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 2022 Recommendations

Table 1. Status of SFY 2022 Recommendations

#	SFY 2022 Recommendation	Responsibility	Findings	Comments
Protocol 1. Validation of Performance Improvement Projects				
1.	**Recommendation for Magellan**: Develop a standardized data validation 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 validation 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	Not Addressed	While a data validation plan was discussed in previous year's reports and during the virtual on-sites, Magellan's PIP documentation did not demonstrate any robust data validation processes beyond noting that personnel will conduct reviews of data as it is collected.
2.	**Recommendation for Magellan**: Conduct an updated formal data-driven evaluation of barriers impacting the effectiveness of PIPs improvement strategies implemented in the past couple of years. 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	Magellan	Not Addressed	Magellan's PIP documentation noted barriers that drove their identified improvement strategies. A provider survey partially informed these barriers in the Prior Authorization PIP documentation, but the other PIP documentation did not have any description of data informing identified barriers.

#	SFY 2022 Recommendation	Responsibility	Findings	Comments
	barriers that may benefit from a targeted PIP. This evaluation should include analyses of data available to Magellan and assessment of previously implemented improvement strategies. This level of evaluation will not only identify barriers to success but should provide guidance to what additional steps Magellan can undertake to achieve success for all of their PIPs. Additionally, Magellan should consider routinely surveying providers to obtain feedback and assess barriers.			
3.	**Recommendation for Magellan:** Identify annual improvement targets that will lead to achievement of the long-term target of the PIPs. Magellan has generally seen improvement for their PIPs, although not statistically significant. It is also clear that Magellan's staff and providers are all engaged and are collaborating in the improvement of the outcomes for the participants while striving to meet the goals of the PIP. To further encourage all stakeholders to achieve the goals of the PIPs, Guidehouse recommends Magellan develop annual performance targets that if achieved will incrementally lead to the ultimate success of their PIPs.	Magellan	Partially Addressed	Magellan's PIP documentation shows desired increases in network provider numbers but does not ground these increases in provider to participant ratios, participants' demand for services, etc. The Engagement and Implementation PIP documentation shows that target measures have decreased their goal values with no accompanying rationale. The goal values apply to each year without targeting relative changes between years.
Protocol 2. Validation of Performance Measures				
4.	**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	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

#	SFY 2022 Recommendation	Responsibility	Findings	Comments
	support acquisition of input data, de-duplication, formatting, calculation of numerator, denominator, and rate for the measures that are not generated via SQL.			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.
5.	**Recommendation for Magellan:** Create and archive a run log with both code and results (roster, costs, etc.) for each output used from the CDF and each quarterly measure creation. Carefully document SAS and SQL scripts to reflect any logic changes that may result in one quarter being calculated differently than another for an individual measure	Magellan	Fully Addressed	Magellan technicians have run logs, including saved results from job executions, throughout the measure review timeframe. Magellan technicians also displayed source code with commented sections describing intended logic as well as dated changes where appropriate.
Protocol 3. Compliance with Medicaid Managed Care Regulations				
6.	**Recommendation for Magellan**: Identify and implement an updated recruitment process to expand YSP access across the State. Currently, recruiting is led by Magellan's Network Strategy Committee who works to develop and implement strategies to meet the needs for network expansion in each region. To address the lack of YSP access, Magellan should work with their Network Strategy committee to reevaluate their current recruiting process and identify steps to ensure the network adequacy requirement is met. Additionally, if the Network Development Team determines network adequacy requirements are unable to be met, Magellan should evaluate whether shifting network adequacy requirements can still meet member needs or whether the program has the capacity to continue providing YSPs as a service for members.	Magellan	Fully Addressed	Magellan has made significant progress in YSP access as demonstrated by their provider and participant geo-mapping and continued efforts to improve network adequacy measurements and compliance with set standards.

#	SFY 2022 Recommendation	Responsibility	Findings	Comments
7.	**Recommendation for Magellan**: Add additional information in member-facing documents to inform members and their families of the data sharing authorities they are agreeing to by onboarding with the CME Program. Magellan's "Choice of Provider" form allows the member to identify clinical eligibility assessors (e.g., independent assessor, qualified mental health professionals) to determine wither they are eligible for enrollment in the CME Program. However, the form does not provide detail to members how information is shared between the assessor and Magellan. To uphold Magellan's guiding principle of family voice and choice, Magellan should update member-facing documentation (i.e., Member Handbook and the Choice of Provider form) to include information that informs members and their families of how assessment results are shared between external evaluators and Magellan.	Magellan	Fully Addressed	Magellan updated member-facing documentation to discuss the parties that their information will be shared with and how it will be shared. It provides language informing members to contact representatives if they would not like information shared with a particular party.
Protocol 4. Validation of Network Adequacy				
8.	**Recommendation for Magellan**: Identify a measure of network adequacy for respite providers. WDH and Magellan need to collaborate to determine a methodology to measure network adequacy for respite provider availability. Identifying network adequacy standards for the CME Program can help Magellan to develop an actionable plan to improve availability of providers for members, and to meet the requirements of the SOW. Potential measurements could include a provider-to-member ratio, of the total number of providers per region. Magellan and WDH should develop and	Magellan	Not Addressed	Magellan has not identified a standard or measure to assess and network adequacy for the respite service beyond a general count of providers.

#	SFY 2022 Recommendation	Responsibility	Findings	Comments
	document a rationale for the measurement methodology they select.			
9.	**Recommendation for Magellan**: Conduct research to understand why respite providers are not being utilized by CME members. Documentation shared by Magellan revealed that Magellan has not received authorizations for respite service for many fiscal years. To date, Magellan has not investigated why respite services have not been requested by members, therefore, cannot accurately estimate future member need for the service. Magellan should collect feedback from, or distribute surveys to, CME members and their families as well as FCCs to better understand why respite services are not being requested. Data from these groups can help Magellan identify ways to increase CME utilization of respite services, or to determine that the program no longer needs to offer the services.	Magellan	Not Addressed	During the virtual on-site meetings, Magellan noted continued interest in exploring demand for respite services and implementing additional related network adequacy measures, but they have not yet conducted these activities.
10.	**Recommendation for Magellan**: Include network adequacy standards in the Member Handbook. Magellan includes the WY CME Member Handbook on their website. However, the document does not include the network adequacy standards for network providers. Magellan should update their Member Handbook to include the network adequacy standards and continue to post the document on their website for easy access by current and potential CME members.	WDH	Partially Addressed	Since network adequacy standards are still being developed and finalized, there are no updated standards outlined in the member handbook. Language regarding general network standards have been added to the member handbook

Worksheet 1.1. Review the Selected PIP Topic

PIP Topic **Improving the Prior Authorization Process**

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.)	X			Topic selection was the result of reflection on SFY22 performance as well as concerns brought forth from youth participants and their families about their experiences with the program. The members of the Wyoming Care Management Entity team met to select the topic and the measures that evaluated it. It also drew on findings from a survey assessing provider experiences.
1.2 Did selection of the PIP topic consider performance on the CMS Child and Adult Core Set measures?			X	The CMS Child and Adult Core Set measures focus on clinical measures and do not apply to this PIP topic as the focus is administrative and procedural.
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.	X			The strategy was built to address an opportunity for improvement in the transfer of complete documentation to providers for Plans of Care development. Delays in plan creation execution, and service authorization due to missing or incomplete documentation were found to contribute to low youth and family satisfaction with the program. The Wyoming Care Management Entity team referenced grievances filed by program participants and their families, feedback from the Member Advisory Group, Wraparound Fidelity Index Survey results, and Member Satisfaction Survey results to select the PIP topic.

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	X			The PIP listed the population served as "Wyoming Care Management Entity youth ages 4-20 years old with a Serious Emotional Disturbance (SED) enrolled during Standard Fiscal Year (SFY) 2024 with an approved Plan of Care."
1.5 Did the PIP topic align with priority areas identified by HHS and/or CMS?	X			
1.6 Overall assessment: In the comments section, note any recommendations for improving the PIP topic.				

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Worksheet 1.2. Review the PIP Aim Statement

PIP Aim Statement

1) Will education to the High Fidelity Wraparound providers concerning the utilization of the completed Child and Adolescent Needs and Strength (CANS) assessment when developing Plans of Care with the youth and their family improve the positive change percentage (CANS) score for items in the Child Strengths domain (specifically Resilience) for Wyoming Care Management Entity youth ages 4-20 years old with a Serious Emotional Disturbance (SED) Diagnosis enrolled during Standard Fiscal Year (SFY) 2024 with an approved Plan of Care?

   Measure #1: Numerator: Number of responses scored as a 2 or less for Discharge CANS.
   Denominator: Number of CANS completed.

2) Will education to the High Fidelity Wraparound providers concerning the utilization of the completed Child and Adolescent Needs and Strength (CANS) assessment when developing Plans of Care with the youth and their family improve the positive change percentage (CANS) score for items in the (CANS) Child Strengths domain (specifically Resourcefulness) for Wyoming Care Management Entity youth ages 4-20 years old with a Serious Emotional Disturbance (SED) Diagnosis enrolled during Standard Fiscal Year (SFY) 2024 with an approved Plan of Care?

   Measure #2: Numerator: Number of responses scored as a 2 or less for Discharge CANS.
   Denominator: Number of CANS completed.

3) Will the introduction of changes in the High Fidelity Wraparound Plan of Care review process (documents required for the prior authorization at the initial submission versus documents that can be submitted after the authorization and the Prior Authorization feedback form) result in members receiving continuous authorizations for Wyoming Care Management Entity youth (ages 4-20 years old with Serious Emotional Disturbance (SED) Diagnosis) enrolled during Standard Fiscal Year (SFY) 2024?

   Measure #3: Numerator: Number of non-authorizations.
   Denominator: Number of Plans of Care.

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?	X			The PIP aim statement identified education to High Fidelity Wraparound (HFW) providers on utilization of CANS assessment when developing Plans of Care and introducing changes to the HFW Plan of Care review process as the strategy. The PIP aim statement identified youths ages 4-20 with SED as the population and SFY 2024 as the time period.
2.2 Did the PIP aim statement clearly specify the population for the PIP?	X			The PIP aim statement identified the population as Wyoming Care Management Entity youth ages 4-20 years old with a Serious Emotional Disturbance (SED) Diagnosis.
2.3 Did the PIP aim statement clearly specify the time period for the PIP?	X			The PIP aim statement identified the time period for the PIP as SFY 2024.
2.4 Was the PIP aim statement concise?	X			The PIP aim statements are three clear and concise sentences / questions.
2.5 Was the PIP aim statement answerable?	X			The PIP aim statements were answerable and clearly measures through metrics defined in each aim statement.
2.6 Was the PIP aim statement measurable?	X			The PIP aim statements were measurable, using the number of responses scored as a 2 via CANS at discharge, the number of CANS completed, the number of non-

Question	Yes	No	NA	Comments
				authorizations that occurred, and the number of Plans of Care to determine meaningful ratios to measure performance and impact.
2.7 Overall assessment: In the comments section, note any recommendations for improving the PIP aim statement.				

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Worksheet 1.3. Review the Identified PIP Population

PIP Population

Wyoming Care Management Entity youth ages 4-20 years old with a Serious Emotional Disturbance (SED) Diagnosis enrolled during SFY 2024 with an approved Plan of Care.

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	X			The population includes active eligibility, diagnosis, age, and time period.
3.2 Was the entire MCP population included in the PIP?	X			The population includes all youth High Fidelity Wraparound participants
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.	X			Data collection methodology captured all enrollees in the PIP topic population. Magellan specified that CANS assessment data is collected via the Fidelity EHR (FEHR) for all WY CME members and authorization/non-authorization data is collected from Electronic Health Records.
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		X		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.				

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Worksheet 1.4. Review the Sampling Method

Overview of Sampling Method _____

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			X	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?			X	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?			X	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?			X	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.			X	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) Will education to the High Fidelity Wraparound providers concerning the utilization of the completed Child and Adolescent Needs and Strength (CANS) assessment when developing Plans of Care with the youth and their family improve the positive change percentage (CANS) score for items in the Child Strengths domain (specifically Resilience) for Wyoming Care Management Entity youth ages 4-20 years old with a Serious Emotional Disturbance (SED) Diagnosis enrolled during Standard Fiscal Year (SFY) 2024 with an approved Plan of Care?

   Measure #1: Numerator: Number of responses scored as a 2 or less for Discharge CANS.
   Denominator: Number of CANS completed.

2) Will education to the High Fidelity Wraparound providers concerning the utilization of the completed Child and Adolescent Needs and Strength (CANS) assessment when developing Plans of Care with the youth and their family improve the positive change percentage (CANS) score for items in the (CANS) Child Strengths domain (specifically Resourcefulness) for Wyoming Care Management Entity youth ages 4-20 years old with a Serious Emotional Disturbance (SED) Diagnosis enrolled during Standard Fiscal Year (SFY) 2024 with an approved Plan of Care?

   Measure #2: Numerator: Number of responses scored as a 2 or less for Discharge CANS.
   Denominator: Number of CANS completed.

3) Will the introduction of changes in the High Fidelity Wraparound Plan of Care review process (documents required for the prior authorization at the initial submission versus documents that can be submitted after the authorization and the Prior Authorization feedback form) result in members receiving continuous authorizations for Wyoming Care Management Entity youth (ages 4-20 years old with Serious Emotional Disturbance (SED) Diagnosis) enrolled during Standard Fiscal Year (SFY) 2024?

   Measure #3: Numerator: Number of non-authorizations.
   Denominator: Number of Plans of Care.

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		X		The measures clearly identified periods for evaluation (quarterly and annually) to reflect the change in that measure over the period examined and are directly compared over that period. They are also evaluating quantifiable values from assessments (CANS scores). However, the variables assessed were only loosely tied to the PIP question surrounding the impact of improving the PA process. While AIM 3 directly looks at non-authorizations, the other AIM statements relate more to Plan of Care development and its impact on participant outcomes via CANS measures.
Performance measures				

Question	Yes	No	NA	Comments
5.2 Did the performance measure assess an important aspect of care that will make a difference to enrollees' health or functional status?	X			Assuring adequate time to authorization of a plan is integral for individuals receiving the services they need for condition management and improvement.
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)?	X			Performance measures were reasonable and directly linked to documentation in the Fidelity EHR (FEHR).
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	X			The measures were based on service authorizations and standardized needs assessments through CANS scores.
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?	X			The performance measures assessed MCPs over a year through assessment and reassessment of participants. It compares performance between years to guide process improvement efforts.
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?		X		The performance measures were generated from an internal understanding of processes and procedures.
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 calculate the measure reliably and accurately? • Were all criteria used in the measure defined clearly (such as time periods, characteristics of eligible enrollees, services to be assessed, and exclusion criteria)?	X			The measures were determined based on provider input and stakeholder concerns as they referred to situations that impacted care. The data used for the measures comes directly from standardized assessments and the participant FEHR and were clearly defined.

Question	Yes	No	NA	Comments
5.8 Did the measures capture changes in enrollee satisfaction or experience of care? • Although enrollee satisfaction/experience is an important outcome of care in clinical areas, improvement in satisfaction should not be the only measured outcome of a clinical project. Some improvement in health or functional status should also be addressed • For projects in nonclinical areas (such as addressing access or availability of services), measurement of health or functional status is preferred		X		The measures only looked at objective values that did not directly examine participant experience or satisfaction.
5.9 Did the measures include a strategy to ensure inter-rater reliability (if applicable)?		X		Inter-rater reliability was not addressed in the PIP documentation. During the virtual on-site with the CME, Magellan reported trainings and assessments for inter-rater reliability what are being developed.
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		X		AIM 3 directly assesses the procedural element being improved. AIMS 1 and 2 have limited narrative tying to PA process improvement with CANS score improvement. The CME elaborated on this link well in virtual on-site meetings. However, there is no clinical evidence, literature, guidelines, or provider consensus cited to link CANS scores and the PA process.
5.10 Overall assessment: In the comments section, note any recommendations for improving the selected PIP variables and performance measures.				

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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?	X			Magellan outlined a an analysis plan, complete with methodology, sources, and the collection cycle.
6.2 Did the PIP design specify the frequency of data collection? If yes, what was the frequency (for example, semi-annually)?	X			Data was to be pulled for monitoring and review quarterly, and full re-measurements were to occur annually. There were also ongoing data collection activities monthly, 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	X			The data sources were identified as the CANS assessment data found in the Fidelity EHR and Authorization/Non-authorization data from the 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)	X			The PIP identified the data collected was to be member ID, name, gender, DOB, race, ethnicity, enrolled date, discharge date, length of stay, reason for discharge, survey date pre enrollment, survey gap pre enrollment, survey date post enrollment, survey gap poste enrollment, all modules (e.g. strength, behavioral, etc.), and Aces Scores.
6.5 Did the data collection plan link to the data analysis plan to ensure that appropriate data would be available for the PIP?		X		The data analysis plan is under development for the next year, since this year was only a collection of baseline data.
6.6 Did the data collection instruments allow for consistent and accurate data collection over the time periods studied?	X			The data collection instruments consistently drew data directly from participant EHRs.
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?			X	Qualitative data collection methods were not used.

Question	Yes	No	NA	Comments
6.8 Overall assessment: In the comments section, note any recommendations for improving the data collection procedures. **Note:** Include assessment of data collection procedures for administrative data sources and medical record review noted below.				

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?			X	Inpatient data was not used.
6.10 If primary care data was used, did primary care providers submit encounter or utilization data for all encounters?			X	Primary care data was not used.
6.11 If specialty care data was used, did specialty care providers submit encounter or utilization data for all encounters?			X	Specialty care data was not used.
6.12 If ancillary data was used, did ancillary service providers submit encounter or utilization data for all services provided?			X	Ancillary data was not used.
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)?	X			LTSS data was used where appropriate. The PIP AIM statements used CANS data accessible from participant assessments. Encounter data, visit verification data, etc. were not relevant for the PIP goals.
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?	X			Workgroup members reviewed data results annually and quarterly for validation. The EHR allowed for data to be checked for accuracy in data entry and clarification of any possible data-related questions when pulled.

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		X		General roles were listed (Clinical Analyst, Senior, Senior Manager Clinical Analytics), but the personnel in those roles, their qualifications, and the qualification for each role were not included.
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)		X		The PIP described data validation opportunities via workgroup interaction with the data. However, the PIP did not outline how inter-rater reliability was assessed or proven and intra-rater reliability was not addressed. The CME noted that inter- and intra-rater reliability was being addressed

Question	Yes	No	NA	Comments
				through CANS assessor trainings and evaluations under development.
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		X		The documentation indicated was not provided by Magellan. Magellan confirmed that the processes and formal documentation of the processes had not yet been developed.

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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?			X	The analysis was conducted in accordance with the data analysis plan outlined in the PIP. However, the analysis is still in its initial phases, so it has not been completed yet.
7.2 Did the analysis include baseline and repeat measurements of project outcomes?			X	The analysis included baseline measurements. The analysis has not included repeat measurements due to its nature as an annual assessment. It's first remeasurement is upcoming.
7.3 Did the analysis assess the statistical significance of any differences between the initial and repeat measurements?		X		The analysis did not include measures of statistical significance.
7.4 Did the analysis account for factors that may influence the comparability of initial and repeat measurements?		X		The documentation provided did not note consideration of factors that may influence the comparability of initial and repeat measurements.
7.5 Did the analysis account for factors that may threaten the internal or external validity of the findings?	X			The analysis does suggest interventions surrounding additional trainings to encourage inter-rater reliability through the continuation 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		X		The analysis does not include more granular components beyond results from the general population.
7.7 Were PIP results and findings presented in a concise and easily understood manner?			X	Findings have not yet been generated due to this year only establishing baseline measures.
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	X			The PIP analysis drew on quantitative results to generate suggested interventions intended to not only improve the prior authorization process, but to also improve data collection and PIP measurement.
7.9 Overall assessment: In the comments section, note any recommendations for improving the analysis and interpretation of PIP results				

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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)?		X		No citation of evidence-based studies or practices was provided to support the link between PA improvement and CANS score improvement.
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	X			Strategies were structured to address the disconnect between providers, care managers, and participants. Notably, some interventions were intended to be tied to particular identified barriers, but the link between them was thin. For example, "clinical strategies implemented for the time allotments in the Prior Authorization process" was meant to address a number of barriers including "providers' reluctance to change," but implemented new strategies does not address this reluctance. Further, continuous measurement of intervention effectiveness is not considered due to remeasurements being limited to annual cycles.
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	X			Magellan stated in the submitted documentation that it used the PDSA approach for PIP development.

[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]	X			Magellan stated 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)?		X		There was no mentions in the submitted documentation of adjustment for confounding variables that could have an impact on PIP outcomes. No consideration of confounders was confirmed in the virtual on-sites.
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?			X	The success of the PIP has not been able to be assessed due to SFY2023 functioning as the baseline. The values found in SFY2024 will be compared to those in SFY2023.
8.7 Overall assessment: In the comments section, note any recommendations for improving the implementation strategies.				

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[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?			X	Repeat measurements cannot be made until the conclusion of SFY2024.
9.2 Was there any quantitative evidence of improvement in processes or outcomes of care?			X	Improvement on SFY2023 values cannot be assessed until the conclusion of SFY2024.
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			X	Improvement on SFY2023 values cannot be assessed until the conclusion of SFY2024.
9.4 Is there statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention?			X	Improvement on SFY2023 values cannot be assessed until the conclusion of SFY2024.
9.5 Was sustained improvement demonstrated through repeated measurements over time?			X	Improvement on SFY2023 values cannot be assessed until the conclusion of SFY2024.
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.				

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Worksheet 1.10. Perform Overall Validation of PIP Results

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

PIP Validation Ratings (check one box)	Comments
Rating 1: EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	The AIM statements do not demonstrate a clear link to the PIP title of "Improving the Prior Authorization Process." The causal link between the PA process and CANS score improvement is not fully established and no clinical, evidence-based, or widely accepted best practice guidelines directly support this claim. While the link can be explained logically, as was done in the virtual on-sites, the documentation does not thoroughly do so. No confounding variables are considered and inter- and intra-rater reliability assurances are still under development/full implementation. No documentation of the data analysis plan was provided, since the analysis plan is still under development following the conclusion of the baseline year.
Rating 2: EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence	Unable to produce evidence of improvement, since the previous year only garnered baseline data.

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

To assist with the analysis portion of the EQR technical report requirement, Worksheet 1.11 should be completed in its entirety for all PIPs. By doing so, it allows the EQRO to generate comparable information for all PIPs.

1. General PIP Information

Managed Care Plan (MCP) Name: Magellan

PIP Title: Improving the Prior Authorization Process

PIP Aim Statement:

1) Will education to the High Fidelity Wraparound providers concerning the utilization of the completed Child and Adolescent Needs and Strength (CANS) assessment when developing Plans of Care with the youth and their family improve the positive change percentage (CANS) score for items in the Child Strengths domain (specifically Resilience) for Wyoming Care Management Entity youth ages 4-20 years old with a Serious Emotional Disturbance (SED) Diagnosis enrolled during Standard Fiscal Year (SFY) 2024 with an approved Plan of Care?

   Measure #1: Numerator: Number of responses scored as a 2 or less for Discharge CANS.
   Denominator: Number of CANS completed.

2) Will education to the High Fidelity Wraparound providers concerning the utilization of the completed Child and Adolescent Needs and Strength (CANS) assessment when developing Plans of Care with the youth and their family improve the positive change percentage (CANS) score for items in the (CANS) Child Strengths domain (specifically Resourcefulness) for Wyoming Care Management Entity youth ages 4-20 years old with a Serious Emotional Disturbance (SED) Diagnosis enrolled during Standard Fiscal Year (SFY) 2024 with an approved Plan of Care?

   Measure #2: Numerator: Number of responses scored as a 2 or less for Discharge CANS.
   Denominator: Number of CANS completed.

3) Will the introduction of changes in the High Fidelity Wraparound Plan of Care review process (documents required for the prior authorization at the initial submission versus documents that can be submitted after the authorization and the Prior Authorization feedback form) result in members receiving continuous authorizations for Wyoming Care Management Entity youth (ages 4-20 years old with Serious Emotional Disturbance (SED) Diagnosis) enrolled during Standard Fiscal Year (SFY) 2024?

   Measure #3: Numerator: Number of non-authorizations.
   Denominator: Number of Plans of Care.

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

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

Target age group (check one):

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

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

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

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

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

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

None

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

- Development of a Prior Authorization review form to be completed by the reviewer during the POC review. Items missed by the provider during the review will be captured on the form and form sent to the agency or solo provider for feedback on incomplete or missing items from a POC review. Providers will receive an automated notification that will be sent to Family Care Coordinators and Clinical Program Directors.. This form will clearly communicate to the provider which documentation requirements have been met and which documentation requirements have not been met.
- Enhancement to PA process review entails that specific minimum documentation requirements must be met for providers to receive a full 90-day authorization. The required items are Medicaid eligibility, CANS assessment completed, Guardian and Family Care Coordinator signature, valid annual assessments, minimum contact requirements, Youth Family Training services (C-Waiver youth only). If any of these items are missing, provider will receive a partial authorization so that there is not a lapse in services to the youth and family, but provider will need to correct POC for missing items and return within required time frames.
- Shape behaviors of providers to utilize the CANs results when developing the POCS with youth and families; Learning Opportunities on the use of the CANS will be provided as well as additional trainings such as an interrater reliability testing among the providers on a CANS vignette during SFY 2024.
- A follow-up survey on the PA process will be sent to the providers in the latter part of SFY 2024 to gain additional feedback on the changes made in the PA process and if positive impact or efficiencies found for the providers.
- Will also solicit providers' feedback during Monthly provider calls, weekly Tuesday at 2 calls as well as the quarterly EQIC meetings.
- Provider Satisfaction survey will also be available for provider feedback.
- New training materials rolling out end of May 2023 that could connect with the CANS Child Strengths domain.
- Reminders will be sent to providers 30 days prior to the POC being due for review. This will aid the provider in timely submission of the POCS and reduce lapses of coverage time for services provided to the families and youth.

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)

None

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**
Number of CANS responses scored at a 2 or lower at discharge (Resilience) / Total Number of CANS completed.	SFY2023	Total MCP population	☒ Not applicable—PIP is in planning or implementation phase, results not available	N/A	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

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
Number of CANS responses scored at a 2 or lower at discharge (Resourcefulness) / Total Number of CANS completed.	SFY2023	Total MCP Population	☒ Not applicable—PIP is in planning or implementation phase, results not available	N/A	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number of non-authorizations / Number of Plans of Care.	SFY2023	Total MCP population	☒ Not applicable—PIP is in planning or implementation phase, results not available	N/A	☐ 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 #1: 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,

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

Validation rating #2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

EQRO comments on validation ratings

Unable to complete validation rating #2 as this was a baseline year.

EQRO recommendations for improvement of PIP:

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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.)			✓	The Engagement and Implementation PIP was included in the 2022 SOW, and therefore was required by the State. The 2023 SOW did not include the PIP topic but the PIP was conducted and evaluation was completed during this year.
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 did not apply to this PIP topic as the focus was 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 as needing assistance fully collaborating with the HFWA model. The PIP topic was developed during 2017 and has been continued through 2023 even though it was not part of the SOW.
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 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.

Question	Yes	No	NA	Comments
1.5 Did the PIP topic align with priority areas identified by HHS and/or CMS?	✓			The Engagement and Implementation PIP aligned 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).* 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.				As stated last year, 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. It appears that Magellan did not take this feedback into consideration. Also this PIP was not included in the SOW for this year.

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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 2023?

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 2023?

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 2023 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 2023.
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.				As stated in last year's review, 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 WY CME youths eligible for the High Fidelity Around program ages 4-20 years old with and SED diagnosis discharged during the measurement period (SFY 2023). Youth enrolled in the High-Fidelity Wraparound program ("HFWA") span ages 4-20 years, have a diagnosis of Severely Emotionally Disturbed (SED) and a CASII or ECSII score indicating a level of need, and are Medicaid Waiver eligible.

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?	✓			Yes, and it is noted that Magellan took the feedback from last year's review and very clearly identified the population.
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.				It was good to see a more descriptive definition of the PIP population.

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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 2023?)

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 2023?)

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 2023 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 2023, 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 2023). 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 calculate the measure reliably and accurately? • 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.

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 previous years, 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.

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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. It did discuss how it was validated from calculation perspective but not the validity of the data.
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

Question	Yes	No	NA	Comments
6.8 Overall assessment: In the comments section, note any recommendations for improving the data collection procedures. **Note:** Include assessment of data collection procedures for administrative data sources and medical record review noted below.				As noted in previous years, 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.

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. As discussed on the other PIPs adding more discussion of the qualifications of the staff would be recommended.
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 previous years' findings were 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 in previous years, 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.

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

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

Question	Yes	No	NA	Comments
8.5 Was the implementation of the strategy designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes (e.g., patient risk factors, Medicaid program changes, provider education, clinic policies or practices)?	✓			The selection criteria did exclude for participants who were discharged with fewer than 60 days of HFWA.
8.6 Building on the findings from the data analysis and interpretation of PIP results (Step 7), did the PIP assess the extent to which the improvement strategy was successful and identify potential follow-up activities?		✓		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 no further discussion was provided, especially since there was lowered benchmarks and the final year of the PIP.
8.7 Overall assessment: In the comments section, note any recommendations for improving the implementation strategies.				There was no discussion as to why Magellan lowered the targets for this year.

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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." This year they did adjust the benchmarks to 16% and 70%.
9.2 Was there any quantitative evidence of improvement in processes or outcomes of care?	✓			Both measures reported continued changes from baseline after five years of the intervention. Measure 1 (goal 16%): The percent of youth and families not reaching engagement threshold at baseline was 16.43%. By 2023, the rate was 13.49%, a difference of only 2.94%. Measure 2 (goal 70%): The rate of Implementation increased from 58.90% as baseline to 58.60% in 2023, a decrease of 0.30%.
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 progress for one measure and regression made this year for the other (Measure1: 12.5% to 13.49%; Measure 2: 69.89% to 58.60%). The trend had been positive but then even with reduced targets and after 4 years of implementation, the PIP was not able to meet the targets.
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

Question	Yes	No	NA	Comments
				statistically significant for SFY 2023 results compared to SFY 2022.
9.5 Was sustained improvement demonstrated through repeated measurements over time?	✓			Both measures reported continued changes from baseline after five years of the intervention. Measure 1 (goal 16%): The percent of youth and families not reaching engagement threshold at baseline was 16.43%. By 2023, the rate was 13.49%, a difference of only 2.94%. Measure 2 (goal 70%): The rate of Implementation increased from 58.90% as baseline to 58.60% in 2023, a decrease of 0.30%.
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 five years of implementation (and this year being the final year), Magellan has continued to see some improvement. This year's progress was not found to be statistically significant, but there was some progress towards the objective. With this being the only PIP that had been implemented for more than a year, it was expected to see a more robust evaluation and assessment of the progress and why greater improvement wasn't achieved.

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Worksheet 1.10. Perform Overall Validation of PIP Results

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

PIP Validation Ratings (check one box)	Comments
Rating 1: EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases ☐ 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.
Rating 2: EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	There has been continued progress for both Engagement and Implementation measures goals but neither have met the stated target, even after the benchmark was lowered. As stated in past years, 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 five years of the implementation of this PIP.

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

To assist with the analysis portion of the EQR technical report requirement, Worksheet 1.11 should be completed in its entirety for all PIPs. By doing so, it allows the EQRO to generate comparable information for all 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 2023?
- 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 2023?

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): Wyoming Care Management Entity WY CME youths eligible for the High Fidelity Around program ages 4-20 years old with and SED diagnosis discharged during the measurement period (SFY 2023). Youth enrolled in the High-Fidelity Wraparound program ("HFWA") span ages 4-20 years, have a diagnosis of Severely Emotionally Disturbed (SED) and a CASII or ECSII score indicating a level of need, and are Medicaid Waiver eligible.

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

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

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

N/A

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

N/A

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

1. Technical assistance given on the new auth process related to move to FFS and providers leaving or considering leaving the network, causing disruption in youth engagement and implementation.
2. Transition of Care process moved away from providers and to Magellan CME for connection to new providers. Updated June 2019.
3. Engagement and Implementation measures added to Provider Scorecard.
4. Scorecard review in all-providers meeting quarterly with talking points for staff, reference to manual, and reminder that past and current materials on website.

5. Provider newsletter included quarterly results
6. Talking points on these measures quarterly
7. Posting on Provider Website
8. Provider review of scorecard scores with network
9. Letter of education available if needed for high disengagement or low implementation. Updated process Jan 2019.
10. Scorecard quarter over quarter trending with QIC and EQIC quarterly.
11. Presentation of Provider Scorecard results in Monthly Provider Calls
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 2023 ☐ Not applicable—PIP is in planning or implementation phase, results not available	N = 215; Rate = 13.49%	☒ 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 2023 ☐ Not applicable—PIP is in planning or implementation phase, results not available	N = 215; Rate = 58.60%	☐ 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): Fifth remeasurement

Validation rating #1: 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,

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating #2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

EQRO comments on validation ratings

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, even after the benchmark was lowered. As stated in past years, 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 five years of the implementation of this PIP.

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Worksheet 1.1. Review the Selected PIP Topic

PIP Topic: Increase the Number of Family Care Coordinators and Respite Providers in the Wyoming Care Management Entity Network

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

Question	Yes	No	NA	Comments
1.1 Was the PIP topic selected through a comprehensive analysis of MCP enrollee needs, care, and services (e.g., consistent with demographic characteristics and health risks, prevalence of conditions, or the need for a specific service by enrollees)? (If the PIP topic was required by the state, please check "not applicable" and note in comments.)			✓	The WY CME Contract requires assessment of network adequacy. Feedback from WY DOH and EQR prioritized increasing availability of providers to deliver the full scope of HFWA services. Availability of FCCs, Family Support Providers, Youth Support Partners and Respite Providers in Network does not currently meet guidelines specified in scope of services.
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 do not apply to this topic.
1.3 Did the selection of the PIP topic consider input from enrollees or providers who are users of, or concerned with, specific service areas? (If the PIP topic was required by the state, please check "not applicable" and note in comments.) • To the extent feasible, input from enrollees who are users of, or concerned with, specific services areas should be obtained.	✓			Provider and member services were evaluated, however they did not include negative feedback from either cohort indicating that network adequacy was a source of concern or dissatisfaction with HFWA Program. PIP topic was selected based on contract requirements and feedback from WY DOH and the EQR.
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	✓			PIP topic focused on ability to maintain fidelity to HFWA Program for individuals diagnosed with SED and ensuring HFWA Network is adequate to maintain sufficient access to and availability of care.
1.5 Did the PIP topic align with priority areas identified by HHS and/or CMS?	✓			

Question	Yes	No	NA	Comments
1.6 Overall assessment: In the comments section, note any recommendations for improving the PIP topic.				Additional clarity is needed on the specific interventions used in the PIP in order to evaluate opportunities for improvement.

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Worksheet 1.2. Review the PIP Aim Statement

PIP Aim Statement

1) **Will targeted recruitment, training, and support by the CME concerning the HFWA program and provider roles with stakeholders throughout the state of Wyoming increase the number of Family Care Coordinators active in the Network for SFY 2024?**

2) **Will targeted recruitment, training, and support by the CME concerning the HFWA program and provider roles with stakeholders throughout the state of Wyoming increase the number of Respite Providers active in the Network for SFY 2024?**

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

Question	Yes	No	NA	Comments
2.1 Did the PIP aim statement clearly specify the improvement strategy, population, and time period for the PIP?		✓		The AIM statement does not clearly define specific improvement strategies deployed. The terms "Targeted recruitment, training and support" and "stakeholders" are not clearly defined.
2.2 Did the PIP aim statement clearly specify the population for the PIP?	✓			The population includes active FFC and Respite Providers in the HFWA program Network.
2.3 Did the PIP aim statement clearly specify the time period for the PIP?	✓			
2.4 Was the PIP aim statement concise?	✓			
2.5 Was the PIP aim statement answerable?	✓			
2.6 Was the PIP aim statement measurable?	✓			
2.7 Overall assessment: In the comments section, note any recommendations for improving the PIP aim statement.				The specific interventions included in "targeted recruitment, training, and support," as well as who is included in the term "stakeholders" should be clearly defined within the PIP write up in order to ensure that these terms are being properly deployed and measured.

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Worksheet 1.3. Review the Identified PIP Population

PIP Population: The number of active Family Care Coordinators and Respite Providers active in the HFWA Program Network.

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 was the number of active FCCs and Respite Providers in the HFWA Program
3.2 Was the entire MCP population included in the PIP?		✓		No, the population was limited to the number of active FCC and Respite Providers
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.			✓	
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		✓		
3.5 Overall assessment: In the comments section, note any recommendations for identifying the project population.				The population was clearly defined, measurable, and appropriate for the topic.

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Worksheet 1.4. Review the Sampling Method

Overview of Sampling Method: Sampling Methodology was not utilized. The population include all active Family Care Coordinators and Respite Providers active in the HFWA Program Network.

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			✓	Sampling Methodology was not utilized. The population include all active Family Care Coordinators and Respite Providers active in the HFWA Program Network.
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?			✓	Sampling Methodology was not utilized. The population include all active Family Care Coordinators and Respite Providers active in the HFWA Program Network.
4.3 Did the sample contain a sufficient number of enrollees taking into account non-response?			✓	Sampling Methodology was not utilized. The population include all active Family Care Coordinators and Respite Providers active in the HFWA Program Network.
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?			✓	Sampling Methodology was not utilized. The population include all active Family Care Coordinators and Respite Providers active in the HFWA Program Network.
4.5 Were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field.			✓	Sampling Methodology was not utilized. The population include all active Family Care Coordinators and Respite Providers active in the HFWA Program Network.
4.6 Overall assessment: In the comments section, note any recommendations for improving the sampling method.				N/A - Sampling Methodology was not utilized. The population include all active Family Care Coordinators and Respite Providers active in the HFWA Program Network.

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Worksheet 1.5. Review the Selected PIP Variables and Performance Measures

Selected PIP Variables and Performance Measures:

Quantifiable Measure 1: *Will targeted recruitment, training, and support by the CME concerning the HFWA program and provider roles with stakeholders throughout the state of Wyoming increase the number of Family Care Coordinators active in the Network for the SFY 2024?*

Baseline Measurement year will be 07/01/2022-June 30, 2023 - Number of Family Care Coordinators was 64 (sixty-four). First remeasurement period will be July 1, 2023-June 30, 2024.

Quantifiable Measure 2: *Will targeted recruitment, training, and support by the CME concerning HFWA Program with Stakeholders throughout the state of Wyoming increase the number of respite providers in the Network for SFY 2024?*

Baseline Measurement year will be 07/01/2022-June 30, 2023 - Number of Respite Providers for that time frame was 1 (one). First remeasurement period will be July 1, 2023-June 30, 2024.

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 objective is to increase the number of active FCCs and Respite Providers active in the HFWA Program Network. Specific measurement periods were provided for the baseline and remeasurements. The measurement periods defined did not allow for measuring variables more than once annually so detailed performance tracking over time could not be performed with the measurement periods as defined.
Performance measures				
5.2 Did the performance measure assess an important aspect of care that will make a difference to enrollees' health or functional status?	✓			The number of active providers will increase access to care. Ensuring network adequacy is a critical component of the MCPs ability deliver timely care to maintain fidelity to the HFWA program model.
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)?	✓			

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
			✓	PIP topic and measure selection were mandated by WDH contract requirements.

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 2023). The measures were compared to baseline measurements from the previous performance period (SFY 2022). Measurements 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?		✓		PIP topic and measure selection were mandated by WDH contract requirements.
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 calculate the measure reliably and accurately? • 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		✓		Although increasing the number of active providers within the HFWA network has the capacity to impact enrollee satisfaction, baseline enrollee satisfaction data did not identify network adequacy as a source of enrollee dissatisfaction for the baseline performance period (SFY 2022).

Question	Yes	No	NA	Comments
5.9 Did the measures include a strategy to ensure inter-rater reliability (if applicable)?			✓	The number of active network providers is an objective measure. Inter-rater reliability strategies are not necessary for objective measurements.
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			✓	Process measures were not included.
5.10 Overall assessment: In the comments section, note any recommendations for improving the selected PIP variables and performance measures.				CMS prefers that measurements be collected more frequently in order to track progress over time. Increasing measurements from annually to quarterly would allow better visibility into performance over time. This would also allow for the opportunity to correlate key interventions such as stakeholder summits, to changes in the number of active network providers.

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Worksheet 1.6. Review the Data Collection Procedures

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

Section 1: Assessment of Overall Data Collection Procedures

Question	Yes	No	NA	Comments
6.1 Did the PIP design specify a systematic method for collecting valid and reliable data that represents the population in the PIP?	✓			A description of the data collection procedure for reviewing the network provider roster was included.
6.2 Did the PIP design specify the frequency of data collection? If yes, what was the frequency (for example, semi-annually)?	✓			The first remeasurement period listed was at the close of the SFY2023, although the description mentions data collection cadences as being annually, quarterly, and weekly. Additional details are required in order to clarify which data is being collected at each cadence listed.
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 only data source clearly described was the procedure for processing applications for network providers and reviewing the current provider roster.
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 only data source clearly described was the procedure for processing applications for network providers and reviewing the current provider roster.
6.5 Did the data collection plan link to the data analysis plan to ensure that appropriate data would be available for the PIP?		✓		Additional clarification has been requested
6.6 Did the data collection instruments allow for consistent and accurate data collection over the time periods studied?		✓		Additional clarification has been requested
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?			✓	It is not clear whether the Member Advisory Group Meetings should be included as one of the data collection methods. Additional clarification has been requested.
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.				

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?			✓	Clinical inpatient data was not used
6.10 If primary care data was used, did primary care providers submit encounter or utilization data for all encounters?			✓	Clinical PCP data was not used
6.11 If specialty care data was used, did specialty care providers submit encounter or utilization data for all encounters?			✓	Encounter and utilization data was not used
6.12 If ancillary data was used, did ancillary service providers submit encounter or utilization data for all services provided?			✓	Encounter and utilization data was not used
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)?			✓	Encounter and utilization data was not used
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?			✓	EHR data was not used

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		✓		Some personnel were included in the procedure for processing and reviewing network providers but relevant qualifications were not included in the list of personnel described.
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)			✓	Qualitative data analysis was not included

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			✓	Medical record review was not included

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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?			✓	Data analysis not provided
7.2 Did the analysis include baseline and repeat measurements of project outcomes?	✓			PIP description included baseline measurements and described reanalysis to be completed at the end of SFY2023, however the results were not submitted to the ERQO for review.
7.3 Did the analysis assess the statistical significance of any differences between the initial and repeat measurements?			✓	Data analysis not provided
7.4 Did the analysis account for factors that may influence the comparability of initial and repeat measurements?			✓	Data analysis not provided
7.5 Did the analysis account for factors that may threaten the internal or external validity of the findings?			✓	Data analysis not provided
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			✓	This PIP does not include multiple entities
7.7 Were PIP results and findings presented in a concise and easily understood manner?			✓	Data analysis not provided
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			✓	Data analysis not provided
7.9 Overall assessment: In the comments section, note any recommendations for improving the analysis and interpretation of PIP results				

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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)?		✓		Improved strategies were cited as being the result of the CME Workgroup. Additional details regarding the rationale for improvement strategy selection has been requested.
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 CME Workgroup identified a list of barriers during the initial development of the PIP. Improvement strategies were selected based on the barriers identified by the workgroup.
8.3 Was the rapid-cycle PDSA approach used to test the selected improvement strategy? • The steps in the PDSA cycle[5] are to: ○ **Plan.** Plan the test or observation, including a plan for collecting data, and interpreting the results ○ **Do.** Try out the test on a small scale ○ **Study.** Set aside time to analyze the data and assess the results ○ **Act.** Refine the change, based on what was learned from the test. Determine how to sustain the intervention, if successful • If tests of change were not successful (i.e., did not achieve significant improvement), a process to identify possible causes and implement solutions should be identified	✓			The PIP description cited the PDSA methodology as being the principal method through which the CME workgroup developed improvement strategies.
8.4 Was the strategy culturally and linguistically appropriate?[6]	✓			The CME Workgroup used Provider and Member Survey data to assess for any cultural or linguistic gaps in the provider. No gaps were identified, however the CME stated that they would continue to assess for any cultural or linguistic needs.

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

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

Question	Yes	No	NA	Comments
8.5 Was the implementation of the strategy designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes (e.g., patient risk factors, Medicaid program changes, provider education, clinic policies or practices)?			✓	Quantifiable measures were limited to the number of active FCC and Respite Providers in the Network
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?			✓	Data analysis not provided. Numerous improvement strategies were listed. It is not clear which strategies were implemented. Outcomes measures were not tied directly to specific improvement strategies.
8.7 Overall assessment: In the comments section, note any recommendations for improving the implementation strategies.				

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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?	✓			
9.2 Was there any quantitative evidence of improvement in processes or outcomes of care?			✓	Data analysis was not provided
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			✓	Quantitative measures listed were not tied to specific improvement strategies
9.4 Is there statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention?			✓	Multiple interventions were listed. Quantitative measures listed were not ties to specific improvement strategies
9.5 Was sustained improvement demonstrated through repeated measurements over time?			✓	PIP description states that remeasurement would not occur until after the close of the SFY. Remeasurement figures were not provided
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.				

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Worksheet 1.10. Perform Overall Validation of PIP Results

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

PIP Validation Ratings (check one box)	Comments
Rating 1: EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	
Rating 2: EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence	Cannot be assessed for improvement due to SFY 2023 being the baseline year.

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

To assist with the analysis portion of the EQR technical report requirement, Worksheet 1.11 should be completed in its entirety for all PIPs. By doing so, it allows the EQRO to generate comparable information for all PIPs.

1. General PIP Information

Managed Care Plan (MCP) Name: Magellan
PIP Title: Increase the Number of Family Care Coordinators and Respite Providers in the Wyoming Care Management Entity Network
PIP Aim Statement: 1) Will targeted recruitment, training, and support by the CME concerning the HFWA Program and provider roles with stakeholders throughout the state of Wyoming increase the number of Family Care Coordinators active in the Network for SFY 2024? **2)** Will targeted recruitment, training, and support by the CME concerning the HFWA Program and provider roles with stakeholders throughout the state of Wyoming increase the number of Respite Providers active in the Network for SFY 2024?
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: 4-20
Target population description, such as duals, LTSS or pregnant women (please specify):
Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

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

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) • Hold a “Summit” call with current Wyoming providers and stakeholders throughout the state (held in Laramie and Natrona counties). • Education and raising awareness of the Wyoming CME throughout the counties of Wyoming. • Leverage current provider contacts throughout the state to recruit new providers. • Contact pediatricians and doctors’ offices, pharmacies, and school districts.
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) • Gather current prevalence data for Wyoming’s counties. • Review SED report to aid in the determination of youth need throughout the counties of Wyoming. • Distribute promotional brochures for the HFWA program throughout the State.

- Publish CME newsletter articles recruiting Respite providers.
- Include in Family Care Coordinator exit process an exit survey sent to the Program Director of the Family Care Coordinator's affiliate agency.

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
Number of Family Care Coordinators in Network.	SFY 2023	MCP Provider Population	☒ Not applicable—PIP is in planning or implementation phase, results not available	N/A	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number of Respite Providers in Network.	SFY 2023	MCP Provider Population	☒ Not applicable—PIP is in planning or implementation phase, results not available	N/A	☐ 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 #1: 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,

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

Validation rating #2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

EQRO comments on validation ratings

Cannot complete validation rating #2 due to it being the baseline year for the PIP.

EQRO recommendations for improvement of PIP:
The submitted documentation did not include detailed approaches to the strategies intended to drive the improvement desired by the PIP. It is recommended that Magellan revise the PIP documentation to more specifically outline the approaches they are taking to improve their provider network beyond general notes on outreach and recruitment. It is also recommended that Magellan leverage data in their PIP topic discussion and proposed improvement strategies to evaluate barriers to care or outcomes that directly measure those improvement activities. The PIP documentation would be strengthened by backing up strategies and identified challenges with detailed discussions of the best practices, data, experience, and research that support the PIP's content.

Acronyms: CHIP = Children's Health Insurance Program; EQR = External Quality Review; EQRO = External Quality Review Organization; IPA = Independent Practice Association; LTSS = Long-Term Services and Supports; MCO = Managed Care Organization; MCP= Managed Care Plan; PAHP= Prepaid Ambulatory Health Plan; PCCM = Primary Care Case Management; PIHP = Prepaid Inpatient Health Plan; PIP = Performance Improvement Project.

Appendix D: Additional Methodology for Protocol 2

Table 1 provides an example of a SOW operational requirement, the corresponding SOW performance measure, and the corresponding set of measures and goals. Table 2, on the following page, further describes each level of analysis and the applicable range of outcomes for each level.

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

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

Table 2. Description of Five Tiers of Analysis

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

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

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

Instructions

Instructions for OPs Tool:

This is the review tool used by Reviewers to assess the Wyoming CME's compliance during SFY 2023 in accordance with the language from the SFY 2021 SOW. Reviewers have populated the following areas in the Contract Review tab:

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

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

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

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

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

OP: The operational requirement number which aligns with the contract. Reviewers developed a naming convention by adding letters to each OP (e.g., OP-01a) to differentiate between the OP's reported measures/goals.

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

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

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

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

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

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

Next Steps: Identification of next steps for review.

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

Summary of SFY 23 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	46.2%
Goal Not Met	23.1%
Not Applicable	30.8%
Insufficient Data	0.0%
Total	100.0%

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

Compliance Result	% of Performance Measures
Yes	52.2%
No	26.1%
Not Applicable	21.7%
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	95.7%
Partially	0.0%
No	4.3%
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 23					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?	Comments
								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%	277.00	312.00	314.00	325.00	1228.00	Goal Met	Yes	Yes	Yes	Yes	
					Ops 8-17A D	Number of standard requests for authorization		280.00	313.00	319.00	329.00	1241.00						
					Ops 8-17A R	Calculated N/D		99%	100%	98%	99%	99%						
					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	Not Applicable	Yes	Yes			No extended standard auths in SFY23
					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	Not Applicable	Yes	Yes	Yes	Yes	No expedited auths in SFY23
					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	Not Applicable	Yes	Yes			No extended expedited auths in SFY23
					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%	42.00	45.00	61.00	49.00	197.00	Goal Met	Yes	Yes	Yes	Yes	
					Ops 8-19D	Data showing compliance with this requirement shall be included in the quarterly data report.		43.00	46.00	63.00	50.00	202.00						
					Ops 8-19R	Calculated N/D		98%	98%	97%	98%	98%						
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 filed orally or in writing at any time. The Contractor must also ensure that individuals making decisions regarding enrollee grievances and appeals are free of conflict, were not involved in any previous level of review or decision-making, have appropriate clinical expertise for treatment, if applicable, and must consider all submitted documents and information, considered at any level of the enrollee grievance and appeal process.	An appeal must be filed by an enrollee within sixty (60) calendar days from the date on the adverse benefit determination notice. An enrollee may file a grievance with the CME at any time. The Contractor must present a proposed resolution to the issue reported within ninety (90) calendar days from the date the Contractor receives the enrollee grievance or appeal. If the Contractor's proposed resolution is not accepted by the individual or entity acting on their behalf, the Contractor has thirty (30) calendar days to review and respond to the enrollee grievance or appeal. After exhausting the enrollee grievance and appeal process with the Contractor, the enrollee must have no less than ninety (90) calendar days the date of the Contractor's final notice of resolution to request an Agency fair hearing. Contractor must resolve enrollee grievances and provide notice according to the enrollee's health condition, no more than ninety (90) calendar days from grievance receipt.	Ops 8-25N	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	Not Applicable	Not Applicable	Yes	Yes	Yes	Ops 8-26, became Op2 8-25 No data in SFY23
					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%						
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	Not Applicable	Not Applicable	Yes	Yes	Yes	The Reported Measure and Findings for SFY 22 align with OP 8-30 No data in SFY23
					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 an 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	Not Applicable	Not Applicable	Yes	Yes	Yes	The Reported Measure and Findings for SFY 22 align with OP 8-31 No data in SFY23
					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 a decision	98%	0.00	0.00	0.00	0.00	0.00	Not Applicable	Not Applicable	Yes	Yes	Yes	The Reported Measure and Findings for SFY 22 align with OP 8-33 No data in SFY23
					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						The Reported Measure and Findings for SFY 22 align with OP 8-33 No data in SFY23

Appendix E: Protocol 2 - Operational Requirements Review Tool

#	Category	Contract Section	Contract Requirement	Performance Expectations/ Measurement	OP	Reported Measure	Goal Threshold	Findings for SFY 23					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?	Comments
								Q1	Q2	Q3	Q4	Annual Total						
					Ops 8-31D	# of Grievances		0.00	0.00	0.00	0.00	0.00	Not Applicable	Not Applicable	Yes	Yes	Yes	
					Ops 8-31R	Calculated N/D		0%	0%	0%	0%	0%						
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%	61.00	24.00	139.00	161.00	385.00	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-3D	# of member referrals		63.00	24.00	140.00	163.00	390.00						
					EM 9-3R	Calculated N/D		97%	100%	99%	99%	99%						
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%	114.00	110.00	228.00	257.00	709.00	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-4D	# of member referrals		122.00	110.00	232.00	261.00	725.00						
					EM 9-4R	Calculated N/D		93%	100%	98%	98%	98%						
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%	37	70	85.00	79.00	271	Goal Not Met	No	Yes	Yes	Yes	
					EM 9-5D	# of applications		37	70	85.00	85.00	277						
					EM 9-5R	Calculated N/D		100%	100%	100%	93%	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%	12.00	22.00	17.00	16.00	67.00	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-6D	# of referrals		12.00	22.00	17.00	16.00	67.00						
					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%	59.00	83.00	83.00	79.00	304.00	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-7D	# of new enrollees		60.00	83.00	84.00	82.00	309.00						
					EM 9-7R	Calculated N/D		98%	100%	99%	96%	98%						
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%	0.00	1.00	5.00	6.00	12.00	Goal Not Met	No	Yes	Yes	Yes	
					EM 9-9D	# of members with a 30 day advance notice of termination.		0.00	1.00	5.00	7.00	13.00						
					EM 9-9R	Calculated N/D		0%	100%	100%	86%	92%						
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%	96.00	128.00	111.00	93.00	428.00	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-12D	# of members with a CASII or ECSII assessment.		97.00	131.00	111.00	93.00	432.00						
					EM 9-12R	Calculated N/D		99%	98%	100%	100%	99%						
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%	59.00	83.00	84.00	82.00	308.00	Goal Met	Yes	Yes	Yes	No	The numerator for this performance measure does not include guardians of the enrollees. Can Magellan identify how this measure is calculated and whether the handbook being sent to guardians is included in the measure?
					EM 9-15D	# of new enrollees.		59.00	83.00	84.00	82.00	308.00						
					EM 9-15R	Calculated N/D		100%	100%	100%	100%	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%	25.00	38.00	56.00	55.00	174.00	Goal Not Met	No	Yes	Yes	Yes	
					EM 9-16D	# of new enrollees.		67.00	59.00	83.00	83.00	292.00						
					EM 9-16R	Calculated N/D		37%	64%	67%	66%	60%						
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%	250	285	314	323	1172	Goal Not Met	No	Yes	Yes	Yes	
					EM 9-17D	# of POCs emailed.		251	286	316	331	1184						

Appendix E: Protocol 2 - Operational Requirements Review Tool

#	Category	Contract Section	Contract Requirement	Performance Expectations/ Measurement	OP	Reported Measure	Goal Threshold	Findings for SFY 23					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?	Comments
								Q1	Q2	Q3	Q4	Annual Total						
					EM 9-17R	Calculated N/D		100%	100%	99%	98%	99%						
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%	460	545	595	638	2238	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-20D	# of youths.		486	550	619	679	2334						
					EM 9-20R	Calculated N/D		95%	99%	96%	94%	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%	138	150	161	181	630	Goal Not Met	No	Yes	Yes	Yes	
					EM 9-22D	# of enrollees with required readiness assessments due.		207	210	237	261	915						
					EM 9-22R	Calculated N/D		67%	71%	68%	69%	69%						
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	123	143	149	534	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-23D	# of enrollees with a FCC Authorizations.		125	129	143	157	554						
					EM 9-23R	Calculated N/D		95%	95%	100%	95%	96%						
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	2	2	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-24D	# of members with respite authorization.		0	0	0	2	2						
					EM 9-24R	Calculated N/D		0%	0%	0%	100%	100%						
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%	36	37	46	47	166	Goal Not Met	No	Yes	Yes	Yes	
					EM 9-29D	# new enrollees		39	39	55	60	193						
					EM 9-29R	Calculated N/D		92%	95%	84%	78%	88%						

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	SFY2023 YTD
Operations Reporting							
Ops 8-17A N	Number of standard auth decisions within timeframe (14 calendar days)		277.00	312.00	314.00	325.00	1228.00
Ops 8-17A D	Number of standard requests for authorization		280.00	313.00	319.00	329.00	1241.00
Ops 8-17A R	Calculated N/D	95%	98.93%	99.68%	98.43%	98.78%	98.95%
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.		42.00	45.00	61.00	49.00	197.00
Ops 8-19D	Data showing compliance with this requirement shall be included in the quarterly data report.		43.00	46.00	63.00	50.00	202.00
Ops 8-19R	Calculated N/D	98%	97.67%	97.83%	96.83%	98.00%	97.52%
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							

Appendix E: Protocol 2 - Operational Requirements Review Tool

OP	Performance Measure Description	Magellan Goals	Q1	Q2	Q3	Q4	SFY2023 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		61.00	24.00	139.00	161.00	385.00
EM 9-3D	# of member referrals		63.00	24.00	140.00	163.00	390.00
EM 9-3R	Calculated N/D	90%	96.83%	100.00%	99.29%	98.77%	98.72%
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,		114.00	110.00	228.00	257.00	709.00
EM 9-4D	# of member referrals		122.00	110.00	232.00	261.00	725.00
EM 9-4R	Calculated N/D	90%	93.44%	100.00%	98.28%	98.47%	97.79%
Process all applications							
EM 9-5N	Process all enrollee applications within three (3) business days once application information is		37.00	70.00	85.00	79.00	271.00
EM 9-5D	# of applications		37.00	70.00	85.00	85.00	277.00
EM 9-5R	Calculated N/D	100%	100.00%	100.00%	100.00%	92.94%	97.83%
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.		12.00	22.00	17.00	16.00	67.00
EM 9-6D	# of referrals		12.00	22.00	17.00	16.00	67.00
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		59.00	83.00	83.00	79.00	304.00
EM 9-7D	# of new enrollees		60.00	83.00	84.00	82.00	309.00
EM 9-7R	Calculated N/D	90%	98.33%	100.00%	98.81%	96.34%	98.38%
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.		0.00	1.00	5.00	6.00	12.00
EM 9-9D	# of members with a 30 day advance notice of termination.		0.00	1.00	5.00	7.00	13.00
EM 9-9R	Calculated N/D	95%	0.00%	100.00%	100.00%	85.71%	92.31%
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.		96.00	128.00	111.00	93.00	428.00
EM 9-12D	# of members with a CASII or ECSII assessment.		97.00	131.00	111.00	93.00	432.00
EM 9-12R	Calculated N/D	95%	98.97%	97.71%	100.00%	100.00%	99.07%
Member Handbook to all new enrollees and their guardians.							
EM 9-15N	# of new enrollees that have received a member handbook.		59.00	83.00	84.00	82.00	308.00
EM 9-15D	# of new enrollees.		59.00	83.00	84.00	82.00	308.00
EM 9-15R	Calculated N/D	95%	100.00%	100.00%	100.00%	100.00%	100.00%
FCC & Plan of Care (POC)							
EM 9-16N	# of new enrollees that have a POC within 46 calendar days after enrollment.		25.00	38.00	56.00	55.00	174.00
EM 9-16D	# of new enrollees.		67.00	59.00	83.00	83.00	292.00
EM 9-16R	Calculated N/D	95%	37.31%	64.41%	67.47%	66.27%	59.59%
Authorize POCs							
EM 9-17N	# of POCs reviewed, the Contractor shall review and process one hundred percent (100%) of all POCs submitted.		250.00	285.00	314.00	323.00	1172.00
EM 9-17D	# of POCs emailed.		251.00	286.00	316.00	331.00	1184.00
EM 9-17R	Calculated N/D	100%	99.60%	99.65%	99.37%	97.58%	98.99%
FCC & Contact with Parent and Youth twice a month in a quarter							

Appendix E: Protocol 2 - Operational Requirements Review Tool

OP	Performance Measure Description	Magellan Goals	Q1	Q2	Q3	Q4	SFY2023 YTD
EM 9-20N	Minimum of two progress notes documenting FCC contacts per month for youth and/or caregiver.		460.00	545.00	595.00	638.00	2238.00
EM 9-20D	# of youths.		486.00	550.00	619.00	679.00	2334.00
EM 9-20R	Calculated N/D	95%	94.65%	99.09%	96.12%	93.96%	95.89%
Routine readiness assessments based on the pre-approved Transition Readiness Scale							
EM 9-22N	# of assessment within 3 months of the previous assessment.		138.00	150.00	161.00	181.00	630.00
EM 9-22D	# of enrollees with required readiness assessments due.		207.00	210.00	237.00	261.00	915.00
EM 9-22R	Calculated N/D	90%	66.67%	71.43%	67.93%	69.35%	68.85%
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	123.00	143.00	149.00	534.00
EM 9-23D	# of enrollees with a FCC Authorizations.		125.00	129.00	143.00	157.00	554.00
EM 9-23R	Calculated N/D	95%	95.20%	95.35%	100.00%	94.90%	96.39%
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	2.00	2.00
EM 9-24D	# of members with respite authorization.		0.00	0.00	0.00	2.00	2.00
EM 9-24R	Calculated N/D	100%	0.00%	0.00%	0.00%	100.00%	100.00%
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.		36.00	37.00	46.00	47.00	166.00
EM 9-29D	# new enrollees		39.00	39.00	55.00	60.00	193.00
EM 9-29R	Calculated N/D	95%	92.31%	94.87%	83.64%	78.33%	86.01%
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.		210.00	240.00	248.00	256.00	954.00
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.		210.00	240.00	248.00	256.00	954.00
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	3.00	3.00	4.00	3.00	N/A
OUT 13-1D	# of youth enrolled with the CME Contractor.	N/A	189.00	218.00	182.00	163.00	N/A
OUT 13-1R	Calculated N/D	N/A	1.59%	1.38%	2.20%	1.84%	1.8%
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	7.44	12.83	11.20	7.80	9.8175

Appendix E: Protocol 2 - Operational Requirements Review Tool

OP	Performance Measure Description	Magellan Goals	Q1	Q2	Q3	Q4	SFY2023 YTD
OUT 13-2_2	# of youth enrolled with the CME Contractor.	N/A	189.00	218.00	182.00	163.00	N/A
Recidivism							
OUT 13-3N	# of youth enrolled in HLOC (PRTF)	N/A	3.00	3.00	4.00	3.00	N/A
OUT 13-3D	# of youth enrolled with the CME Contractor.	N/A	189.00	218.00	182.00	163.00	N/A
OUT 13-3R	Calculated N/D	N/A	1.59%	1.38%	2.20%	1.84%	1.8%
Recidivism (LOC) at six (6)							
OUT 13-4N	# of graduated youth admitted to HLOC w/in 6mths. (PRTF)	N/A	1.00	0.00	0.00	0.00	N/A
OUT 13-4D	# of youth graduated from the CME.	N/A	20.00	24.00	25.00	16.00	N/A
OUT 13-4R	Calculated N/D	N/A	5.00%	0.00%	0.00%	0.00%	1.3%
Primary Care Practitioner Access (EPSDT)							
OUT 13-5N	# of CME enrolled youth with an identified Primary Care Practitioner.	N/A	59.00	82.00	77.00	78.00	N/A
OUT 13-5D	# of youth enrolled in the CME.	N/A	59.00	83.00	83.00	82.00	N/A
OUT 13-5R	Calculated N/D	N/A	100.00%	98.80%	92.77%	95.12%	96.67%
Cost Savings							
OUT 13-6N	total Medicaid cost (WYCME)	N/A	$ 875,290.34	$ 969,920.63	$ 795,275.14	$ 774,818.19	N/A
OUT 13-6D	# of youth enrolled in CME	N/A	189.00	218.00	182.00	163.00	N/A
OUT 13-6A	Average cost of CME youth	N/A	$ 4,631.17	$ 4,449.18	$ 4,369.64	$ 4,753.49	N/A
OUT 13-6RON	Total Medicaid cost (other)	N/A	$ 458,453.56	$ 612,972.55	$ 675,208.86	$ 693,450.54	N/A
OUT 13-6ROD	# of non-HFWA youths w PRTF	N/A	76.00	67.00	69.00	74.00	N/A
OUT 13-6ROA	Average cost of PRTF youth	N/A	$ 6,032.28	$ 9,148.84	$ 9,785.64	$ 9,370.95	$ 2,858.64
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	77.70%	80.90%	74.80%	79.40%	N/A
OUT 13-7D	77.7	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	45.00	44.00	53.00	74.00	216.00
Family and Youth Participation at State-Level Advisory Meetings							
OUT 13-9N	# of Attendees Representing Families	N/A	13	5	1	27	N/A
OUT 13-9D	# of Enrollees	N/A	584	657	728	0	N/A
			2.23%	0.76%	0.14%	#DIV/0!	#DIV/0!
Family and Youth Participation in Communities							
OUT 13-10N	Family and Youth Participation in Communities	N/A	234	541	349	122	N/A
OUT 13-10D	# of Attendees Representing Families	N/A	584	657	728	0	N/A
OUT 13-10R	# of Enrollees	N/A	40.07%	82.34%	47.94%	0.00%	42.59%

Wyoming Department of Health - SFY 2023
External Quality Review Technical Report
Appendix F. Outcome Measures Review Tool

Outcomes Tool

No	2021 SOW Section	Outcome Name - SFY 2023	Outcome Requirement - SFY 2023	Outcome Performance Measure - SFY 2023	Outcome Performance Penalty - SFY 2023	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	N: 3 D: 189 %: 1.6	N: 3 D: 218 %: 1.4	N: 4 D: 182 %: 2.2	N: 3 D: 163 %: 1.8	Meets Requirement	Magellan reported the number and percent of OOH placements on a quarterly basis.
2	OUT 13-2	Decreased Length of Stay (LOS) for Inpatient and Residential Treatment admissions for youth enrolled in the CME.	The Contractor must report the overall length of stays for inpatient psychiatric treatment (PRTF and Acute Psychiatric Stabilization) for youth enrolled in the CME.	Report quarterly for the previous quarter the Average LOS for CME enrolled youth in OOH placement. Average LOS is equal to the average of PRTF and acute psychiatric hospitalization stays.	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next reporting period (following	ALOS: 7.44 days CME Enrolled Youth: 189	ALOS: 12.83 days CME Enrolled Youth: 218	ALOS: 11.2 days CME Enrolled Youth: 182	ALOS: 7.8 days CME Enrolled Youth: 163	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	N: 3 D: 189 %: 1.6	N: 3 D: 218 %: 1.4	N: 4 D: 182 %: 2.2	N: 3 D: 163 %: 1.8	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	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: 1 D:20 %: 5	N: 0 D: 24 %: 0	N: 0 D: 25 %: 0	N: 0 D: 16 %: 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: 59 D: 59 %: 100	N: 82 D: 83 %: 99	N: 77 D: 83 %: 93	N: 78 D: 82 %: 95	Meets Requirement	Magellan reported on EPSDT Compliance / PCP identification on a quarterly basis.

No	2021 SOW Section	Outcome Name - SFY 2023	Outcome Requirement - SFY 2023	Outcome Performance Measure - SFY 2023	Outcome Performance Penalty - SFY 2023	Q1	Q2	Q3	Q4	Status of Goal	Findings and Comments
6	OUT 13-6	Cost Savings (Healthcare Costs)	The Contractor must report healthcare costs to Medicaid for the CME enrolled youth.	Average total Medicaid healthcare costs per CME enrolled youth as compared to the total Medicaid costs for the target eligible population of non-CME enrolled youth with PRTF stays.	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next annual reporting period (following year)	Avg. cost of CME youth (6 mo.): $4,631.17 Avg. cost of PRTF youth (6 mo.): $6,032.28	Avg. cost of CME youth (6 mo.): $4,449.18 Avg. cost of PRTF youth (6 mo.): $9,148.84	Avg. cost of CME youth (6 mo.): $4,369.64 Avg. cost of PRTF youth (6 mo.): $9,785.64	Avg. cost of CME youth (6 mo.): $4,753.49 Avg. cost of PRTF youth (6 mo.): $9,370.95	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	77.7%	80.9%	74.8%	79.4%	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	# of Surveys (average): 45	# of Surveys (average): 44	# of Surveys: 53	# of Surveys: 74	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	N: 11 D: 584 %: 2.2	N: 5 D: 657 %: 0.8	N: 1 D: 728 %: 0.1	N: 27 D: 0 %: 0.0	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: 234 D: 584 %: 40	N: 541 D: 657 %: 82	N: 349 D: 728 %: 48	N: 122 D: 0 %: 0	Meets Requirement	Magellan reported on the Family and Youth Participation in Communities across on a quarterly basis.

Appendix G: Protocol 3 - Compliance Review Tool

#	Federal regulation source(s)	Medicaid/CHIP agency policy/ regulation information needed to determine MCP	SFY2021 Contract Language	Applicable MCP documents	Documents Reviewed	Findings from Document Review	Reviewer Determination
MCP Standards, Including Enrollee Rights and Protections							
1	**Availability of services** **Medicaid:** 42 CFR 438.206 (availability of services) and 42 CFR 10(h) provider directory) **CHIP:** 42 CFR 457.1230(a)	•The state's provider-specific network adequacy requirements and standards (and exceptions, if any)	The Agency does not require the Contractor to contract with more providers than necessary to meet the needs of its enrollees and in consideration of the number of enrollees and expected utilization of services, and the number of providers that have met ratio requirements. [SOW pg. 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 and procedures (ES)	P3.8.WY2023 - Network Development Plan - 2022 - Final P3.8.WY2023 - Network Adequacy Framework - November, 2023 P3.8.WY2023 - Network Development Plan - November 2023	According to the November 2023 **Network Development Plan**, Magellan sets network adequecy standards for both rural and urban communtiies where: • at least one (1) provider must be present within a ten (10) mile radius from a Medicaid beneficiary in urban regions, and • at least one (1) provider must be present within a fifty (50) mile radius in rural regions. (p.6) According to the 2022 **Network Development Plan**, Magellan reported that most recruitment efforts have centered around education of community advisory groups, professional organizations, and government partners, but most new providers are referred in by current network providers. (p.22) Magellan plans to focus outreach efforts on current WY Medicaid enrolled providers. (p.22) Despite high network provider turnover, Magellan reported still being able to meet member needs across regions and quarters. (p.21) The **Network Adequecy Framework** reported a steady increase in claims paid between 2020 and 2023 despite contracted providers decreasing in quantity. (p.6) Magellan conducts quarterly evaluations on provider locations, demographics, adequecy standards compliance, proactive adjustments and continuous improvement. (p.8) Magellan develops weekly reports examining caseloads of providers and members through, detailed caseload analyses, provider-member alignment, resource alloaction, timely adjustments, and quality assurance. (p.9) Magellan is currently in the process of defining adequecy standards to move away from flat ratio targets due to the unique nature of Wyoming's geography and the emergence of telehealth as a viable service delivery method. Network Adequacy Framework is a work in progress as Magellan moves towards new provider outreach and network development strategies as well as firm access standards. A Committee reviews all provider capacities and caseloads weekly and discusses how to best allocate providers with additional capacity to regions in need of providers through telehealth services. "No participant that requests services is unable to receive them."	Partially Met
2		•The state's requirements for the MCP provider directory	A provider directory must also be made available on the Contractor's website in a machine-readable file and format as specified by the Secretary and in 42 CFR 438.10(h)(4). The Contractor's electronic provider directory must be updated no later than thirty (30) calendar days after the Contractor receives updated provider information. [SOW pg. 14]		P3.8.WY - Network Development Plan - 2022 - Final P3.11.WY2023 - WY CME Provider Directory - June 30, 2023 Provider Directory Update Policy	According to the Network Development Plan, Magellan Network Managers review Medicaid provider enrollment reports weekly and compare it to the weekly Provider Directory to ensure that every provider is actively enrolled in Wyoming Medicaid (p.53). Magellan provided the WY CME Provider Directory which was a PDF document containing network providers by county. The provider entries constained practice or individual provider names, county where the provider is located, practice address, practice phone number, the providers' languages, provider gender, provider specialty, and hours of operation. Provider Directory also included on the Magellan website: https://www.magellanofwyoming.com/youth-and-families/find-a-provider/. Magellan states that the directory is updated "daily". The Provider Directory Update Policy notes that provider information automatically updates in the provider registry as provider information changes through the provider enrollment portal	Fully Met

3		Information on the documentation that the state uses to support its certification that the MCP complied with the state's requirements for availability and accessibility of services, including the adequacy of the provider network	The Contractor will also demonstrate that they have complied with availability and accessibility of 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.		P3.8.WY2023 - Network Development Plan - 2022 - Final P3.8.WY2023 - Network Adequacy Framework - November, 2023 P3.8.WY2023 - Network Development Plan - November 2023 P3.11.WY2023 - WY CME Provider Directory - June 30, 2023 P3.44.WY2023 - Geo Maps 2022-2023 P3.44 - Geo Maps 2022-2023 1	According to Magellans document of Geo Maps 2022-2023 (1), in Q3 SFY2023 (January 2023 - March 2023), the CME network contains 62 unique providers for family care coordination, 38 unique proivders for family support services, 1 unique provider for respite services, and 9 unique providers offering services as Youth Support Partners. Magellan provides quarterly geo mapping reports that include a visual representation of providers by role and region (p. 12). Due to restrictive distance and weather events, providers have largely foregone brick and mortar facilities for delivering services in favor of telehealth offerings through Magellan's HIPAA compliant platform. All providers delivering services are included in Magellan's centralized provider data system where each region's provider needs are assessed and providers are referred to another region. As such, providers deliver services in several counties and regions across the state (p.42). Magellan reported increasing respite provider capacity to 7 unique providers, but in the Q3 SFY2023 analysis and maps generated on April 17, 2023, Magellan only reported 1 network respite provider (p.43,58). Magellan provided the WY CME Provider Directory which was a PDF document containing network providers by county. The provider entries constained practice or individual provider names, county where the provider is located, practice address, practice phone number, the providers' languages, provider gender, provider specialty, and hours of operation	Partially Met

4	**Furnishing of services and timely access** **Medicaid:** 42 CFR 438.206(c)(1): Furnishing of services and timely access **CHIP: 42 CFR 457.1230(a):** Availability of services	•Obtain a copy of the state Medicaid/CHIP agency's standards for timely enrollee access to care and services required of Medicaid/CHIP and MCPs.	Geographic mapping is generated and reported on a quarterly basis and is developed by the Contractor and provided to the Agency for use in monitoring marketing, information to beneficiaries, enrollee's free choice of providers, timely access, coordination/continuity of care, coverage/authorization, quality of care, and Provider Selection. The Contractor will map referral and subsequent enrollment patterns to ensure appropriate marketing in all geographic areas. [SOW pg. 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)	Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	**Chapter 47 of Wyoming's Department of Health Administrative Rules** outline the agency's standards for timely enrollee access to care and services required of Medicaid/CHIP and MCPs. Standards are outlined in Section 9 (Availability of Services/Accessibility), and Section 10 (Individualized Plan of Care) (pg. 7-9). The Wyoming Department of Health's Administrative Rules for Medicaid were not included in the documents shared by Magellan (link: https://rules.wyo.gov/Search.aspx?mode=1).	Fully Met

5	**Access and cultural considerations** **Medicaid:** 42 CFR 438.206(c)(2): Furnishing of services and cultural considerations. **CHIP:** 42 CFR 457.1230(a): Access standards	•Descriptive information on the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.	The Contractor is required to participate in the Agency's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. [SOW pg. 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)	P3.24.WY2023 - 2022 WY Member Handbook P3.34.WYH2023 - wysupp - Final 2023 Provider Handbook P3.18.WY2023.SFY 2023WY CME QI_WorkPlan Annual Final P3.17.WY2023.Magellan WY CME Quality Annual Program Evaluation SFY2023 Final	According to the **Master Handbook**, Phase 1 of the HFWA program, Engagement and Planning, includes "cultural discovery" to address participants' needs and plan for care in a culturally competent manner (p.15). Member Rights and Responsibilities indicate that participants have a right to "learn about services in a way that respects your culture" and "get information in a language your family can understand" (p.25). One of Magellan's 10 High Fidelity Wraparound Principles is "Culturally Competent -- The Plan respects and build on the values, preferences, beliefs, and culture of the child/youth and family" (p.8). Magellan notes that they offer free language services to individuals whose primary language is not English through qyalified interpreters, information written in other languages, and auxiliary aids and services (p.33). Magellan follows federal regulations on providing reasonable accommodations when possible. Turnaround got meeting accommodations depends on vendors. Magellan offers alternative solutions to help in the interim (e.g., TTY) (p.7). The **Provider Handbook** outlines cultural humility as a core value in the wraparound process (p.9). Magellan noted that when gaps in services and culture-specific provider needs are identified through its continuous monitoring process, the CME will develop a provider recruitment plan and monitor its effectiveness (p.47). Magellan requires that providers complete the Strengths Need and Culture Discovery (SNCD) assessment during the Summary of the Family Interview in Phase 1 of service delivery (p.85). Magellan's **Quality Improvement Work Plan** contains a Population Assessment objective for 2023 that looks to "evaluate members' needs including demographics; diagnostic prevalence; cultural, ethnic, racial, and linguistic preferences; and complex helath needs." According to the **Quality Annual Program Evaluation**, Magellan conducts an annual assessment of members and providers that examines cultural, ethnic, racial, and linguistic needs as well as key demographic data; disparities in access, engagement, and authorization of care and services; diagnosis prevalence; and systemic barriers.	Fully Met

6		•The requirements the state has communicated to the MCP with respect to how the MCP is expected to participate in the state's efforts to promote the delivery of services in a culturally competent manner.	The Contractor is required to participate in the Agency's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. [SOW pg. 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]	•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	P3.24.WY2023 - 2022 WY Member Handbook P3.34.WYH2023 - wysupp - Final 2023 Provider Handbook P3.18.WY2023.SFY 2023WY CME QI_WorkPlan Annual Final P3.17.WY2023.Magellan WY CME Quality Annual Program Evaluation SFY2023 Final	According to the **Master Handbook**, Phase 1 of the HFWA program, Engagement and Planning, includes "cultural discovery" to address participants' needs and plan for care in a culturally competent manner (p.15). Member Rights and Responsibilities indicate that participants have a right to "learn about services in a way that respects your culture" and "get information in a language your family can understand" (p.25). One of Magellan's 10 High Fidelity Wraparound Principles is "Culturally Competent -- The Plan respects and build on the values, preferences, beliefs, and culture of the child/youth and family" (p.8). Magellan notes that they offer free language services to individuals whose primary language is not English through qyalified interpreters, information written in other languages, and auxiliary aids and services (p.33). Magellan follows federal regulations on providing reasonable accommodations when possible. Turnaround got meeting accommodations depends on vendors. Magellan offers alternative solutions to help in the interim (e.g., TTY) (p.7). The **Provider Handbook** outlines cultural humility as a core value in the wraparound process (p.9). Magellan noted that when gaps in services and culture-specific provider needs are identified through its continuous monitoring process, the CME will develop a provider recruitment plan and monitor its effectiveness (p.47). Magellan requires that providers complete the Strengths Need and Culture Discovery (SNCD) assessment during the Summary of the Family Interview in Phase 1 of service delivery (p.85). Magellan's **Quality Improvement Work Plan** contains a Population Assessment objective for 2023 that looks to "evaluate members' needs including demographics; diagnostic prevalence; cultural, ethnic, racial, and linguistic preferences; and complex helath needs." According to the **Quality Annual Program Evaluation**, Magellan conducts an annual assessment of members and providers that examines cultural, ethnic, racial, and linguistic needs as well as key demographic data; disparities in access, engagement, and authorization of care and services; diagnosis prevalence; and systemic barriers.	Fully Met
7	**Assurances of adequate capacity and services** **Medicaid:** 42 CFR 438.207: Assurances of adequate capacity and services **CHIP: 42 CFR 457.1230(b):** Assurances of adequate capacity and services	•Medicaid/CHIP agency documentation and submission timing standards to assure that the MCP has an appropriate range of preventive, primary care, specialty, and LTSS services that are adequate for the anticipated number of enrollees in the MCP's service area.	The Contractor must "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	P3.24.WY2023 - 2022 WY Member Handbook P3.34.WYH2023 - wysupp - Final 2023 Provider Handbook P3.18.WY2023.SFY 2023WY CME QI_WorkPlan Annual Final P3.17.WY2023.Magellan WY CME Quality Annual Program Evaluation SFY2023 Final	According to the **Provider Handbook**, Family Care Coordinators must document the Child and Family Team along with all attempts to coordinate with the child's PCP (p.23). The **Member Handbook** notes that a Family Care Coordinator will help a participant and/or their family find a PCP if they do not have one (p.21). Magellan notes in the **Provider Handbook** that the CME is intended to discuss PCPs with the family in the care planning phase, but there is no documentation of reporting data on PCP identification (p.86). Magellan states, participant PCP identification is not formally tracked in the EHR, but it is a field in crisis planning, allowing for access to the information through service plan documentation. Magelan recommends that PCP identification be a required and structured data point in the EHR.	Fully Met

8		•Medicaid/CHIP agency documentation and submission timing standards to assure that the MCP maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.	The Contractor 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]		P3.8.WY2023 - Network Development Plan - 2022 - Final P3.8.WY2023 - Network Adequacy Framework - November, 2023 P3.8.WY2023 - Network Development Plan - November 2023 P3.11.WY2023 - WY CME Provider Directory - June 30, 2023 P3.44.WY2023 - Geo Maps 2022-2023 P3.44 - Geo Maps 2022-2023 1	According to Magellans document of **Geo Maps 2022-2023** the CMER provides quarterly geo mapping reports that include a visual representation of providers by role and region (p. 12). Magellan reports information on providers in four (4) groups. • Family Care Coordination • Family Support Services • Respite • Youth Support Partners Due to restrictive distance and weather events, providers have largely foregone brick and mortar facilities for delivering services in favor of telehealth offerings through Magellan's HIPAA compliant platform. All providers delivering services are included in Magellan's centralized provider data system where each region's provider needs are assessed and providers are referred to another region. As such, providers deliver services in several counties and regions across the state (p.42). According to the **November 2023 Network Development Plan**, Magellan sets network adequecy standards for both rural and urban communtiies where: • at least one (1) provider must be present within a ten (10) mile radius from a Medicaid beneficiary in urban regions, and • at least one (1) provider must be present within a fifty (50) mile radius in rural regions. (p.6)	Partially Met
9	**Coordination and continuity of care for all enrollees** **Medicaid:** 42 CFR 438.208: Coordination and continuity of care **CHIP: 42 CFR 457.1230(c):** Coordination and continuity of care	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.	P3.24.WY2023 - 2022 WY Member Handbook P3.34.WY2023 - wysupp - Final 2023 Provider Handbook P3.18.WY2023.SFY 2023WY CME QI_WorkPlan Annual Final P3.17.WY2023.Magellan WY CME Quality Annual Program Evaluation SFY2023 Final	The **WY Member Handbook** defines a Family Care Coordinator as "a person who is trained to coordinate the High Fidelity Wraparound process for a family" (p.34)." The **Provider Handbook** notes that the first point of contact in the eligibility process is connecting a family with a Family Care Coordinator (p.116). All assessments and document are to be uploaded and/or completed in participants' Fidelity EHR (p.80,116). All WY High Fidelity Wraparound providers use Magellan's EHR and each organization involved in an enrollee's care must identify a subject matter expert in their organization to provide tech assistance on the EHR for staff (p.28).	Fully Met
10		•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]		P3.24.WY2023 - 2022 WY Member Handbook P3.34.WY2023 - wysupp - Final 2023 Provider Handbook P3.18.WY2023.SFY 2023WY CME QI_WorkPlan Annual Final P3.17.WY2023.Magellan WY CME Quality Annual Program Evaluation SFY2023 Final	The **WY Member Handbook** defines a Family Care Coordinator as "a person who is trained to coordinate the High Fidelity Wraparound process for a family" (p.34)." The **Provider Handbook** notes that the first point of contact in the eligibility process is connecting a family with a Family Care Coordinator (p.116). It also notes that the Family Care Coordinator "shall work with the family to schedule and document all Team meetings and invite the entire team" (p.25).	Fully Met

11	•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]	P3.24.WY2023 - 2022 WY Member Handbook P3.34.WYH2023 - wysupp - Final 2023 Provider Handbook P3.18.WY2023.SFY 2023WY CME QI_WorkPlan Annual Final P3.17.WY2023.Magellan WY CME Quality Annual Program Evaluation SFY2023 Final P3.13.WY2023.Clinical Manual	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) **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- 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.** 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. The **Clinical Manual** outlines the process through which an independent assessor is chosen	Fully Met

12		•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.WY2023.Clinical Manual	The **Clinical Manual** states that "this process aids compliance with the Statement of Work by ensuring prior authorizations are not extended beyond annual assessment expiration dates in instances when one or both annual assessments are due within the 90-day review period. Once an updated assessment has been uploaded to the electronic health record for the affected youth, prior authorizations are extended as appropriate. Clinical eligibility assessments are required upon initial enrollment and every twelve months thereafter. They are also required upon a youth's return to the community from a higher level of care" (p. 133).	Fully Met
13		•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]		P3.34.WY2023 - wysupp - Final 2023 Provider Handbook	The **Provider Handbook** outlines requirements of the Family Care Coordinator and states that "it is the provider's responsibility to maintaining all member records for a minimum of six years. Providers may be asked to produce those records for auditing purposes" (p.26).	Fully Met
14		•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]		P3.34.WY2023 - wysupp - Final 2023 Provider Handbook	The **Provider Handbook** outlines requirements of the Family Care Coordinator and 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. 23).	Fully Met
15	**Additional coordination and continuity of care requirements: LTSS**	•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	N/A	N/A	Not Applicable

16	**Medicaid:** 42 CFR 438.208: Coordination and continuity of care	•Whether the MCP is required to meet identification, assessment, and treatment planning requirements for dually-enrolled beneficiaries.	None	(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)	N/A	N/A	Not Applicable
17	**CHIP: 42 CFR 457.1230(c):** Coordination and continuity of care	•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		N/A	N/A	Not Applicable
18		•The state's quality assurance and utilization review standards.	The Contractor is required to establish and implement an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) program for the services it furnishes to its enrollees. The QAPI program must include Performance Improvement Projects (PIP), including any required by the Agency or CMS. The QAPI program must include collection and submission of performance measurement data as specified in the Contract and Statement of Work outcome measures and performance requirements and report to the Agency on its performance. Activities of the QAPI program must include mechanisms to detect both underutilization and overutilization of service. [SOW pg. 20]		P3.16.WY2023.Quality Improvement Program - QI.105.17 - Policy P3.15.WY2023.Improving the Prior Authorization Process PIP SFY 2023 Final pages 1-6 P3.15. WY2023.Engagement and Implementation PIP SFY 2023 Final pages 1-4 P3.15.WY2023.Magellan WY CME Quality Annual Program Evaluation SFY2023 Final pages 9, 25	The **Quality Improvement Program Policy** establishes and outlines Magellan's QAPI program. The CE documentation states that Performance indicators have established targets and measures. The work plan includes activities and accurate data to maintain a strong quality program that supports safe, effective, patient-centered, timely, efficient, and equitable service options" (p.3). Magellan notes that they have an Annual Quality Work Plan that builds on previous year's programs and results and outlines the details of each QI activiity and objective (p.4). Magellan notes that any QAPI programs must include mechanisms to detect under and overutilization of services (p.6). The documentation including language outlining that the CE will annually measure and report to the State on its own performance, using the standard measures required by the state (p.7). The **CME Quality Issues Management Procedure** outlines the process through which Magellan identifies underperforming metrics and/or areas of concern and their related follow-up processes. Magellan conducted PIPs in the previous year on **Prior Authorization Process Improvement** and **Engagement and Implementation.** Magellan and WDH clarified and confirmed their process for sharing QI program reporting.	Fully Met

19	**Additional coordination and continuity of care requirements: SHCN** **Medicaid**: 42 CFR 438.208: Coordination and continuity of care **CHIP:** 42 CFR 457.1230(c): Coordination and continuity of care	•Methods used by the Medicaid/CHIP agency to identify to the MCP individuals with special health care needs (SHCNs).	The Contractor must include mechanisms to assess the quality and appropriateness of care coordination furnished to enrollees with special health care needs. [SOW pg. 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)	P3.13,WY2023.Clinical Manual P3.34.WY2023 - wysupp - Final 2023 Provider Handbook P3.22.WY2023. Accessibility of Service and Care Policy CO.4.01.WY.HFWA (1)	The **Clinical Manual** states that referral is the first step for enrollment and is made by HFWA stakeholders like provders, guardians, physicians, and the states's utilization management contractor (p.3). The **Provider Handbook** oulines criteria for enrollment and eligibility (p.44-45). Magellan's definition of special health care needs was not given in any of the documentation provided. The **Accessibility of Service and Care Policy** acknowledges that the WY CME is responsible for monitoring adherence of access standards and annual analaysis of performance through telephone reports from the Call Management System, Critical Incident reports, but does not specifically acknowledge how the quality of care coordination is assessed (p.3)	Fully Met
20		•Whether the MCP is required to implement mechanisms for identifying, assessing, and producing a treatment plan for persons with SHCNs using the state's definition of SHCNs.	The Contractor must include mechanisms to assess the quality and appropriateness of care coordination furnished to enrollees with special health care needs. [SOW pg. 20]		P3.13,WY2023.Clinical Manual P3.34.WY2023 - wysupp - Final 2023 Provider Handbook P3.24.WY2023 - 2022 WY Member Handbook Chapter 1: Definitions Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rule	The **Member Handbook** outlines the HFWA phases to build an enrollee care plan (pg. 15-18) The State definition of special health care needs was not provided by Magellan or in the reviewed State Medicaid documents.	Not Applicable

21	•Whether the MCP is required to meet identification, assessment, and treatment planning requirements for dually-enrolled beneficiaries.	The Contractor must include mechanisms to assess the quality and appropriateness of care coordination furnished to enrollees with special health care needs. [SOW pg. 20]	N/A	N/A	Not Applicable
22	•Any Medicaid/CHIP agency SHCN assessment mechanisms requirements, including the requirement to use appropriate providers or individuals meeting the Medicaid/CHIP agency's LTSS service coordination requirements.	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]	N/A	N/A	Not Applicable
23	•Whether the Medicaid/CHIP agency requires the MCP to produce a treatment or service plan for enrollees with SHCN that are determined through assessment to need a course of treatment or regular care monitoring.	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]	P3.13,WY2023.Clinical Manual P3.34.WY2023 - wysupp - Final 2023 Provider Handbook	The **Provider Handbook** outlines the process through which the provider team builds and revisits Plan of Care for the enrollee (Appendix A) The **Clinical Manua**l outlines the process through which FCCs develop a Plan of Care for each member (pg. 44-46)	Fully Met

24		•The state's quality assurance and utilization review standards.	The Contractor is required to establish and implement an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) program for the services it furnishes to its enrollees. The QAPI program must include Performance Improvement Projects (PIP), including any required by the Agency or CMS. The QAPI program must include collection and submission of performance measurement data as specified in the Contract and Statement of Work outcome measures and performance requirements and report to the Agency on its performance. Activities of the QAPI program must include mechanisms to detect both underutilization and overutilization of service. [SOW pg. 20]		P3.17.WY2023.SFY 2023WY CME QI_WorkPlan Annual Final Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rule P3.18.WY2023.SFY2023 WY CME Program Description Final pp 7,9,14-18 P3.19.WY2023.Quality Improvement Program - QI.105.17 - Policy	The **QI Program Description** outlines Magellan's approach to QAPI programming and the process through which it implements initiatives (p.4-7). The **QI Work Plan** states quality indicators, goals, and outcomes of the goals (pg. 2-3): Positively influencing Health and Well-being, including youth/member safety: 1. Monitor care through Critical Incident Reporting and the Wyoming Clinical (WYClinical) authorization to determine if any member safety concerns exist. 2. Increase the volume of members enrolled in the CME that can benefit from HFWA services. Enhancing Service and the Experience of Care: 3. Meet or exceed the national mean for member and family satisfaction results through monitoring of the Wraparound Fidelity Index, Short Form (WFI EZ). 4. Stabilize and increase volume, including service array representation of the network HFWA providers to improve adequacy across regions. Meeting and exceeding contractual, and regulatory requirements: 5. Maintain compliance with contractual requirements 6. Successful implementation and ongoing monitoring of the Enrollment Pilot Project to identify, prioritize, and pursue opportunities to improve processes by recognizing operational issues or efficiencies. **Chapter 47 of Wyoming's Department of Health Administrative Rules** for Medicaid outline the agency's standards for Quality Reporting. Included in Section 12 (Quality Reporting) (pg. 9) The Wyoming Department of Health's Administrative Rules for Medicaid were not included in the documents shared by Magellan (link: https://rules.wyo.gov/Search.aspx?mode=1)	Fully Met
25	**Disenrollment** **Medicaid:** 42 CFR 438.56: Disenrollment: Requirements and limitations **CHIP:** 42 CFR 457.1212: Disenrollment	•Obtain from the Medicaid/CHIP agency Information on: •Reasons for which the MCP may request the disenrollment of an enrollee.	Disenrollment for enrollees requested by the Contractor will be reviewed and approved by the State. The following are 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)	Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rule P3.13,WY2023.Clinical Manual P3.34.WY2023 - wysupp - Final 2023 Provider Handbook P3.24.WY2023 - 2022 WY Member Handbook General Operations and Enrollee Management Reports Enrollment_Disenrollment_Policy_2018-12-27	**Chapter 47 of Wyoming's Department of Health Administrative Rules** lists the reasons the MCP can request disenrollment including (Section 7; pg. 6): (i) The youth is no longer Medicaid eligible; (ii) The youth moves out of the State; (iii) The youth ages out of the program; (iv) The youth is incarcerated; (v) The youth is no longer financially eligible; (vi) The youth is no longer clinically eligible; (vii) The youth is determined eligible for any excluded program/population pursuant to Section 4; (viii) The youth is in out-of-home placement longer than one hundred eighty(180) days; (ix) The youth needs related services (for example a cesarean section and tubal ligation) to be performed at the same time; not all related services are available within the network; and the youth's Primary Care Provider (PCP) or another provider determines that receiving the services separately would subject the youth to unnecessary risk; or (x) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the youth's specific health care needs. Magellan updated disenrollment policy provided clear guidelines.	Fully Met

26	•Methods by which the MCP assures the Medicaid/CHIP agency that it does not request disenrollment for reasons other than those permitted under the contract.	The Contractor 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]	P3.13,WY2023.Clinical Manual	The **Clinical Manual** states "Upon completion of the above step by the Family Care Coordinator, a semi-automated letter process will trigger a Disenrollment Letter report, which is pulled from the electronic health record and shared daily via the shared WYC!inical email inbox" (p.38). Magellan uploaded the WYClinical inbox to EHR which WDH can access.	Fully Met
27	•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]	P3.13,WY2023.Clinical Manual P3.34.WY2023 - wysupp - Final 2023 Provider Handbook P3.24.WY2023 - 2022 WY Member Handbook Enrollment_Disenrollment_Policy_2018-12-27	There was no mention of limiting disenrollment in any document reviewed. Magellan does not limit disenrollment according to updated documentation.	Fully Met

28		•Medicaid/CHIP agency enrollee disenrollment request policies.	The enrollee (or his or her representative) must submit an oral or written request to the Contractor requesting disenrollment. Causes for disenrollment may include reasons such as a move out of state, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's care needs. [SOW pg. 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]		P3.13,WY2023.Clinical Manual P3.34.WY2023 - wysupp - Final 2023 Provider Handbook P3.24.WY2023 - 2022 WY Member Handbook Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rule Enrollment_Disenrollment_Policy_2018-12-27	**Chapter 47 of Wyoming's Department of Health Administrative Rules** states (pg. 5 & 7): (b) A youth and his or her family may choose to disenroll at any time pursuant to Section 7 of this Chapter. (b) A participant may voluntarily disenroll from the CME without cause at any time There was no discussion about method of enrollee disenrollment requests in any document submitted by Magellan. Enrollees are free to disenroll at their request	Fully Met
29		•Whether the Medicaid/CHIP agency allows the MCP to process enrollee requests for disenrollment.	Disenrollment requested by the enrollee may occur for cause at any time. [SOW pg. 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]		P3.13,WY2023.Clinical Manual P3.34.WY2023 - wysupp - Final 2023 Provider Handbook P3.24.WY2023 - 2022 WY Member Handbook Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rule Enrollment_Disenrollment_Policy_2018-12-27	There was no discussion about approval of enrollee disenrollment requests in any document submitted by Magellan. Magellan processes disenrollments.	Fully Met
30		•Whether the Medicaid/CHIP agency requires enrollees to seek redress through the MCP's grievance system before the Medicaid/CHIP agency makes a disenrollment determination on the enrollee's request.			P3.13,WY2023.Clinical Manual P3.34.WY2023 - wysupp - Final 2023 Provider Handbook P3.24.WY2023 - 2022 WY Member Handbook Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rule Enrollment_Disenrollment_Policy_2018-12-27	There was no discussion about greivances related to enrollee disenrollment requests in any document submitted by Magellan. Magellan states, grievances must be processed in time for disenrollment no later than the first day of the second month following the month in which the enrollee requests disenrollment.	Fully Met

31	**Coverage and authorization of services** **Medicaid:** 42 CFR 438.210(a–e)*: Coverage and authorization of services, including 42 CFR 440.230 Sufficiency of amount, duration, and scope; 42 CFR Part 441, Subpart B: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21;* and 42 CFR 438.114, Emergency and post-stabilization services **CHIP**: 42 CFR 457.1230(d): Coverage and authorization of services 42 CFR 457.1228: Emergency and post-stabilization services *Note: 42 CFR 438.210(a)(5), 438.210(b)(2)(iii), 440.230 and 441 Subpart B do not apply to CHIP	•Obtain from the state any 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)	Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rule P3.20.WY.2023.Quarter1SFY2023.Enrollee.Management P3.20.WY.2023.Quarter2SFY2023.Enrollee.Management P3.20.WY.2023.Quarter3SFY2023.Enrollee.Management P3.20.WY.2023.Quarter4SFY2023.Enrollee.Management	**Chapter 47 of Wyoming's Department of Health Administrative Rules** Outlines State Requirements for Availability of Services/Accessibility (Section 9) and Benefit Plan and Covered Services (Section 11) The **Quarterly Enrollee Management Data Files** show that Magellan is reporting on plan of care reviews prior to submission for prior authorization quarterly. It is unclear if these reports are passed on to the State (p.11) Reviews prior to submission range from 97% to 100%. 2 months in Q4 reported rates of 97%, 1 month in Q3 showed a rate of 98%, 1 month in Q2 showed a rate of 99%, and 1 month in Q1 showered a rate of 99%. Reports are submitted to WDS quarterly. Reviews may not be shown in data due to the process required to mark them. Often, Magellan reviews POCs prior to submission in their direct contact with providers. This activity may not show up in the metric that shows reviews prior to submission. Magellan is undergoing training and education to correct this.	Fully Met
32		•Obtain from the state any statutory, regulatory and policy definitions of “medical necessity”, as well as any quantitative and non-quantitative treatment limitation limits set forth in those sources	The Contractor will only conduct prior authorization (PA)/utilization management (UM) of HFWA, respite and Youth and Family Training (YFT) and Support services provided to enrolled youth. The PA/UM process will require the Contractor to implement a service authorization review process and. During the approved period this will include a concurrent review process to monitor clinical intervention tied to eligibility justification, delivery of benefits (HFWA, Respite, and YFT) and adherence to any benefit limitations. The mechanism and documents to be reviewed for the concurrent review will include the plan of care (POC), crisis plan, CASII, CANS and any other information deemed necessary to determine service authorization. [SOW pg. 43]		Chapter 1: Definitions P3.13,WY2023.Clinical Manual P3.39.W2023.Concurrent Reviews P3.34.WY2023 - wysupp - Final 2023 Provider Handbook	**Chapter 1 of Wyoming's Department of Health Administrative Rules defines medical necessity** as "A determination that a health service is required to diagnose, treat, cure or prevent an illness, injury or disease which has been diagnosed or is reasonably suspected to relieve pain or to improve and preserve health and be essential to life." Limitations for the designation are listed in the document (pg. 19) According to the **Clinical Manua**l, 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 (p.57). 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 (p.57). According to the **Concurrent Reviews** 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 (p.1). The **Provider Handbook** states that the crisis complete documentation for EHR upkeep and service authorization includes documentation pertainting to the Strengths Need and Culture Discover, Plan of Care, Crisis Plan, Transition Plan, Custody Tab, Wraparound Fidelity Index, CASII/ECSII, and level of care (p.13). It also includes discussion of the use of CANS for service authorization and service planning throughout the document.	Fully Met

33		•Obtain from the state Medicaid/CHIP agency the state-established standards for MCP processing of standard authorization decisions.	For standard authorization decisions, the Contractor must issue service authorizations and/or adverse action notifications as a result of the concurrent review no later than fourteen (14) calendar days after receipt of the plan, with a possible extension of fourteen (14) calendar days if the provider or enrollee requests an extension or the Contractor justifies the need for additional information and how the extension is in the enrollee's best interest. [SOW pg. 16]		P3.13,WY2023.Clinical Manual	According to the **Clinical Manual,** 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 (p.57). 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 (p.57).	Fully Met
34		•Any Medicaid/CHIP agency drug authorization requirements, including whether the Medicaid/CHIP agency requires approval of outpatient drugs before its dispensing under Section 1927(d)(5)(A) of the Act.	No mention of drugs or medication in the document		P3.13.WY2023.Clinical Manual P3.34.WY2023 - wysupp - Final 2023 Provider Handbook Medicaid SA Determination	Medicaid SA Determination: The policy outlines notice requirements for outpatient drugs (pg. 7)	Fully Met
35	**Information requirements for all enrollees** **Medicaid:** 42 CFR 438.100(b)(2)(i) Enrollee right to receive information in accordance with 42 CFR 438.10: Information requirements **CHIP:** 42 C.F.R 457.1220: Enrollee rights 42 C.F.R 457.1207: Information requirements	· Whether the Medicaid/CHIP agency, enrollment broker, or MCP must provide all required information to enrollees.	The Contractor must make its written materials available to enrollees including, at a minimum, provider directories, policies and procedures, enrollee handbooks, enrollee rights and responsibilities, appeal and grievance notices, appeals, denial and termination notices, and fair hearing procedures with timeframes as specified in the Agency's rules on beneficiary fair hearing processes. These materials must be drafted using the State developed enrollee notices and Agency model enrollee handbook format and be made available in Spanish, the prevalent non-English language in Wyoming. The Contractor's enrollee handbook must include regarding the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled and the procedures for obtaining such benefits, including requirements for service authorizations. The Contractor must: A. Mail a printed copy of the information to the enrollee's mailing address; B. Provide the information by email after obtaining the enrollee's agreement to receive the information by email; C. Post the information on its website and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and service upon request at no cost; or, D. Provide the information by any other method that can reasonably be expected to result in the enrollee receiving that information. [SOW pg. 11]	•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)	P3.24.WY2023 - 2022 WY Member Handbook	Magellan reported that the full description of benefits is not available in the enrollee handbook. There is family friendly language in the handbook with limited details that does not address topics such as the total allowable volume of a service.	Partially Met

36		· Medicaid/CHIP agency developed definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care.	None	Policy Glossary and Terms 01-2021 Chapter 1: Definitions Chapter 10: Pharmaceutical Services Chapter 26: Covered Services	11.17.2021: Medicaid SA Determination Addendum Attachment: States that the Notice Requirements for Outpatient Drugs does not apply to WY HFWA business	Fully Met
37		· Medicaid/CHIP agency developed model enrollee handbooks and enrollee notices.	The Contractor must make its written materials available to enrollees including, at a minimum, provider directories, policies and procedures, enrollee handbooks, enrollee rights and responsibilities, appeal and grievance notices, appeals, denial and termination notices, and fair hearing procedures with timeframes as specified in the Agency's rules on beneficiary fair hearing processes. These materials must be drafted using the State developed enrollee notices and Agency model enrollee handbook format and be made available in Spanish, the prevalent non-English language in Wyoming. The Contractor's enrollee handbook must include regarding the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled and the procedures for obtaining such benefits, including requirements for service authorizations. [SOW pg. 11]	P3.24.WY2023 - 2022 WY Member Handbook	Magellan provides a provider directory available online at https://www.magellanofwyoming.com/youth-and-families/find-a-provider/. Magellan states that the directory is updated "daily". The Member Handbook includes policies and procedures, rights and responsibilities, appeal and grievance notices, appeals rights, and rights to fair hearings. Magellan reported that the full description of benefits is not available in the enrollee handbook. There is family friendly language in the handbook with limited details that does not address topics such as the total allowable volume of a service.	Partially Met
38		· The language(s) that the Medicaid/CHIP agency determines are prevalent in the MCP's geographic service area, and all non-English languages that the Medicaid/CHIP identifies.	These materials must be drafted using the State developed enrollee notices and Agency model enrollee handbook format and be made available in Spanish, the prevalent non-English language in Wyoming. [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]	P3.13.WY2023.Clinical Manual P3.24.WY2023 - 2022 WY Member Handbook	The **Clinical Handbook** states that "written notices for commercial populations contain a non-English language statement on how to access language services in Spanish, Tagalog, Chinese and Navajo unless the 10% threshold data has indicates a different language or the contractor directs to change one or more of the statements. Upon request, notices will be provided in any applicable non-English language" (p.72). The **Member Handbook** states "If you would like to get written information in your preferred language, such as Spanish, or in a format such as Braille, please contact us using the toll-free number above or our TDD/TTY number. Or visit www.MagellanofWyoming.com" (p.7).	Fully Met

39	· 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]	P3.13.WY2023.Clinical Manual P3.24.WY2023 - 2022 WY Member Handbook	The Rights and Responsibilities in the **Member Handbook** note that enrollees have a right to "get information in a language your family can understand" (p.25). It also notes that Magellan provides free aids and services to people with disabilities to communicate like: Qualified American Sign Language (ASL) interpreters • Written information in other formats (large print, audio, accessible electronic formats, other formats) • Provides free language services to people whose primary language is not English, such as: o Qualified interpreters o Information written in other languages o Auxiliary aids and services (p.33)	Fully Met
40	· 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]	P3.13.WY2023.Clinical Manual P3.24.WY2023 - 2022 WY Member Handbook	The Rights and Responsibilities in the **Member Handbook** note that enrollees have a right to "get information in a language your family can understand" (p.25). It also notes that Magellan provides free aids and services to people with disabilities to communicate like: Qualified American Sign Language (ASL) interpreters • Written information in other formats (large print, audio, accessible electronic formats, other formats) • Provides free language services to people whose primary language is not English, such as: o Qualified interpreters o Information written in other languages o Auxiliary aids and services (p.33) The Clinical Handbook states that "written notices for commercial populations contain a non-English language statement on how to access language services in Spanish, Tagalog, Chinese and Navajo unless the 10% threshold data has indicates a different language or the contractor directs to change one or more of the statements. Upon request, notices will be provided in any applicable non-English language" (p.72). The Member Handbook states "If you would like to get written information in your preferred language, such as Spanish, or in a format such as Braille, please contact us using the toll-free number above or our TDD/TTY number. Or visit www.MagellanofWyoming.com" (p.7).	Fully Met
41	· How the Medicaid/CHIP agency defines 'reasonable time' for purposes of providing the enrollee handbook to enrollees.	The Contractor is required to provide each enrollee notice of any significant change in the information specified in the enrollee handbook at least thirty (30) days before the intended effective date of the change. [SOW pg. 11]	Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rule P3.34.WY2023 - wysupp - Final 2023 Provider Handbook	**Chapter 47 of Wyoming's Department of Health Administrative Rules**: "(i) HFWA Youth and Family Handbooks issued to those automatically referred to the CME. Handbooks shall outline all Federal information requirements and include any additional HFWA educational material that may be helpful to families when being assessed for enrollment." (pg. 15) The **Provider Handbook** states that a family will receive a notification of processing an application within 14 days of application submission and an enrollment letter with a link for the Member Handbook by mail. The enrollment letter will also be saved in teh member's EHR (p.120)	Fully Met
42	· Medicaid/CHIP agency developed or approved language describing grievance, appeal, and fair hearing	The Contractor must make its written materials available to enrollees including, at a minimum, provider directories, policies and procedures, enrollee handbooks, enrollee rights and	P3.24.WY2023 - 2022 WY Member Handbook	Grievance, appeal, and fair hearing rights and procedures are available in the **Member Handbook** (pg. 29-31).	Fully Met
43	· Medicaid/CHIP agency policy on whether enrollee are required to pay costs for services while an appeal or state fair hear is pending – and the final decision is adverse to	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	P3.24.WY2023 - 2022 WY Member Handbook P3.29.WY2023.Medicaid Adverse Benefit Determination Appeal Policy	The **Medicaid Adverse Benefit Determination Appeal Policy** states that if an enrollee continues receiving benefits during a state fair hearing or appeal (at the enrollee's request), Magellan may recover the cost of the services furnished to the enrollee during this period if the final resolution of the appeal or hearing upholds the adverse benefit determination (p.13). The **Member Handbook** notes: "If you are approved to continue to receive care while your	Fully Met

44		· Any content required by the state for the enrollee handbook that is not covered in 42 CFR 438.10(g).	None		Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	Could not identify additional state requirements	Not Applicable
45		· Information on how the state has defined a “significant change” in the information MCPs are required to give enrollees pursuant to 42 C.F.R. § 438.10(g).	The Contractor 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		P3.24.WY2023 - 2022 WY Member Handbook P3.13.WY2023.Clinical Manual P3.34.WY2023 - wysupp - Final 2023 Provider Handbook Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	A definition of "significant change' is provided in the **Wyoming State Medicaid Managed Care Quality Strategy:** WDH defines “significant change” as a modification in the Medicaid program or managed care plans’ operations that would materially affect service delivery or receipt of benefits, including adjustments in services, benefits, geographic service area, payments, eligible populations, or other circumstances which impact delivery or measurement of the quality of services as determined by the State. Significant change may include, but is not limited to: •Addition or removal of service offerings and benefits offered to managed care plan enrollees; •System-wide changes in the composition, frequency, or amount of payments made to the provider network delivering services to enrollees; •New or amended federal and/or State regulations which impact programmatic operations. (PJ)	Fully Met
46		· 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]		P3.24.WY2023 - 2022 WY Member Handbook	The **Member Handbook** states that members have a right to "get a copy of your youth’s records. You can ask that they be changed or corrected" (p.26). It also states that members have the right to "help make decisions about your youth’s healthcare. This includes the right: – To get a second medical opinion. – To say “no” to participation. This is your right unless the court says otherwise" (p.25).	Fully Met

47	**Enrollee right to receive information on available treatment options** **Medicaid**: 42 CFR 438.100(b)(2)(iii) Enrollee right to receive information on available treatment options and alternatives . . . including requirements of 42 CFR 38.102: Provider-enrollee communications **CHIP**: 42 CFR 457.1222: Provider-enrollee communication	Information on whether or not the MCP has documented to the state any moral or religious objection to providing, reimbursing for, or providing coverage of, a counseling or referral service for a particular Medicaid and 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)	P3.24.WY2023 - 2022 WY Member Handbook	The **Member Handbook** states that members have a right to "receive information about the benefits provided by us and about benefits you might have, that are not provided by us. There are not any services we do not cover because of moral or religious objections" (p.26).	Fully Met

48	**Enrollee right to participate in decisions regarding his or her care and be free from any form of restraint** **Medicaid:** 42 CFR 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 CFR 438.3(j): Advance directives **CHIP:** 42 CFR 457.1220: Enrollee rights	•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)	P3.24.WY2023 - 2022 WY Member Handbook	The **Member Handbook** states that members have the right to "help make decisions about your youth's healthcare. This includes the right: – To get a second medical opinion. – To say "no" to participation. This is your right unless the court says otherwise" (p.25).	Fully Met
49		•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		P3.24.WY2023 - 2022 WY Member Handbook	The **Member Handbook** states that members have a right to "receive information about the benefits provided by us and about benefits you might have, that are not provided by us. There are not any services we do not cover because of moral or religious objections" (p.26).	Fully Met

50	**Compliance with other Federal and state laws** **Medicaid:** 42 CFR 438.100(d): Compliance with other federal and state laws **CHIP:** 42 CFR 457.1220: Enrollee rights	Obtain from the state Medicaid and CHIP agency the identification of all State laws that pertain to enrollee rights and with which the state Medicaid and 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) •Staff Orientation and Training Curriculum (SP)	Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	Could not identify enrollee rights with which the state Medicaid Agency requires. Magellan has a compliance officer associated with the contract to review corporate compliance. This includes compliance with enrollees' rights. Providers at the time of enrollment are tasked with explaining to patients their rights and responsibilities. Documents are also presented to enrollees and signed at enrollment. Corporate structures are also in place.	Fully Met
51	**Provider Selection** **Medicaid:** 42 CFR 438.214: Provider selection **CHIP:** 42 CFR 457.1233(a): Provider selection	•Obtain from the state information on any credentialing, re-credentialing, or other provider selection and retention requirements established by the state that address acute, primary, behavioral, substance use disorder, and MLTSS providers, as appropriate.	The Contractor must maintain and monitor a network of appropriate providers that is supported by written agreements and policies and procedures that document the process the Contractor requires for provider credentialing and re-credentialing. [SOW pg. 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	P3.34.WY2023 - wysupp - Final 2023 Provider Handbook	According to the Provider Handbook, providers must notify Magellan of changes to information reviewed during the credentialling process including but not limited to (pg. 30): o Licensure or certification, including state licensing board actions on your license, o Board certification(s), o Hospital privileges, o Insurance coverage, o New information regarding pending or settled malpractice actions. It also outlines the trainings Magellan offers for providers to undergo annual recertification (p.20)	Fully Met
52	**Sub-contractual relationships and delegation** **Medicaid:** 42 CFR 438.230: Subcontractual relationships and delegation **CHIP:** 42 CFR 457.1233(b): Subcontractual relationships and	•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	P3.16.WY2023.WY CME Data Validation- Verification Plan P3.16.WY2023.WY CMS WF-EZ OUT 13-7.13-8 Procedure P3.17.WY2023.SFY 2023WY CME QI_WorkPlan Annual Final P3.16.WY2023.Quality Improvement Program - QI.105.17 - Policy	No documents found to support standard. Magellan has not stated any delegated activites.	Fully Met

53	**Practice Guidelines** **Medicaid:** 42 CFR 438.236: Practice guidelines **CHIP:** 42 CFR 457.1233(c): Practice guidelines	•Information on any state statutory, regulatory, or policy requirements concerning MCP practice guidelines.	The Contractor is required to use practice guidelines developed using the core values and principles of the HFWA practice. Practice guidelines should be adopted in consultation with contracting health care professionals and must be reviewed and updated periodically, as appropriate. The Contractor must disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply will be consistent with the guidelines.[SOW pg. 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)	P3.13.WY2023.Clinical Manual P3.34.WY2023 - wysupp - Final 2023 Provider Handbook P3.17.WY2023.SFY 2023WY CME QI_WorkPlan Annual Final P3.16.WY2023.Quality Improvement Program - QI.105.17 - Policy P3.35.WY2023 - 2022-2023 WY CME HFWA Provider Agreement updated	Practice guidelines noted and described in detail in the **Provider Agreement.**	Fully Met
54	**Health information systems** **Medicaid:** 42 C.F.R. § 438.242 **CHIP**: 42 C.F.R. § 457.1233(d):	· Information on whether or not the state has required the MCP to undergo, or has otherwise received, a recent assessment of the MCP's health information system. If the state has required or received such an assessment, obtain a copy of the information system assessment from the state or the MCP. Also obtain contact information about the person or entity that conducted the assessment and to whom follow-up questions may be addressed.	The Contractor is required to maintain a health information system that collects, analyzes, integrates and reports data. The Contractor's health information system shall provide information on areas including, but not limited to: denials of referrals, requests; utilization; claims; enrollee and provider grievances, complaints, and appeals data; and, disenrollment for reasons other than loss of Medicaid eligibility including disenrollment requests made by an enrollee. [SOW pg. 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)	P3.13.WY2023.Clinical Manual P3.34.WY2023 - wysupp - Final 2023 Provider Handbook P3.17.WY2023.SFY 2023WY CME QI_WorkPlan Annual Final P3.16.WY2023.Quality Improvement Program - QI.105.17 - Policy	Did not find information clarifying state-required health information system assessments or past assessments in submitted documentation Magellan undergoes quarterly security testing and submits the results ot WDH.	Fully Met
55		· 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]		P3.13.WY2023.Clinical Manual P3.17.WY2023.SFY 2023WY CME QI_WorkPlan Annual Final	The **Clinical Manual** includes extensive information on the client data collected during the initial onboarding process (pg. 83-84) **Work Plan** includes list of QI measures tracked by Magellan including measures applicable to both enrollees and providers	Fully Met
56		· Information on whether or not the state has conducted a recent review and validation of the MCP's encounter data, or required the MCP to undergo, or has otherwise received, a recent validation of the MCP's encounter data. If the state has required or received such a validation review, obtain a copy of the review from the state or the MCP. Also obtain contact information about the person or entity that conducted the validation and to whom follow-up questions may be addressed.	None		P3.13.WY2023.Clinical Manual P3.34.WY2023 - wysupp - Final 2023 Provider Handbook P3.17.WY2023.SFY 2023WY CME QI_WorkPlan Annual Final P3.16.WY2023.Quality Improvement Program - QI.105.17 - Policy P3.35.WY2023 - 2022-2023 WY CME HFWA Provider Agreement updated	Did not find other information clarifying state-required health information system assessments or past assessments. Magellan undergoes quarterly security testing and submits the results ot WDH.	Fully Met

57		· State specifications for how MCPs are to (1) collect data elements necessary to enable the mechanized claims processing retrieval systems to provide for electronic transmission of claims data in the format consistent with the Transformed Medicaid Statistical Information System (T-MSIS); (2) collect and transmit data on enrollee and provider characteristics specified by the state, on all services furnished to enrollees through an encounter data system; and (3) Ensure that data received from providers is accurate and complete	The Contractor must 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]		Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules P3.14.WY2023.Magellan WY CME Quality Annual Program Evaluation SFY2023 pages P3.17.WY2023.SFY 2023WY CME QI_WorkPlan Annual Final		Fully Met
58		· Specifications for submitting encounter data to the Medicaid/CHIP agency in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format.	Magellan PMPM claims will be submitted to the Agency in standardized Accredited Standards Committee (ASC) X12N 837 format, the ASC X12N 835 format, and EDI 270/271 Eligibility Benefit Inquiry and Response formats, as appropriate. [SOW pg. 30]		Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	**9.24.2021: Chapter 47 of Wyoming's Department of Health Administrative Rules** included guidelines to ensure that enrollee encounter data was submitted to the state: Section 15 (Provider Record keeping and Data Collection): "For the purposes of data collection, the Medicaid Management Information System shall capture all eligibility data as well as claims and encounter data" (pg. 10) In reviewed documents, could not identify process for submitting encounter data Magellan submits data in accordance with the standard	Fully Met
59		· Make all collected data available to the state and upon request to CMS.	The Contractor is required to maintain a health information system that collects, analyzes, integrates and reports data. The Contractor's health information system shall provide information on areas including, but not limited to: denials of referrals, requests; utilization; claims; enrollee and provider grievances, complaints, and appeals data; and, disenrollment for reasons other than loss of Medicaid eligibility including disenrollment requests made by an enrollee. [SOW pg. 9]		Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	**9.24.2021: Chapter 47 of Wyoming's Department of Health Administrative Rules** included guidelines to ensure that enrollee encounter data was submitted to the state: Section 15 (Provider Record keeping and Data Collection): "For the purposes of data collection, the Medicaid Management Information System shall capture all eligibility data as well as claims and encounter data" (pg. 10) In reviewed documents, could not identify process for sharing data with the state 11.17.2021: Systems are set up to easily create reports that can be shared with the state and other appropriate stakeholders. (KL) Magellan has assured that WDH has access to the Fidelity EHR data	Fully Met
60		· The state's procedures and quality assurance protocols to ensure that enrollee encounter data submitted by the MCP is a complete and accurate representation of the services provided to its enrollees.	The Contract also establishes expectation around continuous quality improvement that includes participating in the development of measures of performance and collecting and reporting baseline data on identified performance indicators, and development and implementation of improvement plans. Measures must be designed with the goal of maintaining quality of services, controlling costs and are consist with its responsibilities to enrollees. The results are reported to the Agency and the Agency discusses the findings and identifies opportunities for improvements. In addition, this information aids in the assessment of the effectiveness of the quality improvement process. The data from all sources is analyzed for compliance. The identified aspects are integrated into the implementation of continuous quality improvement processes. The findings will be included in the Contractor's performance evaluation. The Agency will require the Contractor to undergo annual, external independent reviews of the quality, timeliness, and access to the services covered under this contractual agreement. [SOW pg. 9-10]		Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules	**9.24.2021: Chapter 47 of Wyoming's Department of Health Administrative Rules** included guidelines to ensure that enrollee encounter data was submitted to the state: Section 15 (Provider Record keeping and Data Collection): "For the purposes of data collection, the Medicaid Management Information System shall capture all eligibility data as well as claims and encounter data" (pg. 10) Section 10 (Quality Reporting): (a) The Department shall perform, at minimum, quarterly monitoring of the CME 1915(b) waiver program's impact, access, and quality to ensure access to adequate services where medically necessary. (i) The Department shall establish standards of quality for CME adherence, including, but not limited to, plan assurances on network adequacy. (ii) The Department shall deem the CME in compliance with standards as long as the accrediting agency maintains standards as required by the Department. (pg.10)	Fully Met
Quality Assessment and Performance Improvement							

61	**Quality Assessment and Performance Improvement: General rules** **Medicaid:** 42 CFR 438.330(a): General rules **CHIP:** 42 CFR 457.1240(b): Quality assessment and performance improvement program	•In the event that CMS specifies national performance measures or PIP topics, whether or not the state has requested an exemption from the national performance measures or PIPs.	None	•MCP QAPI implementation documentation (AM)	P3.14.WY2023.Magellan WY CME Quality Annual Program Evaluation SFY2023 pages 24-37 P3.14.WY2023.Quality Improvement Program Policy pp 3-4, 6-7	This is a corporate document and very clinical in nature. There is nothing that discusses or was added the WY specific policies or even addressed the WY population.	Partially Met
62	**Basic elements of quality assessment and performance improvement program** **Medicaid:** 42 CFR 438.330(b): Basic elements of quality assessment and performance improvement programs **CHIP:** 42 CFR 457.1240(b): Quality assessment and performance improvement program	· The state's specifications for performance improvement projects (PIPs) required per paragraph (d) of this section.	The Contractor is required to establish and implement an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) program for the services it furnishes to its enrollees. The QAPI program must include Performance Improvement Projects (PIP), including any required by the Agency or CMS. [SOW pg. 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) •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.	P3.14.WY2023.Magellan WY CME Quality Annual Program Evaluation SFY2023 pages 24-37 P3.14.WY2023.Quality Improvement Program Policy pp 3-4, 6-8	The Quality Improvement Program Policy establishes and outlines Magellan's QAPI program while the Annual Program Evalation is the annual evaluation of the QAPI. The actual QAPI was not submitted. The objectives and components of the QAPI should be more quantative to ensure a more valid evaluation. There were also areas to improve on the stakeholder engagement, surveys, and audit findings.	Partially Met
63		· 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]		P3.14.WY2023.Magellan WY CME Quality Annual Program Evaluation SFY2023 pages 24-37 P3.15. WY2023.Engagement and Implementation PIP SFY 2023 Final pages 1-4 P3.15.WY2023.Improving the Prior Authorization Process PIP SFY 2023 Final pages 1-6 P3.15.WY2023.Increase the number of Family Care Coordinators and Respite providers PIP SFY 2023 pages 1-3	PIPs were submitted but for more indepth evaluation please refer to Protocol 1 findings.	Partially Met
64		· The state's requirements for detection by the MCP of over- and under-utilization.	The Contractor is required to establish and implement an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) program for the services it furnishes to its enrollees...Activities of the QAPI program must include mechanisms to detect both underutilization and overutilization of service. [SOW pg. 20]		P3.14.WY2023.Magellan WY CME Quality Annual Program Evaluation SFY2023 pages 24-37	While over and underutilization was discussed the vendor's definition of each was not clarified. The analysis only evaluated year to year claims and not against actual appropriate number of claims per recipient.	Partially Met
65		· The state's requirements for assessment by the MCP of the quality and appropriateness of care furnished to enrollees with special health care needs, as defined in the state's quality strategy under 438.340 (as cross-referenced for CHIP in 457.1240(e)).	The Contractor must include mechanisms to assess the quality and appropriateness of care coordination furnished to enrollees with special health care needs. [SOW pg. 20]		P3.14.WY2023.Magellan WY CME Quality Annual Program Evaluation SFY2023 pages 24-38	The whole population of the vendor would be considered enrollees with special health care needs. Through the documents and the interviews of the staff they clearly are dedicated and know how to provide appropriate care to the recipients. The documentation of such services could be improved to better demonstrate the care and processes in their policies and procedures.	Fully Met

66		· The state's requirements for assessment by the MCP of the quality and appropriateness of care furnished using LTSS, if applicable, including assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan.	Not Applicable		P3.15.WY2023. Magellan WY CME Quality Annual Program Evaluation SFY2023 Final pages 9, 25	The list of accomplishments is focused on changes to documents and completing contract requirements. They discuss increased respondents of the satisfaction survey but no discussion or mention on survey results. The goals are aspirational but there is no objective, measurable targets identified to determine progress. In the discussion of the provider network there is no statistics or numbers and location of providers. They do address the gender of providers which doesn't seem to be applicable or relevant. There is also no discussion to the access standards in the SOW. There is no listing of any of the performance metrics just that they use them. There was no discussion as to the termination and final outcomes of the Engagement and Implementation PIP. The is no discussion to actual measurable objectives for any of the PIPs. For the initiatives listed on pg. 36 and 37, it was not discussed if it was for providers or staff and most of the items were contractual requirements and not additional initiatives to improve quality. For the provider reviews there was several items that were consistently called out. There was no discussion on efforts to address it proactively, or the plan to expand auditing to a larger sample. The response rates for satisfaction surveys is very small. The analysis of utilization was not very clear, it focused more on number of claims rather than did claims match authorized services and service plans.	Not Met
67		· The state's requirements for the MCP's participation in efforts by the State to prevent, detect, report, investigate and remediate critical incidents, that occur within the delivery of LTSS as well as to track and trend results in order to make systems improvements, if applicable	Not Applicable		P3.14.WY2023.OPS 8-19 Critical Incidents Business Review Document	Adequate critical incident reporting policy.	Fully Met
68	**Performance measurement** **Medicaid:** 42 CFR 438.330(c): Performance measurement **CHIP:** 42 CFR 457.1240(b): Quality assessment and performance improvement program	· 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)	P3.14.WY2023.Magellan WY CME Quality Annual Program Evaluation SFY2023 pages 24-37 P3.16.WY2023.WY CME Data Validation- Verification Plan P3.14.WY2023.Summary Data FY23	The performance measures are documented but based on the evlauation from Protocol 2, PMs should match the PMs identified in the SOW. Overall the vendor does have documented processes and a staff who are familiar with the data and the systems to calculate the measures.	Fully Met
69		· For an MCP providing long-term services and supports, the standard performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving long-term services and supports.	Not Applicable		P3.14.WY2023.Magellan WY CME Quality Annual Program Evaluation SFY2023 pages 24-37 P3.16.WY2023.WY CME Data Validation- Verification Plan P3.14.WY2023.Summary Data FY23	The performance measures are documented but based on the evlauation from Protocol 2, PMs should match the PMs identified in the SOW. Overall the vendor does have documented processes and a staff who are familiar with the data and the systems to calculate the measures.	Fully Met
70		· Information on whether the MCP calculates the performance measure and reports to the state or whether the MCP provides data to the state, which then calculates the PM.	Data on performance measures is reported to the Agency quarterly or as otherwise listed in the contractual requirements negotiated between the Agency and Contractor. The quarterly reports to the Agency aid in the identification of opportunities for quality improvement and the assessment of Contractor effectiveness. [SOW pg. 9]		P3.14.WY2023.Magellan WY CME Quality Annual Program Evaluation SFY2023 pages 24-37 P3.16.WY2023.WY CME Data Validation- Verification Plan P3.14.WY2023.Summary Data FY23	The performance measures are documented but based on the evlauation from Protocol 2, PMs should match the PMs identified in the SOW. Overall the vendor does have documented processes and a staff who are familiar with the data and the systems to calculate the measures.	Fully Met

71	**Performance improvement projects** **Medicaid:** 42 CFR 438.330(d) and **CHIP:** 42 CFR 457.1240(b)	· Information on any PIP requirements specified by the state.	The Contractor's PIP status and results will be reported to the Agency no less than once a year and include at least the following elements: A. Demonstration of significant improvement, sustained over time, in health outcomes and enrollee satisfaction; B. Measurement of performance using objective quality indicators; C. Implementation of interventions to achieve improvement in the access to and quality of care; D. Evaluation of the effectiveness of the interventions based on the performance measures; and, E. Planning and initiation of activities for increasing or sustaining improvement [SOW pg. 20]	•Reports and status documentation of MCP internal QAPI evaluations (AM)	P3.14.WY2023.Magellan WY CME Quality Annual Program Evaluation SFY2023 pages 24-37 P3.15. WY2023.Engagement and Implementation PIP SFY 2023 Final pages 1-4 P3.15.WY2023.Improving the Prior Authorization Process PIP SFY 2023 Final pages 1-6 P3.15.WY2023.Increase the number of Family Care Coordinators and Respite providers PIP SFY 2023 pages 1-3	PIPs were submitted but for more indepth evaluation please refer to Protocol 1 findings.	Fully Met
72		· Information on how often the state requests that each MCP report the status and results of each project conducted per paragraph (d)(1) of this section.	The Contractor's PIP status and results will be reported to the Agency no less than once a year and include at least the following elements: A. Demonstration of significant improvement, sustained over time, in health outcomes and enrollee satisfaction; B. Measurement of performance using objective quality indicators; C. Implementation of interventions to achieve improvement in the access to and quality of care; D. Evaluation of the effectiveness of the interventions based on the performance measures; and, E. Planning and initiation of activities for increasing or sustaining improvement [SOW pg. 20]		P3.14.WY2023.Magellan WY CME Quality Annual Program Evaluation SFY2023 pages 24-37 P3.15. WY2023.Engagement and Implementation PIP SFY 2023 Final pages 1-4 P3.15.WY2023.Improving the Prior Authorization Process PIP SFY 2023 Final pages 1-6 P3.15.WY2023.Increase the number of Family Care Coordinators and Respite providers PIP SFY 2023 pages 1-3	PIPs were submitted but for more indepth evaluation please refer to Protocol 1 findings.	Fully Met
73		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		N/A	N/A	Not Applicable
74	**QAPI evaluations review** **Medicaid:** 42 CFR 438.330(e)(2): Program and review by the state **CHIP:** 42 CFR 457.1240(b): Quality assessment and performance improvement program	•Information on whether the state requires its MCPs to develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program. If so, information on the frequency with which that evaluation must be conducted, and on the state's requirements for how MCPs conduct that process.	The Contractor's PIP status and results will be reported to the Agency no less than once a year and include at least the following elements: A. Demonstration of significant improvement, sustained over time, in health outcomes and enrollee satisfaction; B. Measurement of performance using objective quality indicators; C. Implementation of interventions to achieve improvement in the access to and quality of care; D. Evaluation of the effectiveness of the interventions based on the performance measures; and, E. Planning and initiation of activities for increasing or sustaining improvement [SOW pg. 20]	•Reports and status documentation of MCP internal QAPI evaluations (AM)	P3.15.WY2023. Magellan WY CME Quality Annual Program Evaluation SFY2023 Final pages 9, 25	The list of accomplishments is focused on changes to documents and completing contract requirements. They discuss increased respondents of the satisfaction survey but no discussion or mention on survey results. The goals are aspirational but there is no objective, measurable targets identified to determine progress. In the discussion of the provider network there is no statistics or numbers and location of providers. They do address the gender of providers which doesn't seem to be applicable or relevant. There is also no discussion to the access standards in the SOW. There is no listing of any of the performance metrics just that they use them. There was no discussion as to the termination and final outcomes of the Engagement and Implementation PIP. The is no discussion to actual measurable objectives for any of the PIPs. For the initiatives listed on pg. 36 and 37, it was not discussed if it was for providers or staff and most of the items were contractual requirements and not additional initiatives to improve quality. For the provider reviews there was several items that were consistently called out. There was no discussion on efforts to address it proactively, or the plan to expand auditing to a larger sample. The response rates for satisfaction surveys is very small. The analysis of utilization was not very clear, it focused more on number of claims rather than did claims match authorized services and service plans.	Partially Met

Grievance System							
75	**Grievance Systems** **Medicaid**: 42 C.F.R. § 438.228: Grievance and appeal systems	•Obtain information on: •Whether or not the Medicaid/CHIP agency delegates responsibility to the MCP for providing each enrollee (who has received an adverse decision with respect to a request for a covered service) notice that he or she has the right to a state fair hearing or review to reconsider their request for the covered service.	In the event the Contractor makes an adverse action notification regarding an enrollee or if the action is a denial of payment, written notice of the adverse action notification must be mailed to the enrollee on the date of determination. All notices of adverse action notifications must, at a minimum, explain the determination, reasons for the determination, right to retrieve applicable and related copies of documents and records of the grievance, how and the right to appeal or request State fair hearing. Notices must also include information regarding the expedition of the right to appeal, and the continuation of benefits. [SOW pg. 16]	•MCP QAPI implementation documentation (AM)	P3.29.WY2023.WY CME Grievance Procedure Review Final Approved P3.40.WY2023.Clinical Manual Nonauthorizations P3.34.WY2023 - wysupp - Final 2023 Provider Handbook P3.26.WY2023 Notice of Action Letter P3.29.WY2023.Medicaid Adverse Benefit Determination Appeal Policy	The **Clinical Manual Nonauthorizations** states that a clinical nonauthorization is indicated in the EHR during review, upon which the EHR triggers an automated administrative nonauthorization letter to be printed and mailed to the youth's guardian by "Magellan corporate supports" (p.1,2). The **Notice of Action Letter** notes that providers have the right to speak to the reviewer that made the approval decision and that the individual has a right to appeal the decision as well as the process for doing so. It also provides information on continuation of benefits, access to health records, and right to retrieve records that led to the determination. Magellan has not updated the field description in the documentation. The cusotmizable fields autopopulates from the EHR describing the reason for non-authorization of a service.	Fully Met
76	**General requirements** **Medicaid:** 42 C.F.R. § 438.402: General requirements **CHIP:** 42 C.F.R. § 457.1260: Grievance system	· Information on: · Whether enrollees are required or permitted to file a grievance with either the state or the MCP, or both	None	•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) •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,	P3.24.WY2023 - 2022 WY Member Handbook	The **Member Handbook** states that participants are to send grievances to the MCO (p.29) and appeals via a State Fair Hearing to the Wyoming Department of Health (p.30).	Fully Met
77		· Whether providers, or authorized representatives, can act on behalf of the enrollee to request an appeal, file a grievance, or request a state fair hearing or review request.	Appeals can be filed orally or in writing by the enrollee or an authorized representative, including the provider, within sixty (60) calendar days from the date on the adverse action notice. [SOW pg. 15]		P3.29.WY2023.Medicaid Adverse Benefit Determination Appeal Policy P3.24.WY2023 - 2022 WY Member Handbook	The **Medicaid Adverse Benefit Determination Appeal Policy** states that "a member may designate an authorized representative to request an appeal and participate in the appeal process on his/her behalf" (p.3). It also notes that a provider or authorized representative may request an appeal, file a grievance, or request a State fair hearing on behalf of a participant if that participant has provided written consent (p.3) The **Member Handbook** states that an enrollee has 60 calendars from the date of a written adverse determination letter to file an appeal (p.29). The **Medicaid Adverse Determination Appeal Policy** provides context in which an enrollee or provider may file the appeal orally or in writing (p.10)	Fully Met
78		Whether state offers external medical review.	None		P3.29.WY2023.Medicaid Adverse Benefit Determination Appeal Policy	The **Medicaid Adverse Benefit Determination Appeal Policy** confirms that the State may offer and arrange for an external medical review (p.13). It requires that the following conditions be met in order for the external medical review to occur: 1. The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing; 2. The review must be independent of both the State and MCO; 3. The review must be offered without any cost to the enrollee; 4. The review must not extend any of the timeframes specified in 42 CFR § 438.408 as outlined in this policy; and 5. The review must not disrupt the continuation of benefits in § 438.420 as outlined in this policy.	Fully Met

79	**Timely and Adequate Notice of Adverse Benefit Determination** **Medicaid:** 42 C.F.R. § 438.404: Timely and adequate notice of adverse benefit determination **CHIP**: 42 C.F.R. § 457.1260: Grievance system	•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)	P3.34.WY2023 - wysupp - Final 2023 Provider Handbook P3.13.WY2023.Clinical Manual	The **Provider Handbook** states that Magellan will review prior authortization requests for continuous care within a 14-day timeframe (p.6), but the period is stated to being when a complete request is received. According to the **Clinical Manual**, 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 (p.53). It also stated that any extension Magellan grants to itself requires written notification to the participant that includes notification of their right to file a grievance. The **Provider Handbook** outlines the process for an initial prior authorization that differs from that described in the **Clinical Manual.** It consists of a 46 day prior authorization following approval of a HFWA application that takes an undisclosed number of days to process (p.119). The next set of guidelines expands on this, noting that Magellan will issue a notice of application submission and enrollment 14 days after application submission (p.120).	Fully Met
80	**Handling of Grievances and Appeals** **Medicaid**: 42 C.F.R. § 438.406: Handling of grievances and appeals **CHIP**: 42 C.F.R. § 457.1260: Grievance system	•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)	P3.29.WY2023.Medicaid Adverse Benefit Determination Appeal Policy	The **Medicaid Adverse Benefit Determination Appeal Policy** has language in it defining procedures that perfectly match those set forth in the contract language. There are, thus, no differences between these set of standards and those required by the State.	Fully Met
81	**Resolution and notification: Grievances and appeals** **Medicaid:** 42 C.F.R. §438.408: Resolution and notification, Grievances and appeals **CHIP**: 42 C.F.R. § 457.1260: Grievance system	· 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)	P.3.29.WY2023.WY CME Grievance Procedure Review Final Approved P3.29.WY2023.Medicaid Adverse Benefit Determination Appeal Policy	The **Grievance Procedure Review** states that Magellan will provide a response to all grievances within 90 calendar days from the receipt of the greivance (p.2). It also states that the timeframe can be extended by up to 14 days. It states that Magellan may request an extension 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; • Magellan makes reasonable efforts to give the enrollee prompt oral notice of the delay; • Within two (2) calendar days, Magellan gives the enrollee written notice of the reason for the decision to extend the timeframe and informs the enrollee of the right to file a grievance if he or she disagrees with the decision to extend the time frame.	Fully Met

82		· The methods prescribed by the state that the MCP must follow to notify an enrollee of the disposition of a grievance.	**The Contractor must resolve grievances and provide notice according to the enrollee's health condition, no more than ninety (90) calendar days from grievance receipt.** The Contractor can choose to extend the grievance timeline by up to fourteen (14) calendar days if the enrollee requests an extension or the Contractor justifies a need for additional information and is able to demonstrate how the extension is in the enrollee's best interest. If delayed, the Contractor must provide reasonable efforts to give oral notification, provide written notice within two (2) calendar days, and inform of the right to file a grievance if in disagreement of the delay. Written notice must also be provided to the enrollee of grievance resolution in a reasonable format. [SOW pg. 15]		Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rule P.3.29.WY2023.WY CME Grievance Procedure Review Final Approved P3.29.WY2023.Medicaid Adverse Benefit Determination Appeal Policy P3.34.WY2023 - wysupp - Final 2023 Provider Handbook	**Chapter 47** states: "The CME shall acknowledge in writing, via certified mail, the receipt of a written or oral grievance or complaint within five (5) working days of receipt" (pg. 15). The **Grievance Procedure Review** states that Magellan's Quality Clinical Reviewer provides timely acknowledgement in writing of receipt of the grievance (p.1). The **Medicaid Adverse Benefit Determination Appeal Policy** notes that a written acknowledgement of the filing of a Standard Adverse Benefit Determination appeal is sent to the appellant within 15 days of filing (p.8). The **Provider Handbook** notes that a grievance will be responded to in writing within 2 business days from the date of receipt (p.58).	Fully Met
83		· Information on whether providers, or authorized representatives, can act on behalf of the enrollee to request an appeal, file a grievance, or request a state fair hearing request.	Appeals can be filed orally or in writing by the enrollee or an authorized representative, including the provider, within sixty (60) calendar days from the date on the adverse action notice. [SOW pg. 15]		P3.29.WY2023.Medicaid Adverse Benefit Determination Appeal Policy P3.24.WY2023 - 2022 WY Member Handbook	The **Member Handbook** states that an enrollee has 60 calendar days from the date of a written adverse determination letter to file an appeal (p.29). The **Medicaid Adverse Determination Appeal Policy** provides context in which an enrollee or provider may file the appeal orally or in writing (p.10). The **Medicaid Adverse Benefit Determination Appeal Policy** states that "a member may designate an authorized representative to request an appeal and participate in the appeal process on his/her behalf" (p.3). It also notes that a provider or authorized representative may request an appeal, file a grievance, or request a State fair hearing on behalf of a participant if that participant has provided written consent (p.3).	Fully Met
84	**Expedited resolution of appeals** **Medicaid**: 42 C.F.R. § 438.410: Expedited resolution of appeals **CHIP:** 42 C.F.R. § 457.1260: Grievance system	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)	P3.29.WY2023.Medicaid Adverse Benefit Determination Appeal Policy	The **Medicaid Adverse Benefit Determination Appeal Policy** states that Magellan complies with the requirement when handling Adverse Benefit Determination appelas in which participants are given a "reasonable opportunity to present evidence and testimony, and allegations of fact or law make legal and factual arguments, in person as well as in writing" (p.4). It also notes that "the appeal process is completed (disposition rendered) and notice issued, as expeditiously as the member's health condition requires" (p.5). It states that the time frame for disposition and notice following an appeal is 30 calendar days after receipt of the appeal (p.11).	Fully Met

85	**Information about the grievance system to providers and subcontractors** **Medicaid**: 42 C.F.R. § 438.414: Information about the grievance and appeal system to providers and subcontractors **CHIP:** 42 C.F.R. § 457.1260: Grievance system	· Information on: · Whether the state develops or approves the MCP's description of its grievance system that the MCP is required to provide to all Medicaid/CHIP enrollees (per 438.10(g)(2)(xi). [Note that under regulations at 42 C.F.R. § 438.10(g)(1) the state must either develop a description for use by the MCP or approve a description developed by the MCP.]	The Contractor must resolve grievances and provide notice according to the enrollee's health condition, no more than ninety (90) calendar days from grievance receipt. The Contractor can choose to extend the grievance timeline by up to fourteen (14) calendar days if the enrollee requests an extension or the Contractor justifies a need for additional information and is able to demonstrate how the extension is in the enrollee's best interest. If delayed, the Contractor must provide reasonable efforts to give oral notification, provide written notice within two (2) calendar days, and inform of the right to file a grievance if in disagreement of the delay. Written notice must also be provided to the enrollee of grievance resolution in a reasonable format. [SOW pg. 15] d. The written notice must be in a format and language that meets the requirements of 42 C.F.R. 438.10 and include the results and date of the appeal resolution, the right to request a State fair hearing, request and receive benefits, and notice of liability of cost. [SOW pg. 15] If the provider indicates or the Contractor determines, that following the standard authorization and/or adverse action decision time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice no later than seventy-two (72) hours after receipt of the request for service. This may be extended up to fourteen (14) calendar days if the enrollee requests an extension or the Contractor justifies a need for additional information and is able to demonstrate how the extension is in the enrollee's best interest. [SOW pg. 16]	•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)	Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rule P.3.29.WY2023.WY CME Grievance Procedure Review Final Approved P3.29.WY2023.Medicaid Adverse Benefit Determination Appeal Policy P3.34.WY2023 - wysupp - Final 2023 Provider Handbook	The Medicaid Enrollee Grievances Document has signatures which show that the description of the MCP's grievance system was approved internally by Magellan. However, the document does not show approval from contacts at the State. (pg. 1) The **Member Handbook** document states that an individual has a right to a 72 hour appeal process if the provider indicates that foregoing the service could seriously harm the enrollee's health (p.29).	Fully Met
86		If the states approves, rather than develops, the description of the MCP's grievance system, information on whether or not the state has already approved the MCP's description.	[Language removed from SOW]		P3.29.WY2023.Medicaid Adverse Benefit Determination Appeal Policy	The **Medicaid Adverse Benefit Determination Appeal Policy** document has signatures which show that the description of the MCP's grievance system was approved internally by Magellan. However, the document does not show approval from contacts at the State. (pg. 1) Magellan collaborated with WDH on creation of the grievance system, which was approved by WY.	Fully Met

87	**Recordkeeping requirements** **Medicaid:** 42 C.F.R. § 438.416: Recordkeeping requirements **CHIP:** 42 C.F.R. § 457.1260: Grievance system	•Information on any audits or other reviews of MCP records of grievances and appeals conducted by the state	The Contractor must also ensure that individuals making decisions regarding grievance and appeals are free of conflict, were not involved in any previous level of review or decision making, have appropriate clinical expertise for treatment, if applicable, and must consider all submitted documents and information, considered at any level of the grievance and appeal process. The Contractor must accurately maintain records of grievances and appeals, in a manner accessible to the Agency and available upon request to CMS. Records of grievances or appeals must include a general description of the reason for the appeal or grievance, date received, date of each review or, if applicable, review meeting, resolution information for each level of the appeal or grievance, if applicable, date of resolution at each level, if applicable, and enrollee name for whom the appeal or grievance was filled. [SOW pg. 15]	•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)	P3.29.WY2023.Medicaid Adverse Benefit Determination Appeal Policy	The **Medicaid Adverse Benefit Determination Appeal Policy** states that Magellan complies with the requirement when handling Adverse Benefit Determination appelas in which participants are given a "reasonable opportunity to present evidence and testimony, and allegations of fact or law make legal and factual arguments, in person as well as in writing" (p.4). It also notes that "the appeal process is completed (disposition rendered) and notice issued, as expeditiously as the member's health condition requires" (p.5). It states that the time frame for disposition and notice following an appeal is 30 calendar days after receipt of the appeal (p.11).	Fully Met
88	**Continuation of benefits while the MCP appeal and the state Fair Hearing are pending** 42 C.F.R. § 438.420: Continuation of benefits while the MCO, PIHP, or PAHP appeal and the state fair hearing are pending (Note: This requirement does not apply to CHIP)	· Information on any state requirements concerning continuation of benefits pending appeal and state fair hearing that differ from those required under 42 C.F.R. § 420.	The Contractor must continue the enrollee's benefits if the enrollee files a request for an appeal within sixty (60) calendar days from the adverse action notification, if the appeal involves termination, suspension, or reduction of a previously authorized service, if the enrollee's services were ordered by a provider, and the original authorization has not expired. The request for continuation of benefits must be filed within ten (10) calendar days or the intended effective date of adverse action notification, whichever is later. If, at the enrollee's request, the Contractor continues or reinstates the enrollee's benefits while the appeal or request for State fair hearing is pending, the benefits must continue until the enrollee withdraws the appeal, fails to timely request continuation of benefits, or a State fair hearing decision adverse to the enrollee is issued. If the final resolution of appeal or State fair hearing upholds the adverse action, the Contractor may recover in accordance with State policies, the costs of the enrollee's continued benefits. If services were not furnished during the appeal, the Contractor must authorize or provide the services as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours from the date that the State fair hearing officer reverses a decision to deny, limit or delay services. The Contractor must pay for disputed services if the decision to deny, limit or delay services was overturned. [SOW pg. 17]	•Medicaid enrollee grievance and appeals policies and procedures (ES)	P3.29.WY2023.Medicaid Adverse Benefit Determination Appeal Policy Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rule	The **Medicaid Adverse Benefit Determination Appeal Policy** states that continuation of benefits pending a trial or state fair hearing are in accordance with 42 C.F.R. § 420 (pg. 12). **Chapter 47 of Wyoming's Department of Health Administrative Rule**s states: "The CME's grievance and one-level appeal process must adhere to the timeframes specified in 42 C.F.R. §438.400 and §438.424" (Section 22; pg. 15)	Fully Met
89		· 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	P3.29.WY2023.Medicaid Adverse Benefit Determination Appeal Policy Chapter 47: Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rule	The **Medicaid Adverse Benefit Determination Appeal Policy** states that the MCO maintains a record of appeals that contains, at a minimum (pg. 13-14): 1. A general description of the reason for the appeal; 2. The date received; 3. The date of each review or, if applicable, review meeting; 4. Resolution at each level of the appeal, if applicable; 5. Date of resolution at each level, if applicable; and 6. Name of the covered person for whom the appeal was filed.	Fully Met
90		Whether state permits managed care plans to recover the cost of services. See (d) reference to "state's usual policy."	If the final resolution of appeal or State fair hearing upholds the adverse action, the Contractor may recover in accordance with State policies, the costs of the enrollee's continued benefits. [SOW pg. 17]	P3.29.WY2023.Medicaid Adverse Benefit Determination Appeal Policy	The **Medicaid Adverse Benefit Determination Appeal Policy** states that if an enrollee continues receiving benefits during a state fair hearing or appeal (at the enrollee's request), Magellan may recover the cost of the services furnished to the enrollee during this period if the final resolution of the appeal or hearing upholds the adverse benefit determination (p.13).	Fully Met

91	**Effectuation of reversed appeal resolutions** **Medicaid**: 42 C.F.R. § 438.424: Effectuation of reversed appeal resolutions. **CHIP**: 42 C.F.R. § 457.1260: Grievance system	•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)	P3.29.WY2023.Medicaid Adverse Benefit Determination Appeal Policy The **Medicaid Adverse Benefit Determination Appeal Policy** states "If Magellan or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, Magellan or the State must pay for those services, in accordance with State policy and regulations" (pg.12)	The **Medicaid Adverse Benefit Determination Appeal Policy** states "If Magellan or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, Magellan or the State must pay for those services, in accordance with State policy and regulations" (pg.12). WDH is liable for services.	Fully Met

Appendix H: Protocol 4 - Network Adequacy Review Tool

Wyoming CME - EQR Network Adequacy Tool

No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2021 Contract Language	Findings from CME Documentation (2024)	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].	The **Network Development Plan** states that Magellan has instituted distance standards based on a participant's residence in a rural or urban area. Members living in urban areas are to have a provider located within 10 miles of their residence. Members living in rural areas are to have a provider located within 50 miles of their residence. However, all HFWA providers (specifically FCCs) are capable to providing services virtually. Despite these access standards and data/graphics submitted to demonstrate where Magellan is regarding adherence to the network standards, there is no longer a discussion of the provider to participant ratios. Magellan reported that the QI workgroup meets weekly to manage provider caseloads (as evidenced by a **Weekly Provider Caseload Report** example) and assign providers to participants in need of services. There are no measures regarding ratios or met/unmet capacity and/or needs reported to WDH on a regular basis, according to the submitted documentation. Magellan adheres to their set standards and submits data related to those standards to WDH for review, but their standards could be improved to more fully and objectively reflect member access to services and providers. Further, Magellan reported only Family Care Coordination being a required waiver service for all participants. This, however, does not address the need for access and measurement of access to the additional HFWA services that the CME is obligated to provide to members with the service in their Plan of Care. While FCC is the only "required" service, network adequacy for the other services are necessary for compliance with all contractual obligations moving forward. The **Network Development Plan** and **Network Adequacy Framework** speaks to outrach and network growth strategies employed by Magellan to meet standards for respite providers, YSPs, and FSS. Measures to outline network goals and progress towards those goals would improve Magellan's demonstration of contractual service fulfillment and access/network adequacy across all HFWA services.	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 (2024)	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	Not applicable.
2b	(ii)	OB/GYN.	Not applicable.	Not applicable.	Not applicable.
2c	(iii)	Behavioral health (mental health and substance use disorder), adult and pediatric.	Not applicable.	Not applicable.	Not applicable.
2d	(iv)	Specialist, adult and pediatric.	Not applicable.	Not applicable.	Not applicable.
2e	(v)	Hospital.	Not applicable.	Not applicable.	Not applicable.
2f	(vi)	Pharmacy.	Not applicable.	Not applicable.	Not applicable.
2g	(vii)	Pediatric dental.	Not applicable.	Not applicable.	Not applicable.
2h	(viii)	Additional provider types when it promotes the objectives of the Medicaid program, as determined by CMS, for the provider type to be subject to time and distance access standards.	Not applicable.	Not applicable.	Not applicable.
3	**(b)(2)**	*LTSS.* States with MCO, PIHP or PAHP contracts which cover LTSS must develop:			
3a	(i)	Time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services; and	Not applicable.	Not applicable. This program not does include LTSS.	Not applicable.
3b	(ii)	Network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services.	Not applicable.	Not applicable. This program not does include LTSS.	Not applicable.
4	**(b)(3)**	*Scope of network adequacy standards*. Network standards established in accordance with paragraphs (b)(1) and (2) of this section must include all geographic areas covered by the managed care program or, if applicable, the contract between the State and the MCO, PIHP or PAHP. States are permitted to have varying standards for the same provider type based on geographic areas.	The Contractor must serve all 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	The **Network Development Plan** states that Magellan has instituted distance standards based on a participant's residence in a rural or urban area. Members living in urban areas are to have a provider located within 10 miles of their residence. Members living in rural areas are to have a provider located within 50 miles of their residence. However, all HFWA providers (specifically FCCs) are capable to providing services virtually. Despite these access standards and data/graphics submitted to demonstrate where Magellan is regarding adherence to the network standards, there is no longer a discussion of the provider to participant ratios. The **Network Development Plan** also notes the number of children with SED enrolled in Medicaid, the HFWA population, and the provider population in each WY county through a comprehensive map graphic (p.36). Magellan identifies urban areas that meet network goals of providers located within 10 miles of participants in another map graphic. This shows that 13 urban areas currently meet the established standard, while 4 urban areas do not (p.38). While large swaths of the state are shown to meet rural area adequacy standards, 31 rural areas where participants live do not meet adequacy standards (p.35) and are targeted for network expansion efforts.	1. Complete

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No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2021 Contract Language	Findings from CME Documentation (2024)	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]	According to the **Clinical Manual**, "Youth ages 6-20 must have minimum Child and Adolescent Service Intensity Instrument (CASII) composite score of twenty (20)" and "Youth ages 4 & 5 must have an Early Childhood Intensity Instrument (ECSII) score of eighteen (18) to thirty (30) OR the appropriate social and emotional assessment information provided to illustrate level of service needs" in order for Magellan to enroll the participant in the WY HFWA program (p. 25). The documentation submitted by Magellan did not feature any descriptions of potential participant outreach and engagement to offer services to more individuals.	2. Incomplete
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]	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 **Provider Directory Update Policy** notes that provider information automatically updates in the provider registry as provider information changes through the provider enrollment portal. The **QI Workplan** states that Magellan measures utilization of all HFWA services against expected utilization and goals, submitting quarterly utilization reports to WDH. Participants' Plans of Care are used to check expected utilization and assess access based on actualized utilization (p.61) The **QI Workplan** also notes that utilization data is "primarily used for provider and enrollee monitoring, but also used to monitor enrollment/disenrollment, quality of care, and coverage/authorization (p. 61).	1. Complete
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]	The **Network Development Plan** includes a summary of enrollee demographics. Listed demographics include race / ethnicity, age, gender, and behavioral health diagnosis. It also notes that "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 (p.26). The **QI Workplan** and virtual on-site conversations with Magellan noted that the QI Committee meets weekly to discuss documentation from FCCs, identified needs, and Plan of Care submissions to address and document any developing unmet needs of participants. The **QI Workplan** and the **November 2023 Network Development Plan** highlight Magellan's Prior Authorization Improvement PIP which looks to improve adherence to CANS results for service and needs planning in Plan of Care development. This process aims at encouraging stronger documentation of participant needs for both participant service connections and future service planning by Magellan.	1. Complete

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No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2021 Contract Language	Findings from CME Documentation (2024)	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]	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 SFY23 (i.e., Jul-Sep 2022, Oct-Dec 2022, Jan-Mar 2023, and Apr-Jun 2023). Maps included member and provider counts by county and region as well as unique provider counts. Magellan's documentation does not show goals for participant to provider ratios. During virtual on-site meetings with Magellan staff, Magellan reported that network adequacy standards are currently in flux, and they are changing the firm quantitative standards to best reflect the needs of the population served and the realities of service access in a frontier state like Wyoming. According to the **GeoMaps**, in Q4 SFY 2023, Magellan's HFWA network included 62 FCCs, 38 FSS providers, 1 Respite provider, and 9 YSPs. Magellan reported during the virtual on-site that they have increased respite providers to 5. Magellan reported during the virtual on-site that the network committee meets weekly to assess the needs of participants and the caseload of current providers. They provided an example of a **Weekly Capacity Report** that demonstrated the caseload for each provider. The committee then aligns providers with availabile capacity with participants requesting services. Magellan does not note any firm quantitative measures that allows for objective and rigorous determination of access to services and network adequacy through reported utilization. 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).	1. Complete
5e	(v)	The numbers of network providers who are not accepting new Medicaid patients.	No pertinent language from the SOW.	No pertinent language from the SOW.	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]	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 SFY23 (i.e., Jul-Sep 2022, Oct-Dec 2022, Jan-Mar 2023, and Apr-Jun 2023). Maps included member and provider counts by county and region as well as unique provider counts. According to the **November 2023 Network Development Plan**, Magellan sets network adequecy standards for both rural and urban communtiies where: • at least one (1) provider must be present within a ten (10) mile radius from a Medicaid beneficiary in urban regions, and • at least one (1) provider must be present within a fifty (50) mile radius in rural regions. (p.6) While Magellan is in the process of implementing distance-based network standards, they have not fully implemented the standards and methods for assessing distance when considering delivery options like telehealth.	2. Incomplete

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No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2021 Contract Language	Findings from CME Documentation (2024)	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]	In the **Provider Handbook,** Magellan's cultural competency policy states: "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's efforts to promote cultural competency include: 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 or 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; 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. 6) 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. 7) In general, any document that requires the signature of the member, and that contains vital information regarding treatment, medications or service plans must be translated into their preferred/primary language if requested by the member or their guardian. The **November 2023 Network Development Plan** provides data on the ethnicity, linguisitics, and other demographics represented in the HFWA member population as well as the demographic makeup and linguistic capabilities of the provider network. Magellan notes a commitment to building a provider network that reflects the demographics of its member population. The documentation also notes a robust set of trainings and key competencies related to culturally competent care that providers are required to demonstrate and trained on (p.10 - 26)	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]	The **Network Development Plan**, submitted to WDH annually, notes the demographics of the HFWA program member and provider populations, including gender identity, ethnicity, and linguistics (p.10). Outreach and network development strategies are then constructed to align the provider population with the characteristics and attributes represented in the member population (p.27). The documentation also notes the number of children with SED enrolled in Medicaid, the HFWA population, and the provider population in each WY county through a comprehensive map graphic (p.36). Magellan identifies urban areas that meet network goals of providers located within 10 miles of participants in another map graphic. This shows that 13 urban areas currently meet the established standard, while 4 urban areas do not (p.38). While large swaths of the state are shown to meet rural area adequacy standards, 31 rural areas where participants live do not meet adequacy standards (p.35) and are targeted for network expansion efforts.	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]	The **November 2023 Network Development** notes that 100% of HFWA providers are capable of providing telehealth services (p.36). The **Member Handbook** provides a 24 hour toll free number for members to discuss any grievances or questions (p.7). It notes that participants can talk to Magellan staff from 8AM to 5PM and that they may contact Magellan for any written or verbal translation services. There is a separate TDD/TTY number provided.	1. Complete

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No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2021 Contract Language	Findings from CME Documentation (2024)	Compliance Status
6	**(c)(2)**	States developing standards consistent with paragraph (b)(2) of this section must consider the following:			
6a	(i)	All elements in paragraphs (c)(1)(i) through (ix) of this section.	Not applicable.	Not applicable. This program does not include LTSS.	Not applicable.
6b	(ii)	Elements that would support an enrollee's choice of provider.	Not applicable.	Not applicable. This program does not include LTSS.	Not applicable.
6c	(iii)	Strategies that would ensure the health and welfare of the enrollee and support community integration of the enrollee.	Not applicable.	Not applicable. This program does not include LTSS.	Not applicable.
6d	(iv)	Other considerations that are in the best interest of the enrollees that need LTSS.	Not applicable.	Not applicable. This program does not include LTSS.	Not applicable.
(d) Exceptions process.					
7	**(d)(1)**	To the extent the State permits an exception to any of the provider-specific network standards developed under this section, the standard by which the exception will be evaluated and approved must be:			
7a	(i)	Specified in the MCO, PIHP or PAHP contract.	No pertinent language from the SOW.	Not applicable. The provider-specific network standards do not apply to this program, and therefore there are not exemptions to the provider-specific	Not applicable.
7b	(ii)	Based, at a minimum, on the number of providers in that specialty practicing in the MCO, PIHP, or PAHP service area.	No pertinent language from the SOW.	Not applicable. The provider-specific network standards do not apply to this program, and therefore there are not exemptions to the provider-specific network standards.	Not applicable.
8	**(d)(2)**	States that grant an exception in accordance with paragraph (d)(1) of this section to a MCO, PIHP or PAHP must monitor enrollee access to that provider type on an ongoing basis and include the findings to CMS in the managed care program assessment report required under § 438.66.	Not applicable.	Not applicable. The provider-specific network standards do not apply to this program, and therefore there are not exemptions to the provider-specific network standards.	Not applicable.

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No.	CFR Section	CFR Requirement 42 CFR § 438	SFY 2021 Contract Language	Findings from CME Documentation (2024)	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 **Network Development Plan** notes that a Family-Care Coordinator will be put in place, acting as the central figure in the implementation of auxiliary roles and/or services. (p.19) The **Member Handbook** notes that Magellan provides free language services to those whose primary language is not English such as: Qualified Interpreters, Information written in other languages, and Auxiliary aids and services. (p.33) 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). 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). Magellan confirmed during the virtual on-site meetings 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.	1. Complete
§ 438.14 Requirements that apply to MCO, PIHP, PAHP, PCCM, and PCCM entity contracts involving Indians, Indian health care providers (IHCPs), and Indian managed care entities (IMCEs).					
(b) Network and coverage requirements. All contracts between a State and a MCO, PIHP, PAHP, and PCCM entity, to the extent that the PCCM entity has a provider network, which enroll Indians must:					
10	**(b)(1)**	Require the MCO, PIHP, PAHP, or PCCM entity to demonstrate that there are sufficient IHCPs participating in the provider network of the MCO, PIHP, PAHP, or PCCM entity to ensure timely access to services available under the contract from such providers for Indian enrollees who are eligible to receive services.	No pertinent language from the SOW.	Not applicable. Although Magellan serves members of the tribal community, IHCPs are not involved because the program does not offer clinical services.	Not applicable.

Appendix I: Plan Level Strengths, Areas of Needed Improvement, and Associated Domains

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

#	Finding	Strength or Needed Improvement	Domain
Protocol 1. Validation of Performance Improvement Projects			
1	Documentation maintained for PIPs aligns directly with CMS requirements.	Strength	Quality
2	Magellan's team demonstrates commendable institutional knowledge and a strong desire to improve services and general welfare for the population the Wyoming HFWA program serves.	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's PIPs do not contain sufficient evidence-based research to support their claims and targeted interventions.	Needed Improvement	Quality
5	Despite previous PIPs showing limited sustained improvement, current PIPs do not appear to evaluate improvement activities from the previous year.	Needed Improvement	Quality
6	Performance measures used to evaluate the PIPs' impacts do not clearly align with PIP narratives and, sometimes, with each other.	Needed Improvement	Quality
Protocol 2. Validation of Performance Measures			
7	Clinical and technical teams are knowledgeable, engaged, and invested.	Strength	Quality; Timeliness; Access to Care
8	Documentation describing measure result creation continues to improve.	Strength	Quality; Timeliness; Access to Care
9	Documentation describing measure run logs is critical to the EQR process.	Strength	Quality; Timeliness; Access to Care

#	Finding	Strength or Needed Improvement	Domain
10	Measure creation staff are cross-trained.	Strength	Quality; Timeliness; Access to Care
11	WFI-EZ measure owners are familiar with system.	Strength	Quality; Timeliness; Access to Care
12	Contract and business requirement documents (BRD) require more clarity to adequately inform calculations.	Needed Improvement	Quality
13	Annual measure calculations may require final calculation rather than sum, or average, of prior quarters.	Needed Improvement	Quality
Protocol 3. Compliance with Medicaid Managed Care Regulations			
14	Magellan's team is closely in touch with the operations of Wyoming's youth behavioral health High Fidelity Wraparound program.	Strength	Quality
15	Magellan is in the process of overhauling and improving their approach to network adequacy standards and definitions based on their experience with the unique characteristics of Wyoming's program.	Strength	Quality; Access to Care
16	Magellan did not demonstrate the development or use of clear network adequacy standards beyond citing increased use of telehealth services to provide improved access for individuals in remote and hard-to-reach locations.	Needed Improvement	Quality; Access to Care
17	Magellan did not clearly measure network adequacy through defined metrics and standards.	Needed Improvement	Quality; Access to Care
18	Magellan does not provide a full description of the scope of benefits available to enrollees in its enrollee handbook or direction to a more detailed policy outlining the full scope of benefits.	Needed Improvement	Quality
19	Magellan's team is developing new standards, benchmarks, and measures to evaluate access to services.	Strength	Quality; Access to Care

#	Finding	Strength or Needed Improvement	Domain
20	Magellan did not submit a Quality Assurance and Performance Improvement (QAPI) Plan with strong quantitative components and robust methods for stakeholder engagement, surveys, and auditing.	Needed Improvement	Quality
21	Magellan's QAPI documentation did not detail processes for detection and action plans for over and underutilization of services.	Needed Improvement	Quality
22	Magellan's QAPI does not appropriately document evaluations for quality and appropriateness of care for enrollees.	Needed Improvement	Quality
23	Magellan "fully met" all compliance metrics for the Grievance and Appeals System.	Strength	Quality; Timeliness
Protocol 4. Validation of Network Adequacy			
24	Magellan has made significant improvements in documentation provided for the EQR since the SFY 2021 review.	Strength	Quality; Access to Care
25	Magellan has continued to grow and develop the WY CME provider network to meet the needs of program enrollees.	Needed Improvement	Quality; Access to Care
26	Magellan's documentation does not clearly define provider recruitment, education, and support interventions.	Needed Improvement	Quality
27	Magellan's documentation does not include considerations for the caseload of providers who deliver services across several regions via telehealth.	Needed Improvement	Access to Care
28	Magellan emphasized use of network adequacy standards for the Family Care Coordination service that is required for all participants, but it does not leverage network adequacy standards and measures for the additional HFWA services.	Needed Improvement	Quality; Access to Care