Magellan also includes cultural competency requirements for providers: *1. Provide Magellan with information on languages you speak.* *2. Provide Magellan with any practice specialty information you hold on your certification application.* *3. Provide oral and American Sign Language (ASL) interpretation services. In accordance with Title VI of the Civil Rights Act, Prohibition against National Origin Discrimination, providers must make oral interpretation services available to persons with limited English proficiency (LEP) at all points of contact. Oral interpretation services are provided at no charge to members. Members must be provided with information instructing them how to access these services. Interpretation services are the facilitation of oral or sign-language communication, either simultaneously or consecutively, between users of different languages.* *4. In general, any document that requires the signature of the behavioral health member, and that contains vital information regarding treatment, medications or service plans must be translated into their preferred/primary language if requested by the behavioral health member or his/her guardian.* Last, in the Provider Handbook Magellan outlines their own requirements for assuring cultural competency in care: *1. Provide ongoing education to deliver competent services to people of all cultures, races, ethnic backgrounds, religions and those with 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. The Contractor will also demonstrate that they have complied with availability and accessibility of service requirements. 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. [pg. 13] 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. This information is utilized for performance measures. The primary focus is to obtain information about problems or opportunities for improvement to implement performance measures for quality, access, or coordination of care, or to improve information to beneficiaries. The findings are included in the Contractor's performance evaluation. 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. 14]	Yes	9.14.2021: Magellan's annual reporting for Contract Year SFY 2021 included reporting of demographic data, outcomes measures, utilization, and data on special needs populations relevant to the CME program. Appendix AD of the **Annual Report** includes the CME's Race and Disparity Report 2021. The disparity analysis tracks race of WY CME Youth vs. FidelityEHR and State Medicaid and makes recommendations for the program to remediate disparities and improve access to the program. Magellan outlines criteria for providing services with cultural competency in the **Provider Handbook**. Specifically, Magellan's cultural competence policy: *Magellan staff is trained in cultural diversity and sensitivity in order to refer members to providers appropriate to their needs and preferences. Magellan also provides cultural competency training, technical assistance and online resources to help providers enhance their provision of high quality, culturally appropriate services. Magellan continually assesses network composition by actively recruiting, developing, retaining and monitoring a diverse provider network compatible with the member population.* Magellan also includes cultural competency requirements for providers: *1. Provide Magellan with information on languages you speak.* *2. Provide Magellan with any practice specialty information you hold on your certification application.* *3. Provide oral and American Sign Language (ASL) interpretation services. In accordance with Title VI of the Civil Rights Act, Prohibition against National Origin Discrimination, providers must make oral interpretation services available to persons with limited English proficiency (LEP) at all points of contact. Oral interpretation services are provided at no charge to members. Members must be provided with information instructing them how to access these services. Interpretation services are the facilitation of oral or sign-language communication, either simultaneously or consecutively, between users of different languages.* *4. In general, any document that requires the signature of the behavioral health member, and that contains vital information regarding treatment, medications or service plans must be translated into their preferred/primary language if requested by the behavioral health member or his/her guardian*	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.	The Contractor shall incorporate the use of telehealth services through the Contractor's HIPAA-compliant platform as appropriate for the individual POCs. [SOW pg. 62] The Contractor shall allow providers to use the Contractor-provided or another State-approved HIPAA compliant telehealth platform to deliver services where and when appropriate. [SOW pg. 71] The Contractor must 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. Calls may range from non-urgent requests for referral to behavioral health crises. The 800 number is printed in the enrollee handbook, benefit book and associated materials. The 800 number shall include telephone crisis intervention, risk assessment, and consultation to callers which may include family enrollees or other community agencies regarding behavioral health services. 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. If deficiencies are noted, the Contractor must perform corrective action until compliance is met. Issues are reported to the Agency quarterly and the Agency discusses the findings to identify opportunities for improvement. [SOW pg. 12]	Yes	9.14.2021: Magellan provides a HIPAA-compliant platform for CME providers to meet with members. According to the **Provider Handbook**: *Families also may choose to receive High Fidelity Wraparound services via telehealth or in-person. Providers are given a HIPAA-compliance Zoom account to conduct telehealth services.* Magellan includes additional information on telehealth capabilities in the **Quality Annual Program Evaluation**. Specifically, the evaluation states that the HIPAA compliant Zoom accounts given to providers enables "families or other team members in remote areas, housebound by inclement weather, emergency events or experiencing other unexpected barriers have a connection to the care coordination process." Magellan specifies further in the **Provider Handbook:** *Magellan Care Management Entity staff directory and functions* *Monday through Friday, 8 a.m. to 5 p.m. is 307-459-6162* *Toll-free, after hours number is 1-855-883-8740 (available 24 hours a day, seven days a week)* *TTY Line, for hearing or speech impaired, is 1-800-424-6259* *Website for Magellan in Wyoming is www.MagellanofWyoming.com (available 24 hours a day, seven days a week* Magellan meets all criteria for this requirement. 11.15.2021: Magellan discussed administration of a telehealth program during on-site evaluation. Magellan provided mostly positive feedback on use of telehealth platforms, including maintenance of the provider network during the public health emergency period and expanded choice for youth.	1. Complete
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	Not applicable. This program does not include LTSS.	Not applicable.

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2021 Contract Language	Does Contract Language Reflect CFR?	Findings from CME Documentation	Compliance Status
6b	(ii)	Elements that would support an enrollee's choice of provider.	Not applicable.	Not applicable	Not applicable. This program does not include LTSS.	Not applicable.
6c	(iii)	Strategies that would ensure the health and welfare of the enrollee and support community integration of the enrollee.	Not applicable.	Not applicable	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	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.	No	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.	No	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.	No	Not applicable. The provider-specific network standards do not apply to this program, and therefore there are not exemptions to the provider-specific network standards.	Not applicable.
(e) Publication of network adequacy standards.						
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. The Contractor must make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) calendar days after receipt of issuance of the termination notice, to each enrollee who received his or her care coordination from, or was seen on a regular basis by, the terminated provider. [SOW pg. 14] The Contractor must 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. 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. The Contractor must 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. 12] 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. 11]	Yes	9.15.2021: **The Magellan of Wyoming website** (www.MagellanofWyoming.com) appears to provide an up-to-date provider directory. The provider directory is offered in machine-readable formats (PDF and XML) and is "updated every day" according to Magellan. 11.15.2021: Magellan confirmed that the provider directory at MagellanofWyoming.com is enrollee-facing. 9.15.2021: The SOW requires Magellan to make the provider directory available in "the prevalent non-English language in Wyoming" (Spanish), as well as other accessibility aids and services (e.g., ASL, TTY/TDY, large font). While Magellan offers the ability for the entire MagellanofWyoming.com site to be translated to Spanish, the provider directory is not able to be translated. Additionally, Magellan does not appear to make the provider directory available in larger font and does not provide aids for ASL, or TTY/TDY numbers. 9.15.2021: Magellan also makes member-facing materials, including the **Member Handbook**, **appeal and grievance forms**, **family brochures**, and **program websites**, available in Spanish. The Member Handbook can be made available by Magellan in accessible formats, including Braille, and the Contractor provides TTY/TDY numbers. The Member and Provider Handbooks are both available on the Magellan website (the Provider Handbook is available on MagellanProvider.com). 11.15.2021: Magellan confirmed that member handbooks are mailed to youth upon enrollment.	1. Complete
§ 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	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: Plan Level Strengths, Areas of Needed Improvement, and Associated Domains

Table 1. Plan Level Strengths, Areas of Needed Improvement, and Associated Domains

#	Finding	Strength or Needed Improvement	Domain
Protocol 1. Validation of Performance Improvement Projects			
1	Documentation maintained for PIPs aligns directly with CMS requirements.	Strength	Quality
2	Magellan does not have a standardized data analysis plan for reviewing PIP progress year over year.	Needed Improvement	Quality
3	Magellan has data discrepancies in the QIA forms.	Needed Improvement	Quality
4	Magellan has reported minimal statistically significant improvement across PIPs.	Needed Improvement	Quality
Protocol 2. Validation of Performance Measures			
5	Clinical team is knowledgeable, engaged, and invested.	Strength	Quality; Timeliness; Access to Care
6	Documentation describing measure result creation has improved.	Strength	Quality; Timeliness; Access to Care
7	Measure creation staff are cross-trained.	Strength	Quality; Timeliness; Access to Care
8	Use of WFI-EZ WrapTrack and FidelityEHR ensures accurate reporting of submitted surveys.	Strength	Quality
9	Caregiver HFWA Fidelity scores are consistently above the goal.	Strength	Quality
10	Manually generated measure results did not include process documentation.	Needed Improvement	Quality; Timeliness; Access to Care

#	Finding	Strength or Needed Improvement	Domain
11	Key performance goals were unclear for measures required as part of the CY 2021 SOW.	Needed Improvement	Quality; Timeliness; Access to Care
Protocol 3. Compliance with Medicaid Managed Care Regulations			
12	Magellan "fully met" all compliance metrics for the Quality Assessment and Performance Improvement (QAPI) program required by both CMS and WDH.	Strength	Quality
13	Magellan strengthened the program's grievance and appeals system based on feedback from SFY 2020 EQR process.	Strength	Quality; Timeliness; Access to Care
14	Magellan did not calculate and provide a map of referral and subsequent enrollment patterns as part of the performance evaluation process.	Needed Improvement	Timeliness; Access to Care
15	Minimal access to PCPs among CME youth was reported in Q3 and Q4 of SFY 2021.	Needed Improvement	Timeliness; Access to Care
16	The SOW lacks a requirement for the results of Magellan's assessments to be regularly shared with the State.	Needed Improvement	Quality; Timeliness; Access to Care
17	The SFY 2021 SOW did not include specifications for how Magellan should collect data elements for electronic transmission of data.	Needed Improvement	Quality; Timeliness; Access to Care
Protocol 4. Validation of Network Adequacy			
18	Improved administration of provider trainings led to consistent compliance with provider training and certification requirements.	Strength	Timeliness; Access to Care
19	Magellan has maintained consistent enrollment and program effectiveness amid the substantial policy changes associated with the COVID-19 public health emergency.	Strength	Timeliness; Access to Care
20	Total provider enrollment for the CME Program ultimately declined across the period and ended at a 12-month low count.	Needed Improvement	Timeliness; Access to Care

#	Finding	Strength or Needed Improvement	Domain
21	Network adequacy documentation provided by Magellan contained conflicting or incomplete information.	Needed Improvement	Timeliness; Access to Care
Implementation and Effectiveness of State Quality Strategy			
22	Magellan reviewed and disseminated the 2020 State Medicaid Managed Care Quality Strategy and is actively taking steps to align with guidance.	Strength	Quality
23	Magellan does not maintain documentation related to the 2020 State Medicaid Managed Care Quality Strategy to structure response to guidance set forth in the Quality Strategy.	Needed Improvement	Quality