Appendix A: Abbreviations and Acronyms

BRD	Business Requirement Documents
CANS	Child and Adolescent Needs and Strengths
CDF	Committee Data File
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
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
HLOC	Higher Level of Care
IHCP	Indian Health Care Provider
ISCA	Information System Capabilities Assessment
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
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
QIA	Quality Improvement Activity
QIC	Quality Improvement Committee
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SFY	State Fiscal Year
SNCD	Strengths, Needs, and Culture Discovery
SOW	Statement of Work
SPMI	Serious and Persistent Mental Illness
SQL	Structured Query Language
WDH	Wyoming Department of Health
WFI-EZ	Wraparound Fidelity Index-Short Form
YSP	Youth Support Partner

Appendix B: Status of SFY 2021 Recommendations

Table 1. Status of SFY 2021 Recommendations

#	SFY 2021 Recommendation	Responsibility	Findings	Comments
Protocol 1. Validation of Performance Improvement Projects				
1.	**Recommendation for Magellan**: Develop a standardized data analysis process that is made available in a central, shared location for all involved Magellan business units. WDH should be provided with the initial and all subsequent versions of the plan. Magellan should develop a standardized data analysis plan that is directly affiliated with the Wyoming CME workstream. The plan should be implemented with review and approval from both the Magellan leadership team and WDH, stored in a location accessible to both WDH and all involved Magellan staff, and should include a process for regular updating.	Magellan	Partially Addressed	While a data analysis process was discussed during the WY CME EQR Virtual Onsite, sufficient documentation was not found in the SFY 2022 EQR review. Magellan should work with all components of the data collection and analysis team to develop a data analysis process. The documented process should be stored in a centralized location, accessible to WDH and all involved Magellan staff.
2.	**Recommendation for Magellan**: Identify a quality assurance process to review data collection processes and analyses for accuracy. A quality assurance process should include reviewing data accuracy at multiple times throughout the collection and analysis process. The process should also include review by multiple different individuals to minimize bias during the process.	Magellan	Fully Addressed	Magellan has identified a process for data review across numerous levels. Outcome reports are pulled by the data lead and validated by the quality director. All documents and data are reviewed monthly by the Quality Insurance Committee (QIC). QIC members are comprised of all department heads, clinical quality, management, customer service, and network.
3.	**Recommendation for Magellan:** Conduct an updated formal evaluation of barriers impacting the effectiveness of PIPs.	Magellan	Fully Addressed	Magellan conducts monthly provider calls and quarterly reviews of provider scorecard results. During the calls, providers are asked to discuss barriers they are facing. Notably, Magellan encourages providers who have

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#	SFY 2021 Recommendation	Responsibility	Findings	Comments
	Currently, barriers to meeting PIP goals are identified by PIP workgroups comprised of representation from the Clinical, Quality, Training, and Network Departments, collected during calls with providers and members, or based on results from a provider survey (last conducted in 2019 for the Minimum Contacts PIP). Magellan should organize and conduct a formal barriers analysis and evaluation to enable targeted collection of feedback on the impact of current PIPs and identification of any other barriers that may benefit from a targeted PIP.			previously overcome barriers to share their stories with other providers.
4.	**Recommendation for Magellan:** Identify additional areas of improvement to implement new PIPs that could lead to health and functional status improvements within the CME population. All PIPs active during SFY 2021 are required in the 2021 SOW, including two PIPs (Minimum Contact PIP and Enrollment and Implementation PIP) based on the core values of the HFWA model. Through a review of published literature on improvement strategies for the target population and analysis of patient data, Magellan should identify additional areas of need which may lead to further improvement of the patient experience in the CME Program and help to illustrate the effectiveness of the CME Program.	Magellan	Not Addressed	Magellan looks at minimum contacts, engagement rate, provider ability to submit accurate documentation, graduation rates, WF-EZ surveys, and how family and youth are functioning. To identify areas of need and establish new standards, Magellan utilizes sources from the National Wraparound Program. Additionally, a PIP workgroup meets to discuss current stats and identify items that are not performing well.
5.	**Recommendation for WDH**: Include language in the SOW that gives Magellan the opportunity to adjust a PIP if no improvement is seen. To encourage continuous quality improvement and responsiveness to developing and emergent issues, WDH should include language in the SOW enabling the	WDH	Not Addressed	Guidehouse did not observe documentation which gives Magellan the opportunity to adjust a PIP of no improvement is seen. We recommend Magellan and WDH continue to collaborate on the development of the PIP to align with State priorities which will ensure long term success of the program.

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#	SFY 2021 Recommendation	Responsibility	Findings	Comments
	Contractor to make essential, ad-hoc adjustments to PIP design and implementation. Clearly establishing performance requirements and a process to adjust PIPs when improvements are not observed across multiple measurement periods also will allow the Contractor to maximize feedback and insights on PIP performance to produce effective programs with positive outcomes for CME members.			
Protocol 2. Validation of Performance Measures				
6.	**Recommendation for Magellan**: Develop documentation describing the processes for manual (non-SQL) measure result creation, specifically for OUT 13-5. 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, de-duplication, formatting, calculation of numerator, denominator, and rate for the measures that are not generated via SQL.	Magellan	Fully Addressed	Magellan demonstrated that multiple technical resources could run analytics. At least three members of the analytics staff are trained and ready to perform measure reporting. Measure creators do not use reporting software. The team has authored custom SQL code and stored procedures to extract data and create measure results. For each measure, Magellan provided a report specification based upon the statement of work. Lastly, the team makes updates to ensure each reflects the purpose and requirements for the affected measure. A SAS manual is available at the Magellan/Corporate Level.
7.	**Recommendation for Magellan:** Set numeric goals for each performance measure required by the SOW. Per the SOW, Magellan receives operational requirements and outcome measures from WDH and is required to set performance goals for each (see Figure 3. SOW Requirements, Performance Measures and Goals). Magellan should aim for compliance with this requirement	Magellan	Fully Addressed	Magellan set numeric goals for some, but not all, performance measured required by the SFY 2022 SOW.

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#	SFY 2021 Recommendation	Responsibility	Findings	Comments
	and ensure each metric can be tracked numerically against a goal or threshold. We recommend that Magellan work with WDH to determine appropriate goals to encourage continuous quality improvement.			
Protocol 3. Compliance with Medicaid Managed Care Regulations				
8.	**Recommendation for Magellan**: Expand current calculation and map reporting for performance evaluation process to include referral and enrollment patterns. Magellan is already providing provider and member maps as part of the performance evaluation for network adequacy and tracking referrals to the CME Program for individuals in PRTF level of care as part of their Enrollment Initiative PIP. Magellan should identify a process to track referrals to the CME Program and utilize current calculation and mapping capabilities to report patterns for annual performance evaluation. Magellan should also collaborate with WDH to identify other potential data gaps in their mapping process and have the updated reporting process approved by WDH.	Magellan	Not Addressed	Magellan has made significant improvements in the documentation provided for review such as easy to interpret Geo-maps and clearly identified goals for performance measures. On the day the maps are created, which is typically the fifth day into the quarter, members included in the maps have an active referral and valid Medicaid eligibility. Members are not duplicated across counties and regions. Provider inclusion is based on active status in the network, and contracted level of care, on the same date.
9.	**Recommendation for Magellan**: Identify whether additional training on PCP assistance and tracking is needed for providers. Between SFY 2021 Q2 and Q3, Magellan and WDH introduced a new EHR system to collect and manage member data. The time between Q2 and Q3 also saw a dramatic decrease in PCP compliance among CME members. This decrease indicates a potential documentation barrier or lack of provider knowledge on how to indicate PCP status. Magellan should evaluate	Magellan	Not Addressed	Magellan has provided clear requirements in the Provider Handbook for the provider to update the enrollee's EHR with the enrollee's elected PCP. Notably, the provider must maintain Enrollee Medical Records in accordance with Health and Human Services and the CMS 1500 Provider Manual, all other applicable federal, state and local laws, rules and regulations including, but not limited to, the information required in submission to Magellan for High Fidelity Wraparound. It is Magellan's responsibility to ensure that record

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#	SFY 2021 Recommendation	Responsibility	Findings	Comments
	whether additional training is needed to increase documentation of PCP status for CME members.			reviews of members address adherence to HFWA practice guidelines.
10.	**Recommendation for WDH**: Update PCP performance measure to capture potential barriers more accurately. As previously stated, the PCP measure compliance subsequently dropped following the implementation of a new EHR system. Updating the performance measure to capture more detailed data related to assessing and identifying PCP status may help to identify barriers to reaching compliance. Additional aspects could include assessing whether the provider discussed PCP access with the CME member, or the number of times PCP access was discussed with a member and their family / caregivers.	WDH	Not Addressed	Magellan requires providers to update enrollee EHRs to help track PCP interactions with the youth and family. The provider must maintain a behavioral health record for each member serviced that includes services provided through the provider, date of service, and service site and name of provider. In addition, the FCC is required to document the youth and family team and all attempts to coordinate with the child's PCP in the development of the Individualized POC. In the SFY 2022 SOW, the Ops 8-3 contract requirement states, "Develop policies and procedures that include, at minimum… Process for Identifying PCP." In addition, the EM 9-28 contract requirement states, "Provide a process for assisting families in identifying a PCP when the enrollee or family chooses. Document in the enrollee's health record."
11.	**Recommendation for WDH**: Add language to the SOW to explicitly require Magellan to share all assessment results with WDH. WDH should formalize in the SOW a requirement ensuring the State's receipt of and access to the functional status assessments conducted for CME youth. While assessment results used for CME member functional determinations are program-specific and may not be fully transferrable between State programs, WDH and Magellan should determine which (if any) assessment	WDH	Not Addressed	

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#	SFY 2021 Recommendation	Responsibility	Findings	Comments
	processes are duplicative, and which stakeholders would benefit from assessment results sharing.			
12.	**Recommendation for WDH**: Develop specifications for how Magellan should collect data elements for electronic submission of data. Include specifications in the SOW. WDH should identify elements of data collection necessary for electronic transmission of data and include language explaining the requirements in the SOW.	WDH	Not Addressed	According to the SFY 2022 SOW, 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 and appeals data; and, disenrollment for reasons other than loss of Medicaid eligibility including disenrollment requests made by an enrollee. In addition, the SFY 2022 SOW states the Contract also establish expectations 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 consistent with its responsibilities to enrollees.
Protocol 4. Validation of Network Adequacy				
13.	**Recommendation for Magellan**: Focus and diversify provider retention strategies to maintain an adequate provider network. To date, Magellan has primarily discussed efforts to diversify provider recruitment strategies. These include streamlining cross-certification of providers in CME	Magellan	Not Addressed	The Network Development Plan defines a quality recruitment initiative to recruit providers to the network. The Network Strategy Committee serves to initiate the recruitment of providers, including Family Care Coordinators, Family Support Partners, Youth Support Partners and Respite providers to ensure that unmet needs of the local communities are

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#	SFY 2021 Recommendation	Responsibility	Findings	Comments
	services and other behavioral health services (e.g., Quality Recruitment Initiative, Blended Network Model); conducting targeted recruitment within tribal and underserved communities; and partnering with community advisory groups to recruit new providers. However, the Network Development Plan does not list retention strategies intended to maintain an adequate provider network and avoid declines in provider enrollment. Magellan would benefit from convening a workgroup specifically for developing retention strategies for existing and seasoned providers and integrating strategies as part of the Network Development Plan or program PIPs.			identified and addressed. The committee will look to the development of HFWA service providers on the reservation, including both tribal groups, as a primary goal. Overall, the committee aims to develop and implement strategies to meet the needs for network expansion in each region. Retention is addressed through offering additional trainings and monitoring exit interviews for trends and retention opportunities.
14.	**Recommendation for Magellan**: Clearly define quality control and assurance processes to ensure data integrity. 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	Partially Addressed	Magellan demonstrated that multiple technical resources could run analytics. At least three members of the analytics staff are trained and ready to perform measure reporting. During measure creation, the team mentioned they will consider retaining run logs and/or run results for each quarterly measure creation. At this time, a prior quarter cannot be rerun with a guarantee of the original results.
15.	**Recommendation for WDH**: Require consistent reporting and dashboarding of data elements essential to program operations. Data elements including total youth enrollment and total provider enrollment are required for determining network adequacy and can be considered "essential" for overall program monitoring. As part of the SOW with the CME Contractor, WDH should require reporting and dashboarding of distinct data points for youth and provider enrollment on a consistent basis (at least monthly). Data reporting can be included as part of Committee Data Files	WDH	Fully Addressed	According to the SFY 2022 SOW, PI 4-4 requires Magellan to provide a new Status Report/Dashboard for each weekly Status Meeting during the implementation phase. After implementation, the Contractor and Magellan will schedule meetings as necessary. Youth and Provider enrollment data are pulled *nightly* and *weekly* recon is done to confirm Medicaid eligibility. On a *monthly* basis the

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#	SFY 2021 Recommendation	Responsibility	Findings	Comments
	currently generated by Magellan or using a separate format.			Quality Insurance Committee reviews all data and document updates.
16.	**Recommendation for Magellan:** Streamline design of geo-mapping to facilitate analysis. Magellan can improve and streamline design of the member location geo-mapping to facilitate ongoing monitoring by WDH. Magellan can adjust the heat-scale design to better reflect current ranges of provider enrollment reported in each county (e.g., ranges of 0-5, 5-10, and 10+ providers). Magellan also has the opportunity to add and / or differentiate data elements, including physical location of providers within maps	Magellan	Fully Addressed	Magellan has added the requested ranges for provider enrollment and listed a breakdown of members and providers in each county.
State Quality Strategy				
17.	**Recommendation for Magellan:** Develop comparative analyses to document response to Quality Strategy guidance. Magellan's QIC should develop crosswalks and other comparative analyses aligning Quality Strategy guidance to steps actively taken by Magellan to better document compliance with requirements and resulting program improvements.	Magellan	N/A	Guidehouse did not review the State Quality Strategy during the SFY 2022 EQR process.

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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 was required in the 2021 Statement of Work with the Wyoming Department of Health and was again required in 2022.
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 of Measures focuses primarily on clinical outcomes and this PIP focuses on provider engagement with the participants so they did not apply.
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 was required in the 2021 Statement of Work with the Wyoming Department of Health and was again required in 2022.
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 with a full month of enrollment, ages 4-20 during the measurement period."
1.5 Did the PIP topic align with priority areas identified by HHS and/or CMS?	✓			The PIP 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)*

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Question	Yes	No	NA	Comments
1.6 Overall assessment: In the comments section, note any recommendations for improving the PIP topic.				The only comment would be that the population documented for the PIP was altered from last year as it no longer includes the diagnosis of youth experiencing serious emotional disturbance/serious mental illness.

Worksheet 1.2. Review the PIP Aim Statement

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?

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 clearly identified the improvement strategy of education, training, and coaching; the population of all CME youth enrolled with a full month of enrollment and aged 1-20 years old; and time period of calendar year 2021.
2.2 Did the PIP aim statement clearly specify the population for the PIP?	✓			The PIP aim statement identified the population included as CME 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 identified the time period for the PIP as 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

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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	✓			Although the length of the study was not included in the PIP population description, it was identified as calendar year 2021 in the submitted Rationale/Purpose.
3.2 Was the entire MCP population included in the PIP?	✓			The entire WY CME population was 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.	✓			The data for evaluation was collected from the Fidelity Electronic Health Record (EHR), namely the contact notes entered by the CME providers that captures all contacts and types of contacts for the CME population.
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 stated that no sampling was utilized and that all contact notes were analyzed.
3.5 Overall assessment: In the comments section, note any recommendations for identifying the project population.				Although the length of the study was discussed in other areas, it should be included in the PIP population description for clarity.

Worksheet 1.4. Review the Sampling Method

Overview of Sampling Method

Sampling was not utilized for this PIP

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

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

Question	Yes	No	NA	Comments
4.1 Did the sampling frame contain a complete, recent, and accurate list of the target PIP population? • A sampling frame is the list from which the sample is drawn. It includes the universe of members of the target PIP population, such as individuals, caregivers, households, encounters, providers, or other population units that are eligible to be included in the PIP. The completeness, recency, and accuracy of the sampling frame are key to the representativeness of the sample			✓	N/A – Magellan did not use sampling for the Improving Contact Engagement 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 Improving Contact Engagement 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 Improving Contact Engagement 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 Improving Contact Engagement 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 Improving Contact Engagement PIP.
4.6 Overall assessment: In the comments section, note any recommendations for improving the sampling method.				N/A as sampling was not utilized

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Worksheet 1.5. Review the Selected PIP Variables and Performance Measures

Selected PIP Variables and Performance Measures:

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 calendar year 2021?

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 Performance Measure was an objective, clearly-defined, and time-specific variable, but the ability to evaluate whether the contact met the family's preferred contact method was not clearly identified.
Performance measures				
5.2 Did the performance measure assess an important aspect of care that will make a difference to enrollees' health or functional status?	✓			Magellan stated in submitted PIP documentation that "minimum contact requirement is an integral part of the HFWA process to ensure members and caregivers are engaged in services and able to obtain full benefit from the program. Minimum contact requirements support fidelity and demonstrate consistency of member and caregiver engagement."
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 meeting the minimum contact requirements was easily identified through the Fidelity EHR used by Magellan through the review of contact notes completed by the providers. The identification and contact via the family's choice of contact method though was not discussed in the submitted PIP documentation.

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		✓		In 2020, Magellan conducted a provider survey to identify barriers for FCCs and HFWA coaches to meet 100% adherence to minimum contact requirements. Barriers that the FCCs listed were 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 at times.
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?	✓			Monthly and summary performance on meeting minimum contact requirements were collected and reported on the Quality Improvement Form.
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 quality measures for the selection of the PIP 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 – The performance measure is based on a SOW requirement rather than clinical or health services research.
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		✓		Participants 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.

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Question	Yes	No	NA	Comments
5.9 Did the measures include a strategy to ensure inter-rater reliability (if applicable)?		✓		Magellan reported that use medical/treatment records that are included in the Fidelity EHR system.
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	✓			Magellan reported that the minimum contact requirement is an integral part of the HFWA process to ensure members and caregivers are engaged in services and able to obtain full benefit from the program. Minimum contact requirements support fidelity and demonstrate consistency of member and caregiver engagement so the process measure can be considered as meaningfully associated with outcomes.
5.10 Overall assessment: In the comments section, note any recommendations for improving the selected PIP variables and performance measures.				As stated last year and not addressed this year, Magellan should include data and/or evidence-based research on the benefits of achieving 100% performance on the minimum contacts. Also, Magellan should identify how in the Fidelity EHR the family's choice of contact method is being documented and how provider contact method is being evaluated against the preferred method.

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 submitted PIP documentation discussed the data elements from the Fidelity EHR, but the methodology for the data collection and validation was not included. Also, there was no discussion on the analysis of the provider submitted contact method compared to the family's preferred method of contact.
6.2 Did the PIP design specify the frequency of data collection? If yes, what was the frequency (for example, semi-annually)?	✓			The submitted documentation stated: "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 documentation 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 submitted PIP documentation did not include details for how the data collected from the Fidelity EHR system would be analyzed or validated.
6.6 Did the data collection instruments allow for consistent and accurate data collection over the time periods studied?	✓			Magellan utilized the Fidelity EHR for consistent and accurate data collection but the methodology for consistent collection and validation was not discussed.

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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.				The submitted PIP documentation discussed the data elements from the Fidelity EHR, but the methodology for the data collection and validation was not included. Also, there was no discussion on the analysis of the provider submitted contact method compared to the family's preferred method of contact.

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 utilized analysis of 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 utilized analysis of 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 utilized analysis of 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 utilized analysis of 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 utilized analysis of 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?	✓			Submitted PIP documentation stated "Data is reviewed and verified by the Data Analyst monthly to ensure the information is complete and accurate. Each month the numbers are reran for all previous months to pick up any new process notes that may have been entered late. Additionally, the data is reviewed for anomalies in monthly trends and from one month's run to another." There was no discussion of how the data was validated or the accuracy of the submitted data was evaluated.

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	✓			In the submitted documentation, Magellan identified a "data analyst" as the individual who pulled the data monthly, but the was no relevant qualifications listed. It could 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		✓		There was no discussion of inter-rater or intra-rater reliability in the submitted PIP documentation.

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Question	Yes	No	NA	Comments
judgments by the same abstractor at a different time)				
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 submitted PIP documentation discussed the data elements from the Fidelity EHR, but the methodology for the data collection and validation was not included.

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?	✓			Based on the submitted documentation, it appears the data analysis was followed as described in the plan.
7.2 Did the analysis include baseline and repeat measurements of project outcomes?			✓	The initial measurement period, to determine the baseline was calendar year 2021. There has not been enough time for a repeated measurement period to occur.
7.3 Did the analysis assess the statistical significance of any differences between the initial and repeat measurements?			✓	Magellan stated that “when the first remeasurement is completed, a statistical significance testing with Fisher’s Exact Test will be used.” Since the initial measurement period occurred during calendar year 2021, a remeasurement period has not been completed.
7.4 Did the analysis account for factors that may influence the comparability of initial and repeat measurements?	✓			The submitted PIP documentation stated, “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 submitted PIP documentation stated, “There were no instances found that threatened the reliability or validity of the PIP.”
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		✓		Submitted PIP documentation did not discuss comparing results across differing populations, providers, or other variables.
7.7 Were PIP results and findings presented in a concise and easily understood manner?	✓			PIP results were presented in a clearly readable 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	✓			Magellan did provide an analysis of lessons learned and review of continuing barriers to improvement but stated that Quality Improvement Committee decided to end the PIP on 08/25/2021.
7.9 Overall assessment: In the comments section, note any recommendations for improving the analysis and interpretation of PIP results				Magellan reported performance less than targeted and stated the Quality Improvement Committee chose to end the PIP. The justification for the termination was not provided, but it would be good to understand

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Question	Yes	No	NA	Comments
				considering the less than desired performance and the impact of not achieving the minimum number of contacts on the outcomes for the participants.

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	✓			In submitted documentation, Magellan discussed the results of 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. These identified barriers were targeted in the implementation of the PIP.
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	✓			In the submitted PIP documentation, Magellan stated they utilize the PDSA cycle to “work through the stages” of the PIP.

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[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]	✓			Magellan stated that "a Culturally Competency workgroup meets quarterly to review and 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 was 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?		✓		Magellan did provide an analysis of lessons learned and review of continuing barriers to improvement but stated that Quality Improvement Committee decided to end the PIP on 08/25/2021 so there was no discussion of future improvements or follow-up activities.
8.7 Overall assessment: In the comments section, note any recommendations for improving the implementation strategies.				Magellan reported performance less than targeted and stated the Quality Improvement Committee chose to end the PIP. The justification for the termination was not provided, but it would be good to understand considering the less than desired performance and the impact of not achieving the minimum number of contacts on the outcomes for the participants.

[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?			✓	N/A as the initial measurement period was calendar year 2021, no repeat measurements were available. Magellan ended the PIP on 08/25/2021.
9.2 Was there any quantitative evidence of improvement in processes or outcomes of care?			✓	N/A as the initial measurement period was calendar year 2021, no repeat measurements were available. Magellan ended the PIP on 08/25/2021.
9.3 Was the reported improvement in performance likely to be a result of the selected intervention? • It is not necessary to demonstrate conclusively (e.g., through controlled studies) that a change is an effect of the intervention; it is sufficient to show 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 as the initial measurement period was calendar year 2021, no repeat measurements were available. Magellan ended the PIP on 08/25/2021.
9.4 Is there statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention?			✓	N/A as the initial measurement period was calendar year 2021, no repeat measurements were available. Magellan ended the PIP on 08/25/2021.
9.5 Was sustained improvement demonstrated through repeated measurements over time?			✓	N/A as the initial measurement period was calendar year 2021, no repeat measurements were available. Magellan ended the PIP on 08/25/2021.
9.6 Overall assessment: In the comments section, note any recommendations for improving the significance and sustainability of improvement as a result of the PIP.				N/A as the initial measurement period was calendar year 2021, no repeat measurements were available. Magellan ended the PIP on 08/25/2021.

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Worksheet 1.10. Perform Overall Validation of PIP Results

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	Since the PIP was implemented with the initial measurement period being calendar year 2021, and Magellan ended the PIP on 08/25/2021, the EQRO cannot interpret the results of the PIP or assess the evidence of significant improvement.

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): All WY CME enrolled youths with a full month of enrollment, ages 4-20 during the measurement period.
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 contacts 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. 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. 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. 9. Approved a back-up FCC when the primary FCC is unable to make the visits to the family

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10. 10. Approval of virtual contact through ZOOM/virtual platform

** Magellan reported that Quality Improvement Committee decided to end the PIP on 08/25/2021.**

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 = 1823; Rate = 89.30% **PIP ended 08/25/2021	☒ Not applicable—PIP is in planning or implementation phase, results not available	N/A	☐ Yes ☐ No N/A	☐ 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):
			☐ 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 the PIP was implemented with the initial measurement period being calendar year 2021, and Magellan ended the PIP on 08/25/2021, the EQRO cannot interpret the results of the PIP or assess the evidence of significant improvement.

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. ***12/15/22:*** The Engagement and Implementation PIP is included in the 2022 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?			✓	The CMS Child and Adult Core Set measures focus on clinical measures and do not apply to this PIP topic as the focus is provider engagement of youth and family
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. During the September 2022 Monthly Provider Call, providers were polled again on the items on the scorecard that were most of interest to them. Engagement and implementation were noted by the providers as of interest.

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Question	Yes	No	NA	Comments
1.4 Did the PIP topic address care of special populations or high priority services, such as: • Children with special health care needs • Adults with physical disabilities • Children or adults with behavioral health issues • People with intellectual and developmental disabilities • People with dual eligibility who use long-term services and supports (LTSS) • Preventive care • Acute and chronic care • High-volume or high-risk services • Care received from specialized centers (e.g., burn, transplant, cardiac surgery) • Continuity or coordination of care from multiple providers and over multiple episodes • Appeals and grievances • Access to and availability of care	✓			The PIP 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 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.				Although Magellan included participant and caregiver feedback about the program, it did not include any findings or outcomes of the benefit to the participants. Since this PIP has been undertaken for several years now, it would be good to see targeted progress or expected performance in the aim statements.

Worksheet 1.2. Review the PIP Aim Statement

PIP Aim Statement

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 Standard Fiscal Year 2022?

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 2022?

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 2022 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 2022.
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 statements 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.				Since this PIP has been undertaken for several years now it would be good to set an expected target or performance as part of the aim statements.

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Worksheet 1.3. Review the Identified PIP Population

PIP Population

Wyoming Care Management Entity youth ages 4 – 20 years old who were discharged during the measurement period (SFY 2022).

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 active eligibility, diagnosis, 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 methodology captured all enrollees the PIP topic population 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 a sampling methodology but instead included all participants in the population in the PIP.
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 Methodology was not utilized. Entire PIP population was included.

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.

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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) (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 SFY 2022?)

2. Implementation: percent of you and families reaching implementation threshold (>180 days) (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 SFY 2022?)

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 2022 SFY as the focus of the performance measure. There was also clear event that can be evaluated. 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?	✓			Achieving an appropriate length of care (full engagement and implementation) is a critical factor in the success of the HFWA Program and is required for the participant and their families receiving the full benefit of the 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 SFY 2022, which is available for all Medicaid members enrolled in the Program.

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		✓		No, although the PIPs were not chosen based on clinical knowledge or health services research as identified in submitted documentation, they were selected based upon collaboration with WDH and knowledge of best practices for the success of the HFWA Program.
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 2022). 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		✓		Magellan selected measures that although don't evaluate enrollee satisfaction, do evaluate an aspect of experience of care. It doesn't measure experience of care in the traditional way and thus is marked no. Achieving full engagement and implementation though is a key factor of the HFWA Program and is required for you to obtain full benefit of the CME Program.

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Question	Yes	No	NA	Comments
5.9 Did the measures include a strategy to ensure inter-rater reliability (if applicable)?		✓		Data was extracted from medical records and the EHR, there was no discussion of inter-reliability in the documentation.
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		✓		The performance measures were not chosen based on clinical knowledge or health services research as identified in submitted documentation, but they were selected based upon collaboration with WDH and knowledge of best practices for the success of the HFWA Program. Achieving full engagement and implementation though is a key factor of the HFWA Program and is required for you to obtain full benefit of the CME Program.
5.10 Overall assessment: In the comments section, note any recommendations for improving the selected PIP variables and performance measures.				As noted from last year, Magellan should consider adding additional data or performance measures on the participant benefits of achieving engagement and implementation. Also a more in depth discussion on the validation of the data analysis should be included.

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?	✓			Included in the submitted documentation was a detailed ten step process for the data collection methodology.
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 quarterly and annually.
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		✓		Submitted documentation only stated medical/treatment records and claims were pulled from the Fidelity EHR.
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 Data
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 or validated.
6.6 Did the data collection instruments allow for consistent and accurate data collection over the time periods studied?	✓			Data collection was pulled solely from the Fidelity EHR system.
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.				As noted last year Magellan should include details on how EHR data will be analyzed for measuring progress on the PIP. It would also be beneficial to add in a description of the validation of the EHR data.

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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
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
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
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
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?		✓		Although EHR data was utilized there was no discussion regarding the validation of the data for accuracy or completeness in the submitted documentation.

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 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 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)		✓		There was no discussion of inter-rated or intra-rater reliability discussed in submitted documentation.

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	✓			There was a detailed ten step process included to pull the data from the Fidelity EHR system in the submitted documentation.

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Worksheet 1.7. Review Data Analysis and Interpretation of PIP Results

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

Question	Yes	No	NA	Comments
7.1 Was the analysis conducted in accordance with the data analysis plan?	✓			Based on the submitted documentation, it appears the data analysis was followed as described in the plan.
7.2 Did the analysis include baseline and repeat measurements of project outcomes?	✓			Data included not only the baseline but also subsequent years of reporting.
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. The statistical difference only evaluated from year to year and not from baseline to current year’s performance. Also, last year’s findings are still relevant as they were not addressed this year: “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 of results was not discussed in submitted documents.
7.5 Did the analysis account for factors that may threaten the internal or external validity of the findings?		✓		Internal or external threats to validity of results was not discussed in submitted documents.
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		✓		Magellan only compared results to previous year’s performance and baseline.

Question	Yes	No	NA	Comments
7.7 Were PIP results and findings presented in a concise and easily understood manner?	✓			PIP results were presented in a easy to understand table. Measure 1 and 2 were separated into different 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	✓			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				As noted last year, Magellan should include language addressing comparability and inter/external validity concerns within PIP documentation. Magellan should also review Data analysis methodology to include validity checks of the analysis.

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Worksheet 1.8. Assess the Improvement Strategies

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

Question	Yes	No	NA	Comments
8.1 Was the selected improvement strategy evidence-based, that is, was there existing evidence (published or unpublished) suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes (as measured by the PIP variables)?		✓		There was no documentation or evidence provided in the submitted documents to suggest that the test of change was likely to lead to the desired improvements.
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[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	✓			Magellan did state in the submitted documentation that it used the quality practice of PDSA for PIP development.
8.4 Was the strategy culturally and linguistically appropriate?[4]	✓			Magellan did state that, “No cultural or linguistic concerns were noted during the planning or intervention stages” of the PIP.
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)?	✓			The selection criteria did exclude for participants who were discharged with fewer than 60 days of HFWA.

[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
8.6 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?		✓		Although Magellan previously addressed the success of the PIP and follow-up activities, in this year's documentation there was no such discussion. There was an statistical analysis to the validity of the results, which were found not to be statistically valid, but not further discussion was provided.
8.7 Overall assessment: In the comments section, note any recommendations for improving the implementation strategies.				Considering the length of years this PIP has been implemented there should be some additional search for any evidence to base the PIP on. It was also surprising there was no discussion on the evaluation of the improvement strategy or follow-up activities that Magellan plans to implement in the future.

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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 stated, "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."
9.2 Was there any quantitative evidence of improvement in processes or outcomes of care?	✓			Both measures reported continued changes from baseline after four years of the intervention. Measure 1 (goal 10%): The percent of youth and families not reaching engagement threshold at baseline was 16.43%. By 2022, the rate was 12.5%, a difference of only 3.93%. Measure 2 (goal 80%): The rate of Implementation increased from 58.90% a baseline to 69.89% in 2022, an increase of 10.99%.
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 in past years, there was more progress made this year (Measure1: 14.73% to 12.5%; Measure 2: 64.21% to 69.89%). The trend has continued to be favorable and continued towards the identified goals even if the results were not found to be statistically significant.
9.4 Is there statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention?		✓		Although Fischer's Exact t-tests were conducted to evaluate statistical significance, results for both measures were not found to be statistically significant for SFY 2022 results compared to SFY 2021.
9.5 Was sustained improvement demonstrated through repeated measurements over time?	✓			Both measures have seen continued changes from baseline but have yet

Question	Yes	No	NA	Comments
				to meet their respective goals after four years of the intervention. Measure 1 (goal 10%): The percent of youth and families not reaching engagement threshold at baseline was 16.43%. By 2022, the rate was 12.5%, a difference of only 3.93%. Measure 2 (goal 80%): The rate of Implementation increased from 58.90% a baseline to 69.89% in 2022, an increase of 10.99%.
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.				Although both measures have yet to meet their target after four years of implementation, Magellan has continued to see improvement. This year's progress was not found to be statistically significant, but there was progress towards the objective. Due to the number of years of implementation, it is recommended that Magellan collaborate with the State and providers on what additional recommendations could be made to achieve the goals of the PIP.

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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	The submitted PIP documentation was consistent with federal requirements, but it is recommended that a discussion on the evidence supporting the implementation of the PIP and data validation be included. There has been continued progress for both Engagement and Implementation measures goals but neither have met the stated target. As stated last year, the EQRO suggests reviewing the format and design of other PIP documents to improve the documentation of the process and work achieved by Magellan over the past four years of the implementation of this PIP.

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 2022?
- 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 2022?

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): 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).

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

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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
12. RISE trainings concerning requirements and processes of HFWA
13. Fidelity Electronic Health Record may help with the engagement because providers are able to access record easily and the Plan of Care tracks the family's level of engagement. This was not a question that was asked prior to the electronic health record. The Family Care Coordinator is prompted to complete the radio buttons with the level of family engagement.
14. Provider Dashboard in FEHR. Providers should be encouraged to become familiar with the Provider Dashboard in the FEHR and to complete the dashboard consistently. The dashboard can provide feedback to providers on their performance when it is completed consistently. This could be used as adjunct tool for the provider to assess and be aware of their performance as a HFWA provider.

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 2022 ☐ Not applicable—PIP is in planning or implementation phase, results not available	N = 176; Rate = 12.5%	☒ 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 2022 ☐ Not applicable—PIP is in planning or implementation phase, results not available	N = 176; Rate = 69.89%	☒ 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): Fourth 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: The submitted PIP documentation was consistent with federal requirements, but it is recommended that a discussion on the evidence supporting the implementation of the PIP and data validation be included. There has been continued progress for both Engagement and Implementation measures goals but neither have met the stated target. As stated last year, the EQRO suggests reviewing the format and design of other PIP documents to improve the documentation of the process and work achieved by Magellan over the past four years of the implementation of this PIP.

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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.”

Appendix E: Protocol 2 - Operational Requirements Review Tool

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.

Appendix E: Protocol 2 - Operational Requirements Review Tool

Summary of SFY 22 Compliance with Operational Requirements

Overview

Number of OPs	23
Number of Goals	26

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

Compliance Result	% of Goals
Goal Met	65.4%
Goal Not Met	34.6%
Not Applicable	0.0%
Insufficient Data	0.0%
Total	100.0%

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

Compliance Result	% of Performance Measures
Yes	60.9%
No	39.1%
Not Applicable	0.0%
Insufficient Data	0.0%
Total	100.0%

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

Compliance Result	% of Goals
Yes	100.0%
Partially	0.0%
No	0.0%
Total	100.0%

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

Compliance Result	% of Performance Measures
Yes	100.0%
No	0.0%
Total	100.0%

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

Compliance Result	% of Performance Measures
Yes	60.9%
Partially	0.0%
No	39.1%
Total	100.0%

Appendix E: Protocol 2 - Operational Requirements Review Tool

SFY22 Contract Review

#	Category	Contract Section	Contract Requirement	Performance Expectations/ Measurement	OP	Reported Measure	Goal Threshold	Findings for SFY 22					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	HFWA	Ops 8-17	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.	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 completed plan of care and supporting documents, 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) business days after receipt of the complete documentation that includes the plan of care and other supporting documents required by the Contractor for the service authorization request. 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 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.	Ops 8-17A N	Number of standard auth decisions within timeframe (14 calendar days)	95%	266.00	217.00	243.00	249.00	975.00	Goal Not Met	No	Yes	Yes	Yes
					Ops 8-17A D	Number of standard requests for authorization		307.00	235.00	246.00	250.00	1038.00					
					Ops 8-17A R	Calculated N/D		87%	92%	99%	100%	94%					
					Ops 8-17B N	Number of extended standard auth decisions within additional timeframe (14 calendar days)	95%	0.00	0.00	0.00	0.00	0.00	Goal Met		Yes		
					Ops 8-17B D	Number of standard auth extension requests		0.00	0.00	0.00	0.00	0.00					
					Ops 8-17B R	Calculated N/D		0%	0%	0%	0%	0%					
					Ops 8-17C N	Number of expedited auth decisions within timeframe (3 calendar days)	95%	0.00	0.00	0.00	0.00	0.00	Goal Met		Yes		
					Ops 8-17C D	Number of expedited requests for authorization		0.00	0.00	0.00	0.00	0.00					
					Ops 8-17C R	Calculated N/D		0%	0%	0%	0%	0%					
					Ops 8-17D N	Number of extended expedited auth decisions within additional timeframe (14 calendar days)	95%	0.00	0.00	0.00	0.00	0.00	Goal Met		Yes		
					Ops 8-17D D	Number of expedited auth extension requests		0.00	0.00	0.00	0.00	0.00					
					Ops 8-17D R	Calculated N/D		0%	0%	0%	0%	0%					
2	HFWA	Ops 8-19	**Critical Incidents** 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.	98%	19.00	22.00	27.00	33.00	101.00	Goal Met	Yes	Yes	Yes	Yes
					Ops 8-19D	Data showing compliance with this requirement shall be included in the quarterly data report.		19.00	22.00	27.00	33.00	101.00					
					Ops 8-19R	Calculated N/D		100%	100%	100%	100%	100%					
3	HFWA	Ops 8-25	**Grievances** 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 filled 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 8-25N	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.	100%	0.00	0.00	0.00	0.00	0.00	Goal Met	Yes	Yes	Yes	Yes
					Ops 8-25D	# of Grievances		0.00	0.00	0.00	0.00	0.00					
					Ops 8-25R	Calculated N/D		0%	0%	0%	0%	0%					

Appendix E: Protocol 2 - Operational Requirements Review Tool

#	Category	Contract Section	Contract Requirement	Performance Expectations/ Measurement	OP	Reported Measure	Goal Threshold	Findings for SFY 22					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					
4	HFWA	Ops 8-28	**Handling Expedited Resolution of Appeals** 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 8-28N	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.	98%	0.00	0.00	0.00	0.00	0.00	Goal Met	Yes	Yes	Yes	Yes
					Ops 8-28D	# of Appeals		0.00	0.00	0.00	0.00	0.00					
					Ops 8-28R	Calculated N/D		0%	0%	0%	0%	0%					
5	HFWA	Ops 8-29	**Grievances & Appeals** 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. ME 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 8-29N	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.	98%	0.00	0.00	0.00	0.00	0.00	Goal Met	Yes	Yes	Yes	Yes
					Ops 8-29D	# of Appeals		0.00	0.00	0.00	0.00	0.00					
					Ops 8-29R	Calculated N/D		0%	0%	0%	0%	0%					
6	HFWA	Ops 8-30	**Appeals** 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.	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 hours from the date that the State fair hearing officer reverses a decision to deny, limit or delay services.	Ops 8-30N	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 hours from the date that the State fair hearing officer reverses	98%	0.00	0.00	0.00	0.00	0.00	Goal Met	Yes	Yes	Yes	Yes
					Ops 8-30D	# of Appeals		0.00	0.00	0.00	0.00	0.00					
					Ops 8-30R	Calculated N/D		0%	0%	0%	0%	0%					
7	HFWA	Ops 8-31	**Grievances** The Contractor must send enrollee grievances, received about the Contractor, to the Agency. Data showing compliance with this requirement shall be included in the Quarterly Report.	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 hours from the date that the State fair hearing officer reverses a decision to deny, limit or delay services.	Ops 8-31N	The Contractor must send enrollee grievances, received about the Contractor, to the Agency. Data showing compliance with this requirement shall be included in the Quarterly Report.	100%	0.00	0.00	0.00	0.00	0.00	Goal Met	Yes	Yes	Yes	Yes
					Ops 8-31D	# of Grievances		0.00	0.00	0.00	0.00	0.00					
					Ops 8-31R	Calculated N/D		0%	0%	0%	0%	0%					

Appendix E: Protocol 2 - Operational Requirements Review Tool

#	Category	Contract Section	Contract Requirement	Performance Expectations/ Measurement	OP	Reported Measure	Goal Threshold	Findings for SFY 22					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					
8	Operations	EM 9-3	Process all referrals received by the Contractor.	Respond to any referral or request for enrollment within two (2) business days.	EM 9-3N	# of members that have been sent a referral or request for enrollment within two (2) business days.	90%	74.00	94.00	156.00	110.00	434.00	Goal Not Met	No	Yes	Yes	No
					EM 9-3D	# of member referrals		107.00	121.00	175.00	130.00	533.00					
					EM 9-3R	Calculated N/D		69%	78%	89%	85%	81%					
9	Operations	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 report on the number of children and youth referred, and turnaround time for referrals as part of the Quarterly Report	EM 9-4N	# of member referrals, The Contractor must report on the number of children and youth referred, and turnaround time for referrals as part of the Quarterly Report.	90%	118.00	139.00	205.00	180.00	642.00	Goal Not Met	No	Yes	Yes	No
					EM 9-4D	# of member referrals		143.00	150.00	225.00	201.00	719.00					
					EM 9-4R	Calculated N/D		83%	93%	91%	90%	89%					
10	Operations	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.	100%	25	20	34.00	65.00	144	Goal Not Met	No	Yes	Yes	No
					EM 9-5D	# of applications		25	20	34.00	68.00	147					
					EM 9-5R	Calculated N/D		100%	100%	100%	96%	98%					
11	Operations	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.	100%	13.00	8.00	9.00	19.00	49.00	Goal Met	Yes	Yes	Yes	Yes
					EM 9-6D	# of referrals		13.00	8.00	9.00	19.00	49.00					
					EM 9-6R	Calculated N/D		100%	100%	100%	100%	100%					
12	Operations	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	# of new enrollees that were notified of enrollment within two (2) business days of the final eligibility determination or date of the notification email from the Agency.	90%	49.00	38.00	50.00	61.00	198.00	Goal Met	Yes	Yes	Yes	Yes
					EM 9-7D	# of new enrollees		51.00	40.00	56.00	67.00	214.00					
					EM 9-7R	Calculated N/D		96%	95%	89%	91%	93%					

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#	Category	Contract Section	Contract Requirement	Performance Expectations/ Measurement	OP	Reported Measure	Goal Threshold	Findings for SFY 22					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					
13	Operations	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	# of members that received an advanced notification within thirty (30) calendar days 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.	95%	1.00	0.00	1.00	0.00	1.00	Goal Not Met	No	Yes	Yes	No
					EM 9-9D	# of members with a 30 day advance notice of termination.		2.00	0.00	1.00	0.00	2.00					
					EM 9-9R	Calculated N/D		50%	0%	100%	0%	50%					
14	Proj. Mgmt.	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 reevaluation	EM 9-12N	# of members with a CASII or ECSII that has been signed by a qualified medical health professional. This includes electronic and hardcopy assessments.	95%	78.00	73.00	88.00	89.00	328.00	Goal Not Met	No	Yes	Yes	No
					EM 9-12D	# of members with a CASII or ECSII assessment.		82.00	88.00	88.00	92.00	350.00					
					EM 9-12R	Calculated N/D		95%	83%	100%	97%	94%					
15	Pvdr. Ntwk.	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	# of new enrollees that have received a member handbook.	95%	49.00	40.00	56.00	66.00	211.00	Goal Met	Yes	Yes	Yes	No
					EM 9-15D	# of new enrollees.		49.00	40.00	56.00	67.00	212.00					
					EM 9-15R	Calculated N/D		100%	100%	100%	99%	100%					
16	Syst. of Care	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 new enrollees that have a POC within 46 calendar days after enrollment.	95%	29.00	20.00	43.00	0.00	92.00	Goal Not Met	No	Yes	Yes	No
					EM 9-16D	# of new enrollees.		49.00	40.00	56.00	0.00	145.00					
					EM 9-16R	Calculated N/D		59%	50%	77%	0%	63%					
17	Syst. of Care	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.	100%	255	202	214	225	896	Goal Not Met	No	Yes	Yes	No
					EM 9-17D	# of POCs emailed.		263	202	218	235	918					
					EM 9-17R	Calculated N/D		97%	100%	98%	96%	98%					

Appendix E: Protocol 2 - Operational Requirements Review Tool

#	Category	Contract Section	Contract Requirement	Performance Expectations/ Measurement	OP	Reported Measure	Goal Threshold	Findings for SFY 22					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					
18	Syst. of Care	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.	95%	438	436	417	426	1717	Goal Met	Yes	Yes	Yes	Yes
					EM 9-20D	# of youths.		459	457	430	442	1788					
					EM 9-20R	Calculated N/D		95%	95%	97%	96%	96%					
19	Syst. of Care	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 of the previous assessment.	90%	57	60	90	108	315	Goal Not Met	No	Yes	Yes	No
					EM 9-22D	# of enrollees with required readiness assessments due.		94	111	154	168	527					
					EM 9-22R	Calculated N/D		61%	54%	58%	64%	60%					
20	Syst. of Care	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 enrollees with a POCs that have been created with 30 days of the Auth end Date.	95%	119	112	119	121	471	Goal Met	Yes	Yes	Yes	Yes
					EM 9-23D	# of enrollees with a FCC Authorizations.		129	116	121	121	487					
					EM 9-23R	Calculated N/D		92%	97%	98%	100%	97%					
21	Syst. of Care	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.	100%	0	0	0	0	0	Goal Met	Yes	Yes	Yes	Yes
					EM 9-24D	# of members with respite authorization.		0	0	0	0	0					
					EM 9-24R	Calculated N/D		0%	0%	0%	0%	0%					
22	Technical	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.	95%	53	32	34	29	148	Goal Met	Yes	Yes	Yes	Yes
					EM 9-29D	# new enrollees		54	32	34	29	149					
					EM 9-29R	Calculated N/D		98%	100%	100%	100%	99%					
23		PM 10-4	Conduct initial provider training and certification as an FCC, FSP, YSP, or respite provider prior to being activated to provide CME service.	All providers shall complete and successful pass the certification process prior to providing any CME service. Tier One Training shall be completed for each provider within ninety (90) calendar days of the start of the training for ninety-five percent (95%) of network providers.	PM 10-4N	All providers shall complete and successful pass the certification process prior to providing any CME service. This is reported as the average number of providers.	0%	64.33	57.33	61.66	69.33	58.73	Goal Met	Yes	Yes	Yes	Yes
					PM 10-4D	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. This is reported as the average number of total providers		64.33	57.33	61.66	69.33	58.73					
					PM 10-4R	Calculated N/D		100%	100%	100%	100%	100%					

Appendix E: Protocol 2 - Operational Requirements Review Tool

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

OP	Performance Measure Description	Magellan Goals	Q1	Q2	Q3	Q4	SFY2022 YTD
Operations Reporting							
Ops 8-17A N	Number of standard auth decisions within timeframe (14 calendar days)		266.00	217.00	243.00	249.00	975.00
Ops 8-17A D	Number of standard requests for authorization		307.00	235.00	246.00	250.00	1038.00
Ops 8-17A R	Calculated N/D	95%	86.64%	92.34%	98.78%	99.60%	93.93%
Ops 8-17B N	Number of extended standard auth decisions within additional timeframe (14 calendar days)		0.00	0.00	0.00	0.00	0.00
Ops 8-17B D	Number of standard auth extension requests		0.00	0.00	0.00	0.00	0.00
Ops 8-17B R	Calculated N/D	95%	0.00%	0.00%	0.00%	0.00%	0.00%
Ops 8-17C N	Number of expedited auth decisions within timeframe (3 calendar days)		0.00	0.00	0.00	0.00	0.00
Ops 8-17C D	Number of expedited requests for authorization		0.00	0.00	0.00	0.00	0.00
Ops 8-17C R	Calculated N/D	95%	0.00%	0.00%	0.00%	0.00%	0.00%
Ops 8-17D N	Number of extended expedited auth decisions within additional timeframe (14 calendar days)		0.00	0.00	0.00	0.00	0.00
Ops 8-17D D	Number of expedited auth extension requests		0.00	0.00	0.00	0.00	0.00
Ops 8-17D R	Calculated N/D	95%	0.00%	0.00%	0.00%	0.00%	0.00%
Critical Incidents							
Ops 8-19N	The Contractor shall notify the Agency within two (2) business days of any critical incident event.		19.00	22.00	27.00	33.00	101.00
Ops 8-19D	Data showing compliance with this requirement shall be included in the quarterly data report.		19.00	22.00	27.00	33.00	101.00
Ops 8-19R	Calculated N/D	98%	100.00%	100.00%	100.00%	100.00%	100.00%
Grievances							
Ops 8-25N	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.		0.00	0.00	0.00	0.00	0.00
Ops 8-25D	# of Grievances		0.00	0.00	0.00	0.00	0.00
Ops 8-25R	Calculated N/D	100%	0.00%	0.00%	0.00%	0.00%	0.00%
Handling expedited resolutions of appeals							
Ops 8-28N	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.		0.00	0.00	0.00	0.00	0.00
Ops 8-28D	# of Appeals		0.00	0.00	0.00	0.00	0.00
Ops 8-28R	Calculated N/D	98%	0.00%	0.00%	0.00%	0.00%	0.00%
Grievances & Appeals							
Ops 8-29N	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.		0.00	0.00	0.00	0.00	0.00
Ops 8-29D	# of Appeals		0.00	0.00	0.00	0.00	0.00
Ops 8-29R	Calculated N/D	98%	0.00%	0.00%	0.00%	0.00%	0.00%
Appeals							
Ops 8-30N	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 hours from the date that the State fair hearing officer reverses a decision to deny, limit or delay services.		0.00	0.00	0.00	0.00	0.00
Ops 8-30D	# of Appeals		0.00	0.00	0.00	0.00	0.00
Ops 8-30R	Calculated N/D	98%	0.00%	0.00%	0.00%	0.00%	0.00%
Enrollee Grievances							
Ops 8-31N	The Contractor must send enrollee grievances, received about the Contractor, to the Agency.		0.00	0.00	0.00	0.00	0.00
Ops 8-31D	# of Grievances		0.00	0.00	0.00	0.00	0.00
Ops 8-31R	Calculated N/D	100%	0.00%	0.00%	0.00%	0.00%	0.00%
Enrollee Eligibility and Enrollment							

OP	Performance Measure Description	Magellan Goals	Q1	Q2	Q3	Q4	SFY2022 YTD
Process all referrals received by the Contractor.							
EM 9-3N	# of members that have been sent a referral or request for enrollment within two (2) business		74.00	94.00	156.00	110.00	434.00
EM 9-3D	# of member referrals		107.00	121.00	175.00	130.00	533.00
EM 9-3R	Calculated N/D	90%	69.16%	77.69%	89.14%	84.62%	81.43%
Assist families with the application or admission process for children and youth							
EM 9-4N	# of member referrals, The Contractor must report on the number of children and youth referred,		118.00	139.00	205.00	180.00	642.00
EM 9-4D	# of member referrals		143.00	150.00	225.00	201.00	719.00
EM 9-4R	Calculated N/D	90%	82.52%	92.67%	91.11%	89.55%	89.29%
Process all applications							
EM 9-5N	Process all enrollee applications within three (3) business days once application information is		25.00	20.00	34.00	65.00	144.00
EM 9-5D	# of applications		25.00	20.00	34.00	68.00	147.00
EM 9-5R	Calculated N/D	100%	100.00%	100.00%	100.00%	95.59%	97.96%
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.		13.00	8.00	9.00	19.00	49.00
EM 9-6D	# of referrals		13.00	8.00	9.00	19.00	49.00
EM 9-6R	Calculated N/D	100%	100.00%	100.00%	100.00%	100.00%	100.00%
Youth and/or the families of admission to the CME							
EM 9-7N	# of new enrollees that were notified of enrollment within two (2) business days of the final eligibility		49.00	38.00	50.00	61.00	198.00
EM 9-7D	# of new enrollees		51.00	40.00	56.00	67.00	214.00
EM 9-7R	Calculated N/D	90%	96.08%	95.00%	89.29%	91.04%	92.52%
Client disenrollment if the enrollee meets criteria							
EM 9-9N	# of members that received an advanced notification within thirty (30) calendar days 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.		1.00	0.00	1.00	0.00	1.00
EM 9-9D	# of members with a 30 day advance notice of termination.		2.00	0.00	1.00	0.00	2.00
EM 9-9R	Calculated N/D	95%	50.00%	0.00%	100.00%	0.00%	50.00%
Review all evaluations, including the CASII and ECSII, for completeness							
EM 9-12N	# of members with a CASII or ECSII that has been signed by a qualified medical health professional. This includes electronic and hardcopy assessments.		78.00	73.00	88.00	89.00	328.00
EM 9-12D	# of members with a CASII or ECSII assessment.		82.00	88.00	88.00	92.00	350.00
EM 9-12R	Calculated N/D	95%	95.12%	82.95%	100.00%	96.74%	93.71%
Member Handbook to all new enrollees and their guardians.							
EM 9-15N	# of new enrollees that have received a member handbook.		49.00	40.00	56.00	66.00	211.00
EM 9-15D	# of new enrollees.		49.00	40.00	56.00	67.00	212.00
EM 9-15R	Calculated N/D	95%	100.00%	100.00%	100.00%	98.51%	99.53%
FCC & Plan of Care (POC) Measure is							
EM 9-16N	# of new enrollees that have a POC within 46 calendar days after enrollment.		29.00	20.00	43.00	0.00	92.00
EM 9-16D	# of new enrollees.		49.00	40.00	56.00	0.00	145.00
EM 9-16R	Calculated N/D	95%	59.18%	50.00%	76.79%	0.00%	63.45%
Authorize POCs							
EM 9-17N	# of POCs reviewed, the Contractor shall review and process one hundred percent (100%) of all POCs submitted.		255.00	202.00	214.00	225.00	896.00
EM 9-17D	# of POCs emailed.		263.00	202.00	218.00	235.00	918.00
EM 9-17R	Calculated N/D	100%	96.96%	100.00%	98.17%	95.74%	97.60%
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.		438.00	436.00	417.00	426.00	1717.00

Appendix E: Protocol 2 - Operational Requirements Review Tool

OP	Performance Measure Description	Magellan Goals	Q1	Q2	Q3	Q4	SFY2022 YTD
EM 9-20D	# of youths.		459.00	457.00	430.00	442.00	1788.00
EM 9-20R	Calculated N/D	95%	95.42%	95.40%	96.98%	96.38%	96.03%
Routine readiness assessments based on the pre-approved Transition Readiness Scale							
EM 9-22N	# of assessment within 3 months of the previous assessment.		57.00	60.00	90.00	108.00	315.00
EM 9-22D	# of enrollees with required readiness assessments due.		94.00	111.00	154.00	168.00	527.00
EM 9-22R	Calculated N/D	90%	60.64%	54.05%	58.44%	64.29%	59.77%
FCC holds regularly scheduled CFTs and updates to the POC							
EM 9-23N	# of enrollees with a POCs that have been created with 30 days of the Auth end Date.		119.00	112.00	119.00	121.00	471.00
EM 9-23D	# of enrollees with a FCC Authorizations.		129.00	116.00	121.00	121.00	487.00
EM 9-23R	Calculated N/D	95%	92.25%	96.55%	98.35%	100.00%	96.71%
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.		0.00	0.00	0.00	0.00	0.00
EM 9-24D	# of members with respite authorization.		0.00	0.00	0.00	0.00	0.00
EM 9-24R	Calculated N/D	100%	0.00%	0.00%	0.00%	0.00%	0.00%
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.		53.00	32.00	34.00	29.00	148.00
EM 9-29D	# new enrollees		54.00	32.00	34.00	29.00	149.00
EM 9-29R	Calculated N/D	95%	98.15%	100.00%	100.00%	100.00%	99.33%
Provider Reporting							
Conduct initial provider training and certification as an FCC, FSP, YSP, or respite provider prior to being activated to provide CME service.							
PM 10-4N	All providers shall complete and successful pass the certification process prior to providing any CME service. This is reported as the average number of providers.		64.33	57.33	61.66	69.33	58.73
PM 10-4D	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. This is reported as the average number of total providers.		64.33	57.33	61.66	69.33	58.73
PM 10-4R	Calculated N/D	100%	100.00%	100.00%	100.00%	100.00%	100.00%
Outcome Management							
Out-of-Home (OOH) Placements							
OUT 13-1N	# of enrolled in OOH (PRTF and Acute Psych)	N/A	8.00	3.00	3.00	3.00	N/A
OUT 13-1D	# of youth enrolled with the CME Contractor.	N/A	202.00	203.00	214.00	222.00	N/A
OUT 13-1R	Calculated N/D	N/A	3.96%	1.48%	1.40%	1.35%	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 (PRTF and Acute Psych)	N/A	22.88	12.30	28.50	5.00	N/A
OUT 13-2_2	# of youth enrolled with the CME Contractor.	N/A	202.00	203.00	214.00	222.00	N/A
Recidivism							
OUT 13-3N	# of youth enrolled in HLOC (PRTF)	N/A	8.00	3.00	3.00	3.00	N/A
OUT 13-3D	# of youth enrolled with the CME Contractor.	N/A	202.00	203.00	214.00	222.00	N/A
OUT 13-3R	Calculated N/D	N/A	3.96%	1.48%	1.40%	1.35%	N/A

Appendix E: Protocol 2 - Operational Requirements Review Tool

OP	Performance Measure Description	Magellan Goals	Q1	Q2	Q3	Q4	SFY2022 YTD
Recidivism (LOC) at six (6) months post							
OUT 13-4N	# of graduated youth admitted to HLOC w/in 6mths. (PRTF)	N/A	4.00	0.00	0.00	0.00	N/A
OUT 13-4D	# of youth graduated from the CME.	N/A	10.00	15.00	22.00	15.00	N/A
OUT 13-4R	Calculated N/D	N/A	40.00%	0.00%	0.00%	0.00%	N/A
Primary Care Practitioner Access (EPSDT)							
OUT 13-5N	# of CME enrolled youth with an identified Primary Care Practitioner.	N/A	49.00	38.00	54.00	63.00	N/A
OUT 13-5D	# of youth enrolled in the CME.	N/A	49.00	40.00	56.00	67.00	N/A
OUT 13-5R	Calculated N/D	N/A	100.00%	95.00%	96.43%	94.03%	N/A
Cost Savings							
OUT 13-6N	total Medicaid cost (WYCME)	N/A	$ 758,156.93	$ 754,743.47	$ 776,497.05	$ 762,520.38	N/A
OUT 13-6D	# of youth enrolled in CME	N/A	202.00	203.00	214.00	222.00	N/A
OUT 13-6A	Average cost of CME youth	N/A	$ 3,753.25	$ 3,717.95	$ 3,628.49	$ 3,434.78	N/A
OUT 13-6RON	Total Medicaid cost (other)	N/A	$ 580,251.79	$ 463,937.14	$ 542,023.57	$ 412,944.72	N/A
OUT 13-6ROD	# of non-HFWA youths w PRTF	N/A	82.00	74.00	68.00	70.00	N/A
OUT 13-6ROA	Average cost of PRTF youth	N/A	$ 7,076.24	$ 6,269.42	$ 7,970.93	$ 5,899.21	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	81.70%	81.70%	76.00%	75.30%	N/A
OUT 13-7D	relative to 72%	N/A	72.00%	72.00%	72.00%	72.00%	N/A
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	62.00	33.00	45.00	42.00	N/A
Family and Youth Participation at State-Level Advisory Meetings							
OUT 13-9N	# of Attendees Representing Families	N/A	1	1	1	3	N/A
OUT 13-9D	# of Enrollees	N/A	545	539	533	572	N/A
			0.18%	0.19%	0.19%	0.52%	N/A
Family and Youth Participation in Communities							
OUT 13-10N	Family and Youth Participation in Communities	N/A	137	370	292	195	N/A
OUT 13-10D	# of Attendees Representing Families	N/A	545	539	533	572	N/A
OUT 13-10R	# of Enrollees	N/A	25.14%	68.65%	54.78%	34.09%	N/A

Outcomes Tool

No	2021 SOW Section	Outcome Name - SFY 2022	Outcome Requirement - SFY 2022	Outcome Performance Measure - SFY 2022	Outcome Performance Penalty - SFY 2022	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: 8 D: 202 %: 4	N: 3 D: 203 %: 1.5	N: 3 D: 214 %: 1.4	N: 3 D: 222 %: 1.4	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)	ALOS: 22.9 days CME Enrolled Youth: 202	ALOS: 12.3 days CME Enrolled Youth: 203	ALOS: 28.5 days CME Enrolled Youth: 214	ALOS: 5 days CME Enrolled Youth: 222	Meets Requirement	Magellan reported the average length of stay on a quarterly basis.
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: 202 %: 4	N: 3 D: 203 %: 1.5	N: 3 D: 214 %: 1.4	N: 3 D: 222 %: 1.4	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: 4 D: 10 %: 40	N: 0 D: 15 %: 0	N: 0 D: 22 %: 0	N: 0 D: 15 %: 0	Meets Requirement	Magellan reported data on recidivismat six months post grduation on a quarterly basis.
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: 49 D: 49 %: 100	N: 38 D: 40 %: 95	N: 54 D: 56 %: 96	N: 63 D: 67 %: 94	Meets Requirement	Magellan reported on EPSDT Compliance / PCP identification on a quarterly basis.

No	2021 SOW Section	Outcome Name - SFY 2022	Outcome Requirement - SFY 2022	Outcome Performance Measure - SFY 2022	Outcome Performance Penalty - SFY 2022	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.): $3,753 Avg. cost of PRTF youth (6 mo.): $7,076	Avg. cost of CME youth (6 mo.): $3,628.49 Avg. cost of PRTF youth (6 mo.): $6,269	Avg. cost of CME youth (6 mo.): $3,435 Avg. cost of PRTF youth (6 mo.): $7,971	Avg. cost of CME youth (6 mo.): $3,435 Avg. cost of PRTF youth (6 mo.): $5,899	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)	81.7%	81.7%	76.0%	75.3%	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): 62	# of Surveys (average): 33	# of Surveys: 45	# of Surveys: 42	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: 1 D: 545 %: 0.2	N: 1 D: 539 %: 0.2	N: 1 D: 533 %: 0.2	N: 3 D: 572 %: 0.5	Meets Requirement	Magellan reported on the Family and Youth Participation in State-level Advisory Committees pn a quarterly basis..
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: 137 D: 545 %: 25	N: 370 D: 539 %: 69	N: 292 D: 533 %: 55	N: 195 D: 572 %: 34	Meets Requirement	Magellan reported on the Family and Youth Participation in Communities across on a quarterly basis.

Management Entity (CME) Program
nal Quality Review (EQR) Protocol 3 Crosswalk

Federal regulation source(s)	New or Existing	Medicaid/CHIP agency policy/ regulation information needed to determine MCP compliance	SFY2021 Contract Language	Applicable MCP documents	Documents Reviewed	Findings from Document Review	Reviewer Determination
Standards, Including Enrollee Rights and Protections							
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]	•Service planning documents and provider network planning documents (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments)(AM) •Service availability and accessibility expectations and standards (AM) •Other performance standards and quality indicators established by the MCP (AM) •Any measurement or analysis reports on service availability and accessibility (AM) •List of all care and service providers in the MCP's network (may be the same as the provider directory) (AM) •Organization strategic plans (AM) •Administrative policies and procedures (AM) •Medicaid/CHIP and other enrollee survey results (AM) •Utilization management policies and procedures (UM) •Service authorization policies and procedures (UM) •Provider contracts (PS) •Provider/Contractor procedure manuals (PS) •Provider/Contractor oversight and evaluation policies and procedures, audit tools (PS) •Medicaid/CHIP enrollee services policies and procedures (ES) •Statement of enrollee rights (ES) •Medicaid/CHIP Enrollee Handbooks (ES) •Medicaid/CHIP provider directory •Medicaid/CHIP Enrollee Orientation Curriculum (ES) •Medicaid/CHIP enrollee grievance and appeals policies			Review Not Required
	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]				Review Not Required
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	•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]		• P3.09.WY2022.Appendix K- Geo Mapping - Jul,Aug,Sep - 2021 • P3.09.WY2022.Appendix K- Geo Mapping -Oct, Nov, Dec - 2021 • P3.09.WY2022.Appendix K - Geo Mapping - Apr, May, Jun - 2022 • P3.09.WY2022.Appendix K- Geo Mapping - Jan,Feb,Mar - 2022 • P3.09.WY2022.Appendix K- Geo Mapping - July,Aug,Mar - 2022 • P3.10.WY2022.Appendix K - Geo Maps - Apr, May, Jun - 2022 • P3.08.WY2022.Network Development Plan - 2022 • P2.5 SFY2022 Annual Reports.pdf	**12/22/22:** • **Quarterly Geo Mapping** documents are **produced by the Quest Analytics Suite software** to **provide the number of members in each county eligible** for Family Care Coordination, Family Support Services, Youth Support Partners, and Respite Care - **relative to the number of providers for each service**. On the day the maps are created, which is typically the fifth day into the quarter, m**embers included have an active referral and valid Medicaid eligibility**. • According to the Q4 Apr-June 2022 Appendix Geo Maps, provider's utilize Magellan's HIPAA compliant telehealth platform to increase access to services. **Providers are included for each county they have agreed to cover for each level of care. The report identifies 40 unique providers for Family Care Coordination, 34 unique providers for Family Support Services, 8 unique providers for Respite Services, and 7 unique providers for Youth Support Partners.** • Availability, accessibility, and network adequacy requires 1 provider: 10 enrollees for each Family Care Coordinator (FCC) and Family Support Partner (FSP), and 1 provider: 25 enrollees for each Youth Support Partner (YSP) in all regions. Respite care does not have a standard. According to the Apr-Jun 2022 Geo Map - **WY CME meets the standard in all regions for Family Care Coordination and Family Support Partners**. **The standard is not met for Youth Support Partners in Region 1, 2,4,5, and 7.** • *The Network Development and Management Plan* compares total youth enrollment, B waiver participants, and C waiver participants for CY 2020 and 2021. Additionally, the report analyzes race/ethnicity, age, and gender of high fidelity wraparound members in CY 2020 and 2021. Member linguistics were not included in this report, but will be reported going forward. The report also assesses diagnostic prevalence among youth served in CY 2020 and 2021. Lastly, the report provides provider stats by ethnicity, linguistics, gender, levels of care, turnover rate, and existing providers by month for CY 2020 and 2021. • **The "Accessibility and Availability of Services" section of *The Network Development and Management Plan* details *Scalability*, *Telehealth through Magellan Approved Technology Platform*, *Network Composition and Diversity*, and *Accessing Providers by Region and County*.** • **Members can identify available providers via the Magellan of Wyoming Provider Search located on MagellanOfWyoming.com**. Search options include, but are not limited to, languages spoken, gender, location, services provided, availability, etc. Members may also obtain a printed version of the directory via the icon available on the Provider search page. • According to *The Network Development and Management Plan* the **WY CME maintains a Cultural Competence Program which is used as a strategy for improving the knowledge, attitude, and skills of High Fidelity Wraparound providers.**	Partially Met

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]	• Service planning documents and provider network planning documents (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments)(AM) • Service availability and accessibility expectations and standards (AM) • Other performance standards and quality indicators established by the MCP (AM) • Any measurement or analysis reports on service availability and accessibility (AM) • List of all care and service providers in the MCP's network (may be the same as the provider directory) (AM) • Organization strategic plans (AM) • Administrative policies and procedures (AM) • Medicaid/CHIP and other enrollee survey results (AM) • Utilization management policies and procedures (UM) • Service authorization policies and procedures (UM) • Provider contracts (PS) • Provider/Contractor procedure manuals (PS) • Provider/Contractor oversight and evaluation policies and procedures, audit tools (PS) • Medicaid/CHIP enrollee services policies and procedures (ES) • Statement of enrollee rights (ES) • Medicaid/CHIP Enrollee Handbooks (ES) • Medicaid/CHIP provider directory • Medicaid/CHIP Enrollee Orientation Curriculum (ES) • Medicaid/CHIP enrollee grievance and appeals policies and procedures (ES)			Review Not Required
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]	•Service planning documents and provider network planning documents (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments)(AM) •Service availability and accessibility expectations and standards (AM) •Other performance standards and quality indicators established by the MCP (AM) •Any measurement or analysis reports on service availability and accessibility (AM) •List of all care and service providers in the MCP's network (may be the same as the provider directory) (AM) •Organization strategic plans (AM) •Administrative policies and procedures (AM) •Medicaid/CHIP and other enrollee survey results (AM) •Utilization management policies and procedures (UM) •Service authorization policies and procedures (UM) •Provider contracts (PS) •Provider/Contractor procedure manuals (PS) •Provider/Contractor oversight and evaluation policies and procedures, audit tools (PS) •Medicaid/CHIP enrollee services policies and procedures (ES) •Statement of enrollee rights (ES) •Medicaid/CHIP Enrollee Handbooks (ES) •Medicaid/CHIP provider directory (ES) •Medicaid/CHIP Enrollee Orientation Curriculum (ES) •Medicaid/CHIP enrollee grievance and appeals policies and procedures (ES)			Review Not Required
	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]				Review Not Required
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]	•MCP 42 C.F.R. § 438.207(b) compliance documentation •MCP 42 C.F.R. § 438.207(c) compliance documentation •MCP 42 C.F.R. § 457.1230(b) compliance documentation	• P3.44.WY2022.Appendix K - Geo Mapping - Apr, May Jun - 2022 • P3.44.WY2022.2021 WY Member Handbook • P3.14.WY2022.OUT 13-5 Primary Care Practitioner Access • P3.22.WY2022.2022 Provider Handbook Final • P2.5 SFY2022 Annual Reports.pdf	**12/22/22:** • The Member Handbook outlines the family care coordinator process. If the enrollee does not have a primary care physician, the family care coordinator will help the family find one upon request from the enrollee or family. • According to the Provider Handbook Final document, the family care coordinator must submit documentation into the electronic health record to be maintained and available upon request for inspection. • The OUT 13-5 Plan of Care: Primary Care Practitioner Access (EPSDT) document reports quarterly on the previous quarter's rate of youth enrolled in the CME with an identified Primary Care Provider. Specifically, the numerator is the number of CME enrolled youth with an identified Primary Care Practitioner and the denominator is the # of youth enrolled in the CME. • Quarterly Geo Mapping documents provide the number of members in each county and region who are eligible for Family Care Coordination, Family Support Services, Youth Support Partners, and Respite Care relative to the number of providers for each service. On the day the maps are created, which is typically the fifth day into the quarter, members included have an active referral and valid Medicaid eligibility. • According to the Q4 Apr-June 2022 Appendix Geo Maps, provider's utilize Magellan's HIPAA compliant telehealth platform to increase access to services. Providers are included for each county they have agreed to cover for each level of care. The report identifies 40 unique providers for Family Care Coordination, 34 unique providers for Family Support Services, 8 unique providers for Respite Services, and 7 unique providers for Youth Support Partners.H14 **2/16/23:** •During the WY CME Virtual Onsite, Magellan stated they require the provider to update an enrollee's EHR with the enrollee's elected Primary Care Provider. The EHR update helps Magellan track if a PCP has checked in with a family or if the PCP is actively working with the family. This is defined in the P3.22.WY2022 Provider Handbook Final, which details that providers must maintain Enrollee Medical Records in accordance with Health and Human Services and the CMS 1500 Provider Manual, all other applicable federal, state and local laws, rules and regulations including, but not limited to, the information required in submission to Magellan for High Fidelity Wraparound. It is the provider's responsibility to maintain a behavioral health record for each member serviced that includes services provided through the provider, date of service, and service site and name of provider. It is Magellan's responsibility to ensure that record reviews of members address adherence to HFWA practice guidelines. Lastly, The Family Care Coordinator will document that the youth and family's support network comprise a team of natural and professional supports chosen by the youth and family. • During the WY CME Virtual Onsite, Magellan stated that they coach their FCCs to work with families to call Medicaid to see what services are available in the area. It is important to note this process is *not* defined in Magellan's documentation. • According to the P3.22.WY2022.2022 Provider Handbook Final, The Family Care Coordinator must document the Child and Family Team and all attempts to coordinate with the child's primary care physician in the development of the Individualized Plan of Care. If the child's primary care physician wishes to take part in the development of the Individualized Plan of Care, the Family Care Coordinator must ensure that the primary care physician is involved to the extent he or she desires.	Fully Met

	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]				Review Not Required
Coordination and continuity of care for all enrollees **Medicaid**: 42 C.F.R. § 438.208: Coordination and continuity of care and 42 C.F.R. § 438.224: Confidentiality **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]	•Practice guidelines adopted by the MCP (AM) •Provider/Contractor Services policies and procedures manuals (PS) •Provider contracts (PS) •Provider/Contractor procedure manuals (PS) •Medicaid/CHIP enrollee services policies and procedures (ES) •Medicaid/CHIP enrollment and disenrollment policies and procedures (ES) •Medicaid/CHIP Enrollee Handbooks (ES) •Care coordination policies and procedures, and enrollee records (ES) •Sample of Medicaid/CHIP enrollee records (ES) •Medicaid/CHIP enrollment and disenrollment policies and procedures (ES) •A copy of the state-MCP contract provisions, which specify the methods by which the MCP assures the state Medicaid/CHIP agency that it does not request disenrollment for reasons other than those permitted under the contract.			Review Not Required
	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]				Review Not Required
	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]				Review Not Required

	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]		• P3.13.WY2022.ClinicalManual2021-2022 • P3.25.WY2022.Information Governance IG.1501.02 - Policy (1) • P3.22.WY2022.2022 Provider Handbook Final • WY CME EQR Example Choice of Provider form_Redacted - February 2023 • P2.5 SFY2022 Annual Reports.pdf	**2/22/23:** • According to the Clinical Manual, Criteria for Enrollment Section II Enrollment - Intensity and Quality of Service, Criteria A and B must be met. (A) This service is performed by the Family Care Coordinator as an administrative joint treatment planning activity to develop and facilitate implementation of individualized Plans of Care for children and youth; (B) **Assessments, Plans of Care, and other required clinical documentation will be submitted in a timely and correct manner** as required in the 1915(b) and 1915(c) waivers and other governing documents. • According to the Provider Handbook Final document, youth referred to the Care Management Entity, must meet the following criteria: 1) Youth ages 6 to 20 must have a minimum Child and Adolescent Service Intensity Instrument (CASII) composite score of 20 and a maximum score of 26, and youth ages 4 and 5 must have an Early Childhood Service Intensity Instrument (ECSII) score of 18 to 30 OR the appropriate social and emotional assessment information provided to illustrate level of service needs. 2) **A licensed clinician certifies the youth has a DSM 5 or must have a DSM Axis 1 or an ICD 10 diagnosis that meets the State's diagnostic criteria** and that the youth's needs may be safely met in the community with access to intensive,, community based, behavioral health and care coordination. • The Provider Handbook Final document states that it is the **responsibility of the Family Care Coordinator to verify the Care Management Entity program eligibility at least monthly** with the legal guardian to ensure services provided can be billed to Medicaid. • According to the Provider Handbook Final document, it is Magellan's responsibility to maintain a process to prepare, evaluate, and certify network providers that **does not discriminate based on a member's benefit plan coverage**, race, color, creed, religion, gender, sexual orientation, marital status, age, national origin, ancestry, citizenship, **physical disability, or any other status protected by applicable law.** • According to the Member Handbook - Final, the family care coordinator **must submit documentation into the electronic health record to be maintained and available upon request for inspection.** • According to the Provider Handbook Final document- Documentation, Plan of Care, and progress notes must demonstrate throughout the wraparound process a focus on planning for a purposeful transition out of formal wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the regulate Medicaid or behavioral health system). The focus on purposeful transition is continual during the wraparound process, and the preparation for transition is apparent even during the initial engagement activities. **Documentation must be maintained and available upon request.** • According to Information Governance IG.1501.02 Standards section I, B(6) - Business Managers and Information Owners are responsible for ensuring that their employees know where to locate the current retention schedule; that the Retention Schedule reflects all of their company Records; and that **hard copy and electronic records are kept, stored, or destroyed in compliance with this Policy.** **2/16/23:** • On the initial choice of provider form there is a section for the enrollee to identify clinical eligibility assessors (i.e., independent assessor, qualified mental health professional, and phone or email for QMHP). During the onsite, Magellan stated they ask providers to help [enrollee's] identify both the qualified mental health professional who will be completing the independent assessment and individual care provider that will be conducting the CASI assessment. • During the WY CME Virtual Onsite, Magellan stated that Provider's are given access to the enrollee's case for a limited amount of time to document the CASI or FC assessment. Additionally, Magellan noted the level of care has to be completed by a qualified professional. Qualified mental health professionals also have the option to complete a paper assessment which is then uploaded by the FCC into the enrollee's EHR. •During the WY CME virtual onsite, Magellan stated the process to ensure members are not duplicated. There are instances when enrolled youth will have multiple Medicaid IDs - where the state shows one Medicaid ID and Magellan shows another. To account for these errors, recon is done between Magellan and the State to flag and track discrepancies. To prevent downstream complications, Magellan leaves a record of all associated IDs with an enrollee in their system. Additionally, there is a single unique case associated with each enrollee. If a provider produces a duplicate case, Magellan has the capability to go in and disable the duplicate case. Magellan will then work with providers to pull information from the duplicate case into the original case. • While Magellan's choice of provider form allows enrollee's to define their independent assessor and qualified mental health assessor, it does not detail how this allows the youth/family to provide appropriate authority to send the assessment directly to Magellan.	Partially Met
	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]				Review Not Required
	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]		• P3.22.WY2022.2022 Provider Handbook Final	**12/22/22:** • 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). This meets the requirments outlined in 42 C.F.R. § 438.224: Confidentiality.	Fully Met
Additional coordination and continuity of care requirements: LTSS **Medicaid**: 42 C.F.R. § 438.208: Coordination and continuity of care **CHIP:** 42 C.F.R. § 457.1230(c): Coordination and continuity of care	Existing Requirement	•Methods used by the Medicaid/CHIP agency to identify to the MCP enrollees who need LTSS.	None	•Practice guidelines adopted by the MCP (AM) •Provider/Contractor Services policies and procedures manuals (PS) •Provider contracts (PS) •Provider/Contractor procedure manuals (PS) •Enrollee services policies and procedures (ES) •Enrollee Handbooks (ES) •Care coordination policies and procedures, and enrollee records (ES) •Sample of enrollee records (ES)			Not Applicable
	Existing Requirement	•Whether the MCP is required to meet identification, assessment, and treatment planning requirements for dually-enrolled beneficiaries.	None				Not Applicable

	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
	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]				Review Not Required
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]	•Practice guidelines adopted by the MCP (AM) •Provider/Contractor Services policies and procedures manuals (PS) •Provider contracts (PS) •Provider/Contractor procedure manuals (PS) •Enrollee services policies and procedures (ES) •Enrollee Handbooks (ES) •Care coordination policies and procedures, and enrollee records (ES) •Sample of enrollee records (ES)			Review Not Required
	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]				Review Not Required
	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
	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
	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]				Review Not Required
	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]				Review Not Required

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]	•Medicaid/CHIP enrollment and disenrollment policies and procedures (ES)			Review Not Required
	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]				Review Not Required
	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]				Review Not Required
	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]				Review Not Required
	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]				Review Not Required
	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.					Review Not Required
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]	•Provider contracts (PS) •Contracts or written agreements with organizational subcontractors (AM) •Completed evaluations of entities conducted before delegation is granted (AM) •Medicaid/CHIP and other enrollee grievance and appeals data (AM) •Utilization management policies and procedures (UM) •Coverage rules and payment policies (UM) •Data on claims denials (UM) •Service authorization policies and procedures (standard, expedited and extensions) (UM) •Policies and procedures for notifying providers and enrollees of denials of service (UM)			Review Not Required
	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]				Review Not Required

	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]		• P3.13.WY2022.ClinicalManual2021-2022 •P3.36.WY2022.ClinicalManualConcurrentReviews • P3.36.WY2022.ClinicalManualNonauthorizations	• According to the Clinical Manual 2021-2022, Standards section II B.1, standard UM service authorization reviews are completed as quickly as the member's condition requires, but no longer than fourteen (14) data of the receipt of the request. Section II B.3(a) states, **the standard processing time may be extended once prior to the expiration of the standard processing time for up to fourteen (14) calendar days. An extension request may be made by the member, ordering and/or rendering provider, or Magellan**. Extension Requests Made by Magellan: This extension can occur if **Magellan justifies (to the State agency, upon request) a need for additional information and documents how the delay is in the member's interest**. When Magellan grants itself an extension, the member is notified in writing of the reason(s) for the delay and of the member's right to file a grievance if s/he disagrees with the extension as outlined in Standard IV below. Magellan maintains sufficient documentation of extension determinations to demonstrate, upon the State agency's request, that the extension was justified. • According to the HFWA Concurrent Review Process Document, the service authorization request is initiated by the Family Care Coordinator (FCC), who submits all required documentation into Fidelity EHR for WY Clinical review. Once a service authorization request has been submitted, WY Clinical must review the request within 14 days. Upon review of the service authorization request, WY Clinical will ensure all documents and Custom Assessments submitted are accurate, complete, and have been submitted within the required timelines. If a service authorization request cannot be approved for administrative or clinical reasons, follow the no authorization process (see Administrative Nonauthorization Process and Clinical Nonauthorization Process). • According to the HFWA Administrative Nonauthorization Process Document, the service authorization request is initiated by the Family Care Coordinator (FCC), who submits all required documentation into Fidelity EHR for WY Clinical review. Once a service authorization request has been submitted, WY Clinical must review the request within 14 days. Upon review of the service authorization request, WY Clinical will ensure all documents submitted are accurate, complete, and have been submitted within the required timelines. If documentation is late, missing, or incomplete, WY Clinical will 1) outreach provider to request correction, if review occurs prior to the last covered day of the authorization or 2) issue an administrative nonauthorization to the provider. The administrative nonauthorization will remain in effect until the provider submits a complete service authorization	Fully Met
	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				Review Not Required
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	•Medicaid/CHIP and other enrollee survey results (AM) •Provider contracts (PS) •Enrollee services policies and procedures (ES) •Statement of enrollee rights (ES) •Enrollee marketing materials •Medicaid/CHIP marketing plans, policies and procedures (ES) •Medicaid/CHIP enrollment and disenrollment policies and procedures (ES) •Enrollee Handbooks (ES) •Enrollee grievance and appeals policies and procedures (ES) •Staff Handbooks (SP) •Staff Orientation and Training Curriculum (SP) •MCP provider directory (ES) •MCP Formulary (ES) •MCP website (ES)			Review Not Required
	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				Review Not Required
	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]				Review Not Required

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]			Review Not Required
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]			Review Not Required
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]			Review Not Required
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]			Review Not Required
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]			Review Not Required
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]			Review Not Required
Existing Requirement	· Any content required by the state for the enrollee handbook that is not covered in 42 CFR 438.10(g).	None			Review Not Required

	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]				Review Not Required
	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]				Review Not Required
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	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]	•Medicaid/CHIP and other enrollee survey results (AM) •Provider contracts (PS) •Medicaid/CHIP enrollee services policies and procedures (ES) •Statement of enrollee rights (ES) •Medicaid/CHIP enrollee marketing materials (ES) •Medicaid/CHIP marketing plans, policies and procedures (ES) •Medicaid/CHIP enrollment and disenrollment policies and procedures (ES) •Medicaid/CHIP Enrollee Handbooks (ES) •Medicaid/CHIP Enrollee Orientation Curriculum (ES) •Medicaid/CHIP enrollee grievance and appeals policies and procedures (ES) •Staff Handbooks (SP) •Staff Orientation and Training Curriculum (SP)			Review Not Required
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]	•Medicaid/CHIP and other enrollee survey results (AM) •Provider contracts (PS) •Medicaid/CHIP enrollee services policies and procedures (ES) •Statement of enrollee rights (ES) •Medicaid/CHIP enrollee marketing materials (ES)			Review Not Required
	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				Review Not Required
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	•Medicaid/CHIP and other enrollee survey results (AM) •Provider contracts (PS) •Medicaid/CHIP enrollee services policies and procedures (ES) •Statement of enrollee rights (ES) •Medicaid/CHIP enrollee marketing materials (ES) •Medicaid/CHIP marketing plans, policies and procedures (ES) •Medicaid/CHIP enrollment and disenrollment policies and procedures (ES) •Medicaid/CHIP Enrollee Handbooks (ES) •Medicaid/CHIP Enrollee Orientation Curriculum (ES) •Medicaid/CHIP enrollee grievance and appeals policies and procedures (ES) •Staff Handbooks (SP)			Review Not Required

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]	•Service planning documents and provider network planning documents (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) (AM) •Contracts or written agreements with organizational subcontractors (AM) •Procedures and methodology for oversight, monitoring, and review of delegated activities (AM) •Contracts or written agreements with organizational subcontractors (AM) •Completed evaluations of entities conducted before delegation is granted (AM) •Provider/Contractor files, 15-20 individual health care professional files, and 15-20 institutional provider files (PS) •Credentialing committee or other provider review mechanism meeting minutes (PS) •Sample of files of practitioners who have not been appointed or reappointed (PS)			Review Not Required
Sub-contractual relationships and delegation **Medicaid**: 42 C.F.R. § 438.230: Sub contractual 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]	•Procedures and methodology for oversight, monitoring, and review of delegated activities (AM) •Contracts or written agreements with organizational subcontractors (AM) •Completed evaluations of entities conducted before delegation is granted (AM) •Ongoing evaluations of entities performing delegated activities			Review Not Required
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]	•Provider contracts (PS) •Contracts or written agreements with organizational subcontractors (AM) •Practice guidelines (AM) •Provider/Contractor Services policies and procedures manuals (PS) •Medicaid/CHIP enrollee services policies and procedures (ES)			Review Not Required
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]	•QAPI project descriptions, including data sources and data audit results (AM) •Medicaid/CHIP and other enrollee grievance and appeals data (AM) •Analytic reports of service utilization (UM) •Information systems capability assessment reports (IS) •Policies and procedures for auditing data or descriptions of other mechanisms used to check the accuracy and completeness of data (internally generated and externally generated data) information system •Completed audits of data or other evidence of data monitoring for accuracy and completeness both for MCP data and information system •Provider/Contractor Services policies and procedures manuals (PS) •Provider contracts (PS)			Review Not Required
	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]				Review Not Required
	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				Review Not Required

	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]		• P3.20.WY2022.Annual Report Utilization Management • P3.30.WY2022.WY CME Quality Annual Program Evaluation SFY2022 • P2.5 SFY2022 Annual Reports.pdf	• 2.16.23 -During the WY CME Virtual Onsite, Magellan stated they conduct virtual onsite reviews with their providers due to many providers not working in brick and mortar locations. The virtual onsite between the provider and Magellan covers documentation audits and reviews to ensure provider quality is up to date. It is important to note that the virtual component of the audit is not defined in Magellan's documentation (not in Annual Quality Improvement Clinical Management Program Evaluation). • The **Annual Utilization Management Report** displays the number of enrollments, encounters, and authorizations, for HFWA services of Family Care Coordination, Family Support Partner, Youth Support Partner, Youth and Family Training, and Respite care. • The CME Quality Annual Program Evaluation SFY 2022 states that **Magellan's QI committees oversee the Quality Management Process and a spectrum of measures and activities. Oversight includes the monitoring of a spectrum of measures of the quality of care and service, including utilization data**, member and provider satisfaction survey results, grievances, complaints, and other quality monitors. Each of these quality improvement and utilization management activities is described, trended, and analyzed in the annual program evaluation of the overall effectiveness of the Quality Improvement program. • As stated in the CME Quality Annual Program Evaluation SFY 2022, **WY CME collects data from a wide range of sources** to ensure our quality improvement activities are driven by qualitative and quantitative data. **Data sources can include but are not limited to internal platforms for network provider data, internal member health records for authorization and episode of care data, grievance/complaint/appeals data, and member/provider experience of care and survey data**. When available, **the data is transferred to Magellan's data warehouse for integrated reporting of quality measures**. The Fidelity Electronic Health Record (EHR) was implemented on January 1, 2021. Providers now use the EHR system to enter member case information instead of the Magellan.com provider portal. **Data is extracted from the EHR for quality monitoring purposes.** • According to the CME Quality Annual Program Evaluation SFY 2022, **Magellan has processes in place to monitor for under or over utilization on a continuing basis to facilitate the timely indication of any trends suggestive of under-utilization or over-utilization Magellan monitor the number of enrollments, encounters, authorization, paid claims** for HFWA services of Family Care Coordination, Family Support Partner, Youth Support Partner, Youth and Family Training, 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. Utilization data is primarily used for provider and enrollee monitoring, but also used to monitor enrollment/disenrollment, quality of care and coverage/authorization. The data is utilized to indicate opportunities for improvement and to assess compliance with utilization policies and procedures at the provider and contractor level. Service authorizations requested through the Plan of Care (POC) process have specific parameters that must be included in the request for the POC to be authorized. This includes details regarding how the service supports the HFWA program for the enrollee and family. Determination of authorizations are made based on information provided in the POC. The POC is also referenced and helps to shape utilization and minimize over or under utilization of services. The Magellan HFWA clinical team monitors service utilization patterns to detect over or under utilization of services and addresses with provider(s) as applicable. Discussion of any concerns about over or underutilization are also brought to ad hoc work groups and the Quality Improvement Committee members.	Fully Met
	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]				Review Not Required
	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]				Review Not Required
	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]				Review Not Required
ty Assessment and Performance Improvement							
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	•MCP QAPI implementation documentation (AM)			Review Not Required
Basic elements of quality assessment and performance improvement program **Medicaid**: 42 C.F.R. §	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]	•Policies and procedures related to QAPI project metrics (AM) •QAPI project quality indicators, the selection or development criteria, and processes for selection or development (AM) •Performance standards and quality indicators established by the MCP (AM)			Review Not Required

Guidehouse

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 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]	established by the MCP (AM) •Performance measure reports and data provided to the state (AM) •Utilization management policies and procedures (UM) •Medicaid/CHIP and other enrollee MLTSS tracking reports (AM) •Policies and procedures related to data collection and data quality checks for QAPI projects (AM) •Policies and procedures for assessment of MLTSS services between care settings and comparison of services and supports received with those set forth in the enrollee's treatment/service plan (AM) •Policies and procedures for assisting the state in the prevention, detection and remediation of critical incidents that occur within the delivery of MLTSS.				Review Not Required
	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]					Review Not Required
	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]					Review Not Required
	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					Review Not Required
	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					Review Not Required
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]	•Performance measure reports and data provided to the state (AM)				Review Not Required
	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					Review Not Required
	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]					Review Not Required

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]	•Reports and status documentation of MCP internal QAPI evaluations (AM)			Review Not Required
	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]				Review Not Required
	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
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]	•Reports and status documentation of MCP internal QAPI evaluations (AM)			Review Not Required
ance System							
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]	•Enrollee grievance and appeals policies and procedures (ES) •Enrollee grievance and appeal tracking reports (ES)			Review Not Required
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/CHIP enrollee grievance and appeals policies and procedures (ES) •Medicaid/CHIP and other enrollee grievance and appeals data (AM) •Analytic reports of service utilization (UM) •Information systems capability assessment reports (information systems) •Policies and procedures for auditing data or descriptions of other mechanisms used to check the accuracy and completeness of both internally generated and externally generated data (Information systems) •Completed audits of data or other evidence of data monitoring for accuracy and completeness both for MCP data and contractor (delegate) data (information systems) •Provider/Contractor Services policies and procedures manuals (PS) •Provider contracts (PS)			Review Not Required
	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]				Review Not Required

	Existing Requirement	Whether state offers external medical review.	None				Review Not Required
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]	•Data on claims denials (UM) •Medicaid/CHIP enrollee grievance and appeals policies and procedures (ES) •MCP adverse benefit determinations (ES) •Timing data on adverse benefit determination mailings (ES)	• P3.13.WY2022.ClinicalManual2021-2022	• According to the Clinical Manual 2021- 2022, **standard UM Service Authorization Reviews are completed as quickly as the member's condition requires, but no longer than fourteen (14) calendar days of the receipt of the request**. A review is considered to be complete when: a) A service authorization determination is made in accordance with notification requirements as outlined in the applicable State Medicaid contract, based on a medical necessity decision or administrative reason; and b) **In the case of an adverse benefit determination, written notice is given to the member and provider. The standard processing time may be extended once prior to the expiration of the standard processing time for up to fourteen (14) calendar days**. An extension request may be made by the member, ordering and/or rendering provider, or Magellan. Extension Requests Made by the Member or the Ordering and/or Rendering Provider: This extension is allowed to occur if it is requested orally or in writing by the member, the member's designee or the ordering and/or rendering provider; or Extension Requests Made by Magellan: This extension can occur **if Magellan justifies (to the State agency, upon request) a need for additional information and documents how the delay is in the member's interest**. When Magellan grants itself an extension, **the member is notified in writing of the reason(s) for the delay and of the member's right to file a grievance if s/he disagrees with the extension as outlined in Standard IV below**. Magellan maintains sufficient documentation of extension determinations to demonstrate, upon the State agency's request, that the extension was justified. b) Magellan issues and carries out its determination as expeditiously as the member's condition requires but no later than the date the extension expires.	Fully Met
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]	•Medicaid/CHIP enrollee grievance and appeals policies and procedures (ES) •Medicaid/CHIP and other enrollee grievance and appeals data (AM)			Review Not Required
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/CHIP enrollee grievance and appeals policies and procedures (ES) •Medicaid/CHIP enrollee grievance and appeal tracking reports (ES) •MCP appeal resolution notices (ES)			Review Not Required
	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]				Review Not Required
	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]				Review Not Required

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]	•Medicaid/CHIP enrollee grievance and appeals policies and procedures (ES) •Medicaid/CHIP enrollee grievance and appeal tracking reports (ES)			Review Not Required
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	•Contracts or written agreements with organizational subcontractors (AM) •Completed evaluations of entities conducted before delegation is granted (AM) •Provider contracts (PS) •Provider/Contractor procedure manuals (PS)			Review Not Required
	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]				Review Not Required
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	•Medicaid/CHIP enrollee grievance and appeals policies and procedures (ES) •Medicaid/CHIP enrollee grievance and appeal tracking reports (ES) •Sample records of grievances and appeals (ES)			Review Not Required
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	•Medicaid enrollee grievance and appeals policies and procedures (ES)			Review Not Required
	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				Review Not Required

	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]				Review Not Required
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/CHIP enrollee grievance and appeals policies and procedures (ES)			Review Not Required

Appendix H: Protocol 4 - Network Adequacy Review Tool

Wyoming CME - EQR Network Adequacy Tool

Hidden column

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2021 Contract Language	Findings from CME Documentation	Internal Comments	Compliance Status
§ 438.358 Activities related to external quality review.						
0	(b)(1)(iv)	(1) For each MCO, PIHP, or PAHP the following EQR-related activities must be performed: (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 be responsible for the following General responsibilities and comply with requirements: •Comply with the external quality review (EQR), as required by federal regulations at 42 CFR § 438, subpart E. (GR 5-7) [SOW pg. 23]			
§ 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].	**01/16/23:** Magellan provided **GeoMaps** with the number of members and the number of providers for each HFWA service, including FCC, FSP, YSP, and Respite for each quarter in SFY22 (i.e., Jul-Sep 2021, Oct-Dec 2021, Jan-Mar 2022, and Apr-Jun 2022). Maps for the first half of the fiscal year (i.e., Jul-Dec 2022) included member and provider counts by county, but did not include unduplicated provider counts as providers can provide services in more than one county / region. However, the maps for the second half of the fiscal year (i.e., Jan-June 2022) included provider and member counts by county / region, and the unduplicated provider counts. In the **2022 Provider Handbook,** Magellan identifies provider service limits / ratios as listed below: •FCCs - 1 provider: 10 youth •FSP - 1 provider: 10 youth •YSP - 1 provider: 25 youth Magellan did not identify service limits / ratios for respite providers. According to data included in the **GeoMaps,** the ratio of FCCs and FSPs is above the required 1 provider: 10 enrollees ratio for all regions and for the overall state for all of SFY 2022. However, the ratio of YSPs to enrollees exceeds the required 1 provider: 25 enrollees in every quarter of SFY 22 despite noticeable growth in YSPs from Q1 to Q4. In Q4, YSPs exceeds the 1:25 YSP ratio in most of the regions (excluding regions 3 and 6) and in the state overall (1 provider: 30 youth). In the **Network Development and Management Plan**, Magellan states that "The Network team has implemented a Network Strategy Committee whose primary purpose is to review service capacity and program development initiatives. The Network Strategy Committee will initiate the recruitment of providers, including Family Care Coordinators, Family Support Partners, Youth Support Partners and Respite providers to ensure that unmet needs of the local communities are identified and addressed." (pg. 22) **02/20/23:** During the WY CME EQR Virtual Onsite, Magellan confirmed that following a October 2021 amendment of the SOW, the provider to enrollee ratios have increased to the following levels for FCCs and FSPs: •FCCs - 1 provider: 15 youth •FSP - 1 provider: 25 youth Providers that are certified as both FCCs and FSPs cannot serve in both roles for an enrollee. A provider that is certified as an FSP and FCC can only serve up to 25 enrollees total. Magellan confirmed that provider ratios are not established for respite providers. However, respite services are required to be provided to enrollees on a one-on-one basis (i.e., providers cannot physically provide services to two enrollees at the same time). Magellan did not identify a formal process / methodology to provide respite services in regions without providers or to educate FCCs / enrollees in those regions of how to access services outside of their area. Magellan stated that FCCs will work directly with Magellan in cases where respite providers are not available to provide service within a member's region. Magellan is actively working to recruit more respite providers and to contract with agencies that provide respite services. According to the GeoMaps, the number of FFCs in Region 3 (i.e., Sheridan, Johnson, Campbell, Crook, and Weston Counties) decreased significantly from 30 in Q1 to 10 by Q3. Magellan provided documentation following the virtual onsite stating describing the cause of the decrease. Six of the providers between Q1 and Q3 were from two agencies that enacted their 30-dy notice. Additionally, Magellan updated their Geomapping process during SFY 2022 to more accurately provide unique provider counts. The updated methodology removed provider duplication in reporting.	Can Magellan please confirm whether provider ratios have been established for Respite providers? If so, what are the ratios and where are they documented? Respite providers are not available in 2 regions of the state. Can Magellan confirm how you are ensuring that respite services are available for the enrollees located in those regions? According to the GeoMaps, The number of FFCs in Region 3 (i.e., Sheridan, Johnson, Campbell, Crook, and Weston Counties) decreased from 30 in Q1 to 10 by Q3. Can you please describe why the number of providers decreased so rapidly? In the Provider Handbook it is noted that providers that are certified as both FCCs and FSPs, they can cumulatively serve up to 10 youth at a time in both their roles. Can one provider serve as both the FCC and the FSP for a single youth? If so, would the youth count as one or two enrollees for the provider?	2. Incomplete

Appendix H: Protocol 4 - Network Adequacy Review Tool

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2021 Contract Language	Findings from CME Documentation	Internal Comments	Compliance Status
(b) Provider-specific network adequacy standards						
2	**(b)(1)**	At a minimum, a State must develop time and distance standards for the following provider types, if covered under the contract:				
2a	(i)	Primary care, adult and pediatric.	Not applicable.	Not applicable. Time and distance standards do not apply to the CME program. Providers travel to the members in this program, rather than members traveling to a clinic or facility, therefore, time and distance standards do not impact member access. Rather, CME measures capacity and network adequacy through provider: beneficiary ratios.	N/A	Not applicable.
2b	(ii)	OB/GYN.	Not applicable.	Not applicable.	N/A	Not applicable.
2c	(iii)	Behavioral health (mental health and substance use disorder), adult and pediatric.	Not applicable.	Not applicable.	N/A	Not applicable.
2d	(iv)	Specialist, adult and pediatric.	Not applicable.	Not applicable.	N/A	Not applicable.
2e	(v)	Hospital.	Not applicable.	Not applicable.	N/A	Not applicable.
2f	(vi)	Pharmacy.	Not applicable.	Not applicable.	N/A	Not applicable.
2g	(vii)	Pediatric dental.	Not applicable.	Not applicable.	N/A	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.	N/A	Not applicable.
3	**(b)(2)**	*LTSS.* States with MCO, PIHP or PAHP contracts which cover LTSS must develop:				
3a	(i)	Time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services; and	Not applicable.	Not applicable. This program not does include LTSS.	N/A	Not applicable.
3b	(ii)	Network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services.	Not applicable.	Not applicable. This program not does include LTSS.	N/A	Not applicable.
4	**(b)(3)**	*Scope of network adequacy standards*. Network standards established in accordance with paragraphs (b)(1) and (2) of this section must include all geographic areas covered by the managed care program or, if applicable, the contract between the State and the MCO, PIHP or PAHP. States are permitted to have varying standards for the same provider type based on geographic areas.	The Contractor must serve all 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]	**01/16/23:** Magellan provided **GeoMaps** with the number of members and the number of providers for each HFWA service, including FCC, FSP, YSP, and Respite for each quarter in SFY22 (i.e., Jul-Sep 2021, Oct-Dec 2021, Jan-Mar 2022, and Apr-Jun 2022). Maps for the first half of the fiscal year (i.e., Jul-Dec 2022) included member and provider counts by county, but did not include unduplicated provider counts as providers can provide services in more than one county / region. However, the maps for the second half of the fiscal year (i.e., Jan-June 2022) included provider and member counts by county / region, and the unduplicated provider counts. In the **2022 Provider Handbook**, Magellan identifies provider service limits / ratios as listed below: •FCCs - 1 provider: 10 youth •FSP - 1 provider: 10 youth •YSP - 1 provider: 25 youth Magellan did not identify service limits / ratios for respite providers. According to data included in the **GeoMaps**, the ratio of FCCs and FSPs is above the required 1 provider: 10 enrollees ratio for all regions and for the overall state for all of SFY 2022. However, the ratio of YSPs to enrollees exceeds the required 1 provider: 25 enrollees in every quarter of SFY 22 despite noticeable growth in YSPs from Q1 to Q4. In Q4, YSPs exceeds the 1:25 YSP ratio in most of the regions (excluding regions 3 and 6) and in the state overall (1 provider: 30 youth). In the **Network Development and Management Plan**, Magellan states that "The Network team has implemented a Network Strategy Committee whose primary purpose is to review service capacity and program development initiatives. The Network Strategy Committee will initiate the recruitment of providers, including Family Care Coordinators, Family Support Partners, Youth Support Partners and Respite providers to ensure that unmet needs of the local communities are identified and addressed." (pg. 22) **02/20/23:** During the WY CME EQR Virtual Onsite, Magellan confirmed that following a October 2021 amendment of the SOW, the provider to enrollee ratios have increased to the following levels for FCCs and FSPs: •FCCs - 1 provider: 15 youth •FSP - 1 provider: 25 youth Providers that are certified as both FCCs and FSPs cannot serve in both roles for an enrollee. A provider that is certified s an FSP and FCC can only serve up to 25 enrollees total. Magellan confirmed that provider ratios are not established for respite providers. However, respite services are required to be provided to enrollees on a one-on-one basis (i.e., providers cannot physically provide services to two enrollees at the same time). Magellan did not identify a formal process / methodology to provide respite services in regions without providers or to educate FCCs / enrollees in those regions of how to access services outside of their area.		2. Incomplete

Appendix H: Protocol 4 - Network Adequacy Review Tool

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2021 Contract Language	Findings from CME Documentation	Internal Comments	Compliance Status
(c) Development of network adequacy standards.						
5	(c)(1)	States developing network adequacy standards consistent with paragraph (b)(1) of this section must consider, at a minimum, the following elements:				
5a	(i)	The anticipated Medicaid enrollment.	The 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]	**01/16/23:** According to the **Network Development Plan**, to ensure the Accessibility and Scalability of services, Magellan " develops and maintains a number of provider onboarding and training processes to meet community needs and stakeholder embracement of a growing wraparound approach to serving families (pg. 18)." This responsive network scalability approach allows for rapid growth in number of providers if there were to be an influx of new youth. The CME Program also allows providers to offer services through telehealth and approved technology platforms. Allowing youth to receive services through telehealth provides the following benefits (**Network Development Plan, pg. 18)**: •Fewer no shows or missed appointments – Child and family team members are less likely to run into problems when they can meet from wherever they are. •Greater accessibility – Allows for care coordination with families which is more accessible and flexible for team members, including weekend and evening options. •Improved compliance – Team members find it easier to follow through on care coordination planning.		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. 15]	**01/16/23:** One of the Pillars of the High Fidelity Wraparound Model is Utilization Management. According to Magellan this includes "[Collaborating] with providers to help tailor care to each person's needs, ensuring the individual's culture, preferences and goals are considered. This includes ongoing case reviews and authorizations for High Fidelity Wraparound." (**Network Development Plan,** pg. 28). Magellan's clinical team also reviews utilization patterns (e.g., under and overutilization patterns), claims and authorizations. There was no respite utilization. The CME Program also allows providers to offer services through telehealth and approved technology platforms. Allowing youth to receive services through telehealth provides the following benefits (**Network Development Plan**, pg. 18): •Fewer no shows or missed appointments – Child and family team members are less likely to run into problems when they can meet from wherever they are. •Greater accessibility – Allows for care coordination with families which is more accessible and flexible for team members, including weekend and evening options. •Improved compliance – Team members find it easier to follow through on care coordination planning. **2/20/23:** During the WY CME Virtual Onsite, Magellan confirmed that the clinical team reviews the number of units being requested by providers for under and overutilization trends. Review considers which stage of HFWA an enrollee is currently in when review is conducted. When unfavorable trends are identified, concerns are escalated to the According to utilization data, there were no respite authorization during SFY 22, which was determined to be "consistent with previous years". During the WY CME Virtual Onsite, Magellan stated that research has not been conducted to identify why FCCs and enrollees are not utilizing respite services.	Can Magellan please confirm how often the clinical team reviews utilization metrics (over / underutilization)? Can you provide examples of actions taken to address utilization trends? Has there been any research into why there is no respite utilization? Have any actions been identified to improve respite utilization?	2. Incomplete
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]	**01/16/23:** The **Network Development Plan** includes a summary of enrollee demographics. Listed demographics include race / ethnicity, age, gender, and behavioral health diagnosis. The document notes that member linguistics were not measured in SFY 22, but that the Fidelity EHR has been updated to collect and analyze the information going forward. Additionally, in the **Network Development Plan,** Magellan stated that "CME contracted with its first tribal agency to provide High Fidelity Wrap Around services on the Wind River Reservation" which will serve the American Native population / youth on the reservation. According to the **Network Development Plan** (pg. 26), "Magellan develops and monitors an annual Wyoming Care Management Entity Work Plan, with specific measurable objectives and activities. The objectives and activities are identified through the previous year's Annual Reporting to the State of Wyoming, ongoing internal review, and results from regulatory activities" One of the Key Program Activities in the Workplan is the Cultural Competency Program, which has identified cultural competence and competency training as a tool to improve racial / ethic disparities in the care of CME youth. The Quality Improvement committee is currently identifying a go-forward strategy.		1. Complete

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2021 Contract Language	Findings from CME Documentation	Internal Comments	Compliance Status
5d	(iv)	The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services.	The provider network must be sufficient to provide adequate access to all services covered under the contractual agreement for all enrollees, including those with limited English proficiency or physical or mental disabilities. 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]	**01/16/23:** Magellan provided GeoMaps with the number of members and the number of providers for each HFWA service, including FCC, FSP, YSP, and Respite for each quarter in SFY22 (i.e., Jul-Sep 2021, Oct-Dec 2021, Jan-Mar 2022, and Apr-Jun 2022). Maps for the first half of the fiscal year (i.e., Jul-Dec 2022) included member and provider counts by county, but did not include unduplicated provider counts as providers can provide services in more than one county / region. However, the maps for the second half of the fiscal year (i.e., Jan-June 2022) included provider and member counts by county / region, and the unduplicated provider counts. In the 2022 Provider Handbook, Magellan identifies provider service limits / ratios as listed below: •FCCs - 1 provider: 10 youth •FSP - 1 provider: 10 youth •YSP - 1 provider: 25 youth Magellan did not identify service limits / ratios for respite providers. According to data included in the GeoMaps, the ratio of FCCs and FSPs is above the required 1 provider: 10 enrollees ratio for all regions and for the overall state for all of SFY 2022. However, the ratio of YSPs to enrollees exceeds the required 1 provider: 25 enrollees in every quarter of SFY 22 despite noticeable growth in YSPs from Q1 to Q4. In Q4, YSPs exceeds the 1:25 YSP ratio in most of the regions (excluding regions 3 and 6) and in the state overall (1 provider: 30 youth). In the Network Development and Management Plan, Magellan states that "The Network team has implemented a Network Strategy Committee whose primary purpose is to review service capacity and program development initiatives. The Network Strategy Committee will initiate the recruitment of providers, including Family Care Coordinators, Family Support Partners, Youth Support Partners and Respite providers to ensure that unmet needs of the local communities are identified and addressed." (pg. 22) **02/20/23:** During the WY CME EQR Virtual Onsite, Magellan confirmed that following a October 2021 amendment of the SOW, the provider to enrollee ratios have increased to the following levels for FCCs and FSPs: •FCCs - 1 provider: 15 youth •FSP - 1 provider: 25 youth Providers that are certified as both FCCs and FSPs cannot serve in both roles for an enrollee. A provider that is certified s an FSP and FCC can only serve up to 25 enrollees total. Magellan confirmed that provider ratios are not established for respite providers. However, respite services are required to be provided to enrollees on a one-on-one basis (i.e., providers cannot physically provide services to two enrollees at the same time).		2. Incomplete
5e	(v)	The numbers of network providers who are not accepting new Medicaid patients.	No pertinent language from the SOW.	N/A		1. Complete
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]	**01/16/23:** Magellan provided GeoMaps with the number of members and the number of providers for each HFWA service, including FCC, FSP, YSP, and Respite for each quarter in SFY22 (i.e., Jul-Sep 2021, Oct-Dec 2021, Jan-Mar 2022, and Apr-Jun 2022). Maps for the first half of the fiscal year (i.e., Jul-Dec 2022) included member and provider counts by county, but did not include unduplicated provider counts as providers can provide services in more than one county / region. However, the maps for the second half of the fiscal year (i.e., Jan-June 2022) included provider and member counts by county / region, and the unduplicated provider counts. According to data included in the GeoMaps, the ratio of FCCs and FSPs is above the required 1 provider: 10 enrollees ratio for all regions and for the overall state for all of SFY 2022. However, the ratio of YSPs to enrollees exceeds the required 1 provider: 25 enrollees in every quarter of SFY 22 despite noticeable growth in YSPs from Q1 to Q4. In Q4, YSPs exceeds the 1:25 YSP ratio in most of the regions (excluding regions 3 and 6) and in the state overall (1 provider: 30 youth). The CME Program also allows providers to offer services through telehealth and approved technology platforms. Allowing youth to receive services through telehealth provides the following benefits (Network Development Plan, pg. 18): •Fewer no shows or missed appointments – Child and family team members are less likely to run into problems when they can meet from wherever they are. •Greater accessibility – Allows for care coordination with families which is more accessible and flexible for team members, including weekend and evening options. •Improved compliance – Team members find it easier to follow through on care coordination planning.		1. Complete

Appendix H: Protocol 4 - Network Adequacy Review Tool

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2021 Contract Language	Findings from CME Documentation	Internal Comments	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]	**01/16/23:** 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 (pg. 44): 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 (pg. 44): 1. Provide ongoing education to deliver competent services to people of all cultures, races, ethnic backgrounds, religions and those with disabilities. 2. Provide language assistance, to Magellan call-center callers using interpreter services, to those with limited English proficiency during all hours of operation at no cost to the member. 3. Assist providers in locating interpreters for our members when requested by the member or when requested by the provider. 4. Provide easily understood member materials, available in the languages of the commonly encountered groups and/or groups represented in the service area; and 5. Monitor gaps in services and other culture-specific provider service needs. When gaps are identified, Magellan will develop a provider recruitment plan and monitor its effectiveness. The **Network Development Plan** notes that member linguistics were not measured in SFY 22, but that the Fidelity EHR has been updated to collect and analyze the information going forward.		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]	**01/16/23:** 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 (pg. 44): 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. The **Network Development Plan** notes that member linguistics were not measured in SFY 22, but that the Fidelity EHR has been updated to collect and analyze the information going forward. The CME Program also allows providers to offer services through telehealth and approved technology platforms. Allowing youth to receive services through telehealth provides the following benefits (**Network Development Plan,** pg. 18): •Fewer no shows or missed appointments – Child and family team members are less likely to run into problems when they can meet from wherever they are. •Greater accessibility – Allows for care coordination with families which is more accessible and flexible for team members, including weekend and evening options. •Improved compliance – Team members find it easier to follow through on care coordination planning.		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]	**01/16/23:** The CME Program also allows providers to offer services through telehealth and approved technology platforms. Allowing youth to receive services through telehealth provides the following benefits (Network Development Plan, pg. 18): •Fewer no shows or missed appointments – Child and family team members are less likely to run into problems when they can meet from wherever they are. •Greater accessibility – Allows for care coordination with families which is more accessible and flexible for team members, including weekend and evening options. •Improved compliance – Team members find it easier to follow through on care coordination planning. 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		1. Complete

Appendix H: Protocol 4 - Network Adequacy Review Tool

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2021 Contract Language	Findings from CME Documentation	Internal Comments	Compliance Status
6	**(c)(2)**	States developing standards consistent with paragraph (b)(2) of this section must consider the following:				
6a	(i)	All elements in paragraphs (c)(1)(i) through (ix) of this section.	Not applicable.	Not applicable. This program does not include LTSS.		Not applicable.
6b	(ii)	Elements that would support an enrollee's choice of provider.	Not applicable.	Not applicable. This program does not include LTSS.	N/A	Not applicable.
6c	(iii)	Strategies that would ensure the health and welfare of the enrollee and support community integration of the enrollee.	Not applicable.	Not applicable. This program does not include LTSS.	N/A	Not applicable.
6d	(iv)	Other considerations that are in the best interest of the enrollees that need LTSS.	Not applicable.	Not applicable. This program does not include LTSS.	N/A	Not applicable.
(d) Exceptions process.						
7	**(d)(1)**	To the extent the State permits an exception to any of the provider-specific network standards developed under this section, the standard by which the exception will be evaluated and approved must be:				
7a	(i)	Specified in the MCO, PIHP or PAHP contract.	No pertinent language from the SOW.	Not applicable. The provider-specific network standards do not apply to this program, and therefore there are not exemptions to the provider-specific network standards.	N/A	Not applicable.
7b	(ii)	Based, at a minimum, on the number of providers in that specialty practicing in the MCO, PIHP, or PAHP service area.	No pertinent language from the SOW.	Not applicable. The provider-specific network standards do not apply to this program, and therefore there are not exemptions to the provider-specific network standards.	N/A	Not applicable.
8	**(d)(2)**	States that grant an exception in accordance with paragraph (d)(1) of this section to a MCO, PIHP or PAHP must monitor enrollee access to that provider type on an ongoing basis and include the findings to CMS in the managed care program assessment report required under § 438.66.	Not applicable.	Not applicable. The provider-specific network standards do not apply to this program, and therefore there are not exemptions to the provider-specific network standards.	N/A	Not applicable.

Appendix H: Protocol 4 - Network Adequacy Review Tool

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2021 Contract Language	Findings from CME Documentation	Internal Comments	Compliance Status
(e) Publication of network adequacy standards.						
9	**(e)**	States must publish the standards developed in accordance with paragraphs (b)(1) and (2) of this section on the Web site required by § 438.10. Upon request, network adequacy standards must also be made available at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services.	A provider directory must also be made available on the Contractor's website in a machine-readable file and format as specified by the Secretary and in 42 CFR 438.10(h)(4). The Contractor's electronic provider directory must be updated no later than thirty (30) calendar days after the Contractor receives updated provider information. 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]	**01/16/23**: **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). 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. [PJ] 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). **02/20/23:** During the WY CME Virtual Onsite, Magellan confirmed provider ratios are not included in member-facing documents (e.g., the Member Handbook) or on the Magellan of Wyoming Website (www.MagellanofWyoming.com), However, CME enrollees will be informed of network adequacy standards if requested. Magellan also confirmed that the provider and the contractor share the responsibility of shifting a provider's status from "accepting new patients" to not accepting patients. Magellan regularly checks provider availability against program-defined provider: enrollee ratios.	Can you confirm what triggers a provider's status to switch from accepting patients to not accepting patients. Is this a responsibility of the provider, Magellan, or an automatic process? If this is the responsibility of Magellan, how often can you confirm whether enrollees are informed of the provider to enrollee ratios established in the provider handbook as they are not included in the member handbook or on the website	2. Incomplete
§ 438.14 Requirements that apply to MCO, PIHP, PAHP, PCCM, and PCCM entity contracts involving Indians, Indian health care providers (IHCPs), and Indian managed care entities (IMCEs).						
(b) Network and coverage requirements. All contracts between a State and a MCO, PIHP, PAHP, and PCCM entity, to the extent that the PCCM entity has a provider network, which enroll Indians must:						
10	**(b)(1)**	Require the MCO, PIHP, PAHP, or PCCM entity to demonstrate that there are sufficient IHCPs participating in the provider network of the MCO, PIHP, PAHP, or PCCM entity to ensure timely access to services available under the contract from such providers for Indian enrollees who are eligible to receive services.	No pertinent language from the SOW.	Not applicable. Although Magellan serves members of the tribal community, IHCPs are not involved because the program does not offer clinical services.		Not applicable.

EQR Findings	Associated Quality Strategy Objective	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)	EQRO Suggestions for WDH
Goal 1: Reduce rate of admissions to inpatient psychiatric treatment facilities.				
The average rate of Out-of-Home (OOH) Placements for CME Youth in SFY 2022 is 2.0%. This is one-third the baseline rate in SFY 2020.	1. Decrease OOH placements of CME youth.	6.8% (SFY 2020)	N/A	N/A
Goal 2: Reduce frequency of readmissions to inpatient psychiatric treatment facilities.				
The average rate of CME youth moving from a lower level of care to a higher level of care in SFY 2022 is 2.0%. This is half the baseline rate in SFY 2020.	3. Decrease recidivism of CME youth moving from a lower level of care to a higher level of care.	4.3% (SFY 2020)	N/A	N/A
The average rate of youth who graduated from the CME program and move into a higher level of care within 6 months is 10.0% in SFY 2022. This is higher than the baseline measure of 2.0% in SFY 2021. However, the baseline value was calculated based on Q3 and Q4 in SFY 2021, and therefore it is unclear if the measure is representative of annual statewide performance.	4. Decrease recidivism of youth who graduated from the CME program having met their goals and who are moving from a lower level of care to a higher level of care within six months of graduation from the CME program.	2.0% (SFY 2021)	N/A	WDH should consider including a methodology to calculate baseline measures for all Quality Strategy Objectives in the Quality Strategy.
Goal 3: Reduce length of stay in inpatient and residential psychiatric treatment facilities.				
The average length of stay (LOS) for inpatient and residential treatment admissions for youth enrolled in the CME Program was 17.2 days in SFY 2022. This	2. Decrease LOS for inpatient and residential treatment admissions for youth enrolled in the CME program.	30.8 days (SFY 2020)	N/A	N/A

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EQR Findings	Associated Quality Strategy Objective	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)	EQRO Suggestions for WDH
is much lower than the baseline measure in SFY 2020.				
Goal 4: Reduce overall Medicaid cost of care for enrolled youth.				
The average difference between Medicaid costs for CME youth and non-CME enrolled youth was $3,170.33 in SFY 2022. This is notably lower than the baseline difference in SFY 2020. However, the average Medicaid costs for non-CME enrolled youth decreased significantly between SFY 2020 and SFY 2022 (from $20,226 in SFY 2020 to $6,803 in SFY 22). This difference may in part have been caused by youth enrollment in the CME Program.	6. Decrease Medicaid costs compared to the target eligible population of non-CME enrolled youth with PRTF stays.	$14,230.39 (SFY 2020)	N/A	Given the drastic shift in Medicaid costs for non-CME enrolled youth, the state should consider whether to reformat the measure to indicate Medicaid cost savings in a different way.
Goal 5: Improve child and family integration into home and community life. **Goal 6:** Assist enrolled youth in cultivating family partnerships and natural supports.				
The average rate of CME youth with identified primary care practitioners was 96.4% in SFY 2022. This is significantly higher than the rate at baseline in SFY 2020. However, the baseline value was calculated based on Q3 and Q4 in SFY 2021, and therefore it is unclear if the measure is representative of	5. Increase compliance with EPSDT / increase number of CME youth who have an identified primary care practitioner.	14.0% (SFY 2021)	N/A	WDH should consider including a methodology to calculate baseline measures for all Quality Strategy Objectives in the Quality Strategy.

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EQR Findings	Associated Quality Strategy Objective	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)	EQRO Suggestions for WDH
annual statewide performance.				
The total number of WFI-EZ surveys received in SFY 22 was 182. This is less than half the surveys that were received at baseline in SFY 2020.	8. Increase participation with the WFI-EZ, as measured by the number of WFI-EZ surveys received.	444 (SFY 2020)	N/A	WDH should consider updating the objective to measure the rate of surveys completed rather than the total number of surveys completed to simplify comparison year to year. WDH should also consider including an objective to encourage Magellan and CME providers to increase collection of the surveys.
The average rate of families and youth participating in State-level Advisory Committees was 0.3% in SFY 2022. This rate is significantly lower than the rate at baseline in SFY 2020. However, the method of measure calculation in SFY 2020 and 2022 were different. Both years used the number of CME families and youth that participated in the Advisory Board meetings as the numerator for the measure. But, in SFY 2020, the denominator for the measure was the total number of people that attended the Advisory Board meeting (ranging from 7 to 25), while the denominator in 2022 was the number of	9. Increase family and youth participation at State-level Advisory Committees.	55% (SFY 2020)	N/A	WDH should consider re-confirming what is being measured by the objective, updating the measure language if needed, and identify how to uniformly calculate the measure year to year. The Quality Strategy should be updated to reflect changes to the measure.

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EQR Findings	Associated Quality Strategy Objective	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)	EQRO Suggestions for WDH
enrollees / family member are in the CME program (ranging from 533 to 572).				
The average rate of families and youth participating in communities was 45.7% in SFY 2022. This rate is slightly higher than baseline in SFY 2020.	10. Increase family and youth participation in communities (e.g., community advisory boards, support groups, other stakeholder meetings).	40.4% (SFY 2020)	N/A	N/A

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Appendix J: 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's collaboration with stakeholders is demonstrated by its continued improvement and engagement of providers.	Strength	Quality
3	Magellan does not have a standardized data validation plan for reviewing PIP data that is collected and analyzed.	Needed Improvement	Quality
4	Magellan has reported minimal statistically significant improvement across PIPs.	Needed Improvement	Quality
Protocol 2. Validation of Performance Measures			
5	Clinical and technical teams are knowledgeable, engaged, and invested.	Strength	Quality; Timeliness; Access to Care
6	Documentation describing measure result creation continues to improve.	Strength	Quality; Timeliness; Access to Care
7	Measure creation staff are cross-trained.	Strength	Quality; Timeliness; Access to Care
8	Magellan now has access to extract the raw CME membership data from Izenda/Fidelity and import to its own data warehouse which is now the source for the denominator creation processes.	Strength	Quality
9	Numerator and denominator alignment to guarantee accurate measure rate or average.	Needed Improvement	Quality
10	Measure creation team is unable to recreate results as of a prior time period making it difficult to validate results.	Needed Improvement	Quality

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#	Finding	Strength or Needed Improvement	Domain
11	Contract and business requirement documents (BRD) require more clarity.	Needed Improvement	Quality
Protocol 3. Compliance with Medicaid Managed Care Regulations			
12	Magellan "fully met" all compliance metrics for the Grievance and Appeals System.	Strength	Quality
13	Magellan did not demonstrate the ability to meet the State's network adequacy requirement for YSPs in five of the seven geographic regions in the State	Needed Improvement	Access to Care
14	Magellan did not clarify in member-facing documents how members and their families provide authority to an evaluator to send external clinical assessment results directly to Magellan.	Needed Improvement	Timeliness; Access to Care
Protocol 4. Validation of Network Adequacy			
15	Magellan updated their Geo-mapping methodology to more accurately demonstrate the number of providers available by region and their ability to meet provider-to-member ratios.	Strength	Quality
16	Magellan and WDH do not have network adequacy standards for respite providers.	Needed Improvement	Timeliness; Access to Care
17	Magellan does not include established network adequacy standards on the program website.	Needed Improvement	Quality

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