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
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 2023 Recommendations

Table 1. Status of SFY 2023 Recommendations

#	SFY 2023 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	Partially Addressed	Magellan's PIPs mention some data validation checks during data collection processes. The changes improve the reliability of the PIPs' data. However, some data measures still demonstrate inconsistencies across various reports. For example, there are several inconsistencies in the values Magellan cites for total number of enrolled members. Additionally, the documentation Magellan provided did not indicate that WDH was provided with formal, standardized data validation plans.
2.	**Recommendation for Magellan**: Provide additional research and best practice documentation to support PIP elements and conclusions that are woven into the PIP narrative and description. All Magellan's PIPs would benefit from a stronger foundation in clinical and public health evidence established as best practice. Current documentation and improvement strategies are explained as though they hinge on internal discussions. Supporting these strategies with national evidence and industry-supported approaches would	Magellan	Fully Addressed	Magellan's PIP documentation featured substantially improved citations to support the claims in the PIPs and the interventions designed.

#	SFY 2023 Recommendation	Responsibility	Findings	Comments
	greatly strengthen PIP narratives and interventions.			
3.	**Recommendation for Magellan:** Incorporate consistent evaluation of PIP impacts and create pre-determined checkpoints to consider if improvement strategies would best be amended. As the HFWA program evolves, the PIPs pushing it forward should evolve along with it. While previous PIPs have been shown to struggle when providing sustained improvement, the PIPs were not structured to encourage intervention evaluation and adjustment throughout the life of the PIP. Each year, Magellan would benefit from creating set evaluations with well described measures that highlight opportunities for adjustment and improvement of developed PIPs.	Magellan	Not Addressed	Magellan's PIP documentation did not feature a description of the demonstrated effect of individual interventions or objective measures to assess the relative impact and effectiveness of each individual intervention. While Magellan's presentation of the PIPs' interventions and the identified barriers that informed them improved substantially upon the previous year's documentation, there was no discussion of objective methods to assess individual interventions and adjust the interventions accordingly.
4.	**Recommendation for Magellan:** Clarify how performance measures align with the goals of the PIP and adjust PIP framing to fully encapsulate and provide sufficient attention to the scope of the PIP. The Network PIP and Prior Authorization Process PIP would both benefit from closer connected narrative framing, goals, and performance evaluation. Magellan has several avenues to address these concerns such as: o Cross-walking interventions and performance measures.	Magellan	Fully Addressed	The PIPs' goals and narrative was adjusted to align and clearly address a distinct topic.

#	SFY 2023 Recommendation	Responsibility	Findings	Comments
	o Tailoring the narrative and/or PIP titles to the full aims of the PIP. o Fine tuning specific measurements to empirically assess PIP impact. o Grounding quantitative performance goals in evidence-based determinations and actualizable outcomes. o Addressing potential confounding in the relationship between performance measures and improvement strategies.			
Protocol 2. Validation of Performance Measures				
5.	**Recommendation for WDH**: Include more detail in the contract and subsequently the BRDs. To avoid assumptions which may lead to under- or over-reporting of rates, cost, averages, etc., consider more specific documentation describing the exact inclusions and exclusions required for each measure. Rather than stating "number of CME members", clearly state "CME members in the program as of the last day of the quarter", "CME members with at least one day of membership at any point during the quarter", "CME members for a minimum of six continuous months", for example. Each of these statements may yield a different number for membership. Consider updating the criteria for Measure OUT 13-8 to track the number of surveys returned this timeframe over the number of possible surveys (youth in	WDH	Not Met	Recommendation not implemented; however, it may be the intent of WDH to only track the number of surveys received and not consider the value as a subset of the number possible or as a comparison to prior years.

#	SFY 2023 Recommendation	Responsibility	Findings	Comments
	program at least 6 months) also in this timeframe. The current measure of receipts this timeframe over the receipts in the same timeframe of the previous year provides no indication of improvement.			
6.	**Recommendation for Magellan:** Clarify with the clinical the intent of each measure and ensure logic/process is accurate. For Measure OUT 13-5, for example, the CDF states the denominator is "Number of youth enrolled in the waiver program', but measure logic is coded to count *newly* enrolled youth to waiver program at some point in the quarter. All agree that this is the intent, but this is not reflected in the value descriptions. For Measure OP 8-36S, for example, the CDF states the numerator is "number of participants who have identified a Primary Care Provider at the first Plan of Care authorization", but the coding logic appears to be counting "number of participants who have identified a Primary Care Provider as of the query run date". Consider moving the process documentation comment on the referral and crisis plan up to describe the numerator, not the denominator. *(This is a continued recommendation from SFY 2021 and 2022).*	Magellan	Not Met	Recommendation not implemented; however, it may be the intent of WDH to describe the measures as currently stated.
7.	**Recommendation for WDH:** Review each measure where the final annual amount is simply a sum of the four quarters, or in	WDH	N/A	This recommendation is quite similar to the one below.

#	SFY 2023 Recommendation	Responsibility	Findings	Comments
	some cases an average of the four quarters and consider calculating a final annual amount. WDH clinical experts and measure authors should review each measure and determine if the annual report value displayed in the CDF should be the result of a simple total or average of the four quarters or if the measure should be run for the full fiscal year. Re-running the measure would result in the true total or true weighted average, but recipients of the CDF would have to understand that the annual value may not appear as a perfect sum or average of the monthly or quarterly values. Occurrences such as disabled providers, retroactive enrollment, or other factors may result in an annual value being higher or lower than the values calculated on the inclusive months or quarters. WDH should have clear documentation regarding the decision for each Measure.			
8.	**Recommendation for Magellan:** Discuss with WDH any measure(s) where the year-end value displayed in the Committee Data File requires a separate annual calculation encompassing all dates within the SFY. Magellan staff are currently responsible for monthly/quarterly measure calculations, and in most cases, it appears the team uses Excel formulas to sum or average the months or quarters in the fiscal year yielding the annual value displayed in the CDF. In many cases, this annual	Magellan	Partially Met	Magellan indicated quarterly queries can be updated to include annual date spans. When running Q4, we recommend and additional run for the year to populate the Annual value.

#	SFY 2023 Recommendation	Responsibility	Findings	Comments
	calculation is an understated or overstated value. For some measures, such as OUT 13-5, OPS 8-36S, and OUT 13-7, WDH is currently calculating the annual value as the average of the quarterly averages, and this does not allow for proper weighting.			
Protocol 3. Compliance with Medicaid Managed Care Regulations				
9.	**Recommendation for Magellan**: Improve reporting materials to include narrative around provider ratios and access differences across regions. Magellan reported that the organization is turning to standards of at least one (1) provider being present within a ten (10) mile radius from a program participant in urban regions and within a fifty (50) mile radius from a participant in a rural region. Magellan staff noted that the organization is currently in the process of defining new adequacy standards that account for the unique nature of Wyoming's geography and distribution of participants as well as telehealth's emergence as a viable service delivery method. While these standards and initiatives are meaningful and hold promise, current documentation does not describe this system or these standards thoroughly. Magellan would benefit from finalizing adequacy standards to clearly measure access beyond what appear to be meaningful access for all participants from a qualitative assessment. The organization's	Magellan	N/A	This Protocol 3 recommendation was made in SFY 2023 as part of the evaluation of *MCP Standards, Including Enrollee Rights and Protections.* The *MCP Standards, Including Enrollee Rights and Protections* section of Protocol 3 was not assessed in SFY 2024; therefore, progress towards this recommendation was also not assessed.

#	SFY 2023 Recommendation	Responsibility	Findings	Comments
	process of leveraging committees to weekly discuss provider caseloads and participants' access to providers is meaningful. Providing further documentation that outlines these reviews and the measures the committee uses will improve Magellan's compliance with contract requirements and better position the organization for initiatives to improve access and its provider network where most needed.			
10	**Recommendation for Magellan**: Develop and standardize thorough network adequacy measures for WDH reporting and proof of compliance with network adequacy standards. Magellan's internal committees that govern provider assignment and recruitment have a very clear idea of the needs of and on-the-ground services delivered to participants. Its teams do exemplary work communicating closely with participants and providers to ensure adequate delivery of services. The organization reported that they are currently reworking their network adequacy framework and measures to better add data-driven context to their qualitative practices and understanding. Magellan would benefit from expediting this measure development process and incorporating any new measures into the reports submitted to WDH. Possible measures include the number of plans of care requesting a particular service relative to the number of individuals actually receiving a service or surveys for all enrollees delivered by Family	Magellan	N/A	This Protocol 3 recommendation was made in SFY 2023 as part of the evaluation of *MCP Standards, Including Enrollee Rights and Protections.* The *MCP Standards, Including Enrollee Rights and Protections* section of Protocol 3 was not assessed in SFY 2024; therefore, progress towards this recommendation was also not assessed.

#	SFY 2023 Recommendation	Responsibility	Findings	Comments
	Care Coordinators that inform participants of services available to them where they can indicate an unmet need for a service. Further, Magellan must delineate between providers serving several regions when assessing provider-to-participant ratios for a true assessment of how provider capacity in its geographic maps of providers and participants.			
11	**Recommendation for Magellan**: Add additional information in enrollee-facing documents to inform enrollees and their families of the full scope, amount, and duration of benefits to which they are entitled in the CME Program. Magellan's enrollee handbook details how enrollees receive services and service authorizations, but it does not outline the scope and maximum amount of those authorized services. It is important that enrollees have easy access to information regarding their maximum benefits to inform their cadence of service receipt and promote transparency in the service authorization and care plan process. Magellan can refrain from including all such information in the enrollee manual if there is language in the manual clearly directing enrollees to easily found online documents that further detail their scope of benefits in plain language.	Magellan	N/A	This Protocol 3 recommendation was made in SFY 2023 as part of the evaluation of *MCP Standards, Including Enrollee Rights and Protections.* The *MCP Standards, Including Enrollee Rights and Protections* section of Protocol 3 was not assessed in SFY 2024; therefore, progress towards this recommendation was also not assessed.
12	**Recommendation for Magellan:** In the QAPI, provide clear quantitative objectives and components. Magellan can improve their QAPI by tying objective, quantitative measures to performance, thus	Magellan	Not Met	The overall, prioritized goals and objectives that frame the QAPI document are minimally tied to quantitative objectives or components. Out of the three goals guiding the SFY 2024 QAPI, the current report offers seven supporting objectives.

#	SFY 2023 Recommendation	Responsibility	Findings	Comments
	improving the validity of their QAPI and evaluation and proving performance improvement. These quantitative measurements can also be linked to needed improvements and evaluation of stakeholder engagement practices, provider and enrollee surveys, and audit findings to better direct QAPI structure and initiatives.			Only one of the current objectives includes reported quantitative values to demonstrate progress and performance.
13	**Recommendation for Magellan:** Define over and underutilization in QAPI documentations while outlining targets for utilization and evaluating utilization against those targets. Magellan's current QAPI does not clearly indicate how it defines over and underutilization. As it moves to detect and address utilization challenges, it would be recommended that Magellan clearly outline how it describes appropriate and inappropriate utilization in its formal documentation, like the QAPI. Further, the current analysis conducted to address non-optimal service use does not compare to benchmarks or stated goals. It carries what may be suboptimal utilization across years, comparing one year to the next. While this approach does have its merits, it would be most effective when coupled with an evaluation of actual utilization to the expected appropriate number of claims submitted by a recipient. In doing so, Magellan will clearly define its utilization expectations and move towards a service volume goal while measuring changes in utilization over time.	Magellan	Partially Addressed	The *Evaluation of Over/Under Utilization of Services* section of the SFY 2024 QAPI report offers two metrics of utilization: the percentage of providers who meet the minimum of two member contacts per month and the number of authorizations and claims per role. While both metrics initiate some understanding of service utilization, they do not offer direct insight into whether services were appropriately utilized by providers to serve members. Applying additional metrics that specifically measure occurrences of over/under utilization would fully address this recommendation.

#	SFY 2023 Recommendation	Responsibility	Findings	Comments
14	**Recommendation for Magellan:** Document the evaluation activities Magellan conducts for quality and appropriateness of care coordination along with the rationale for the quantitative measures and benchmarks used in the evaluation. Magellan's current documentation would be improved by detailing the performance measures it uses and how they determined what value of each measure was acceptable performance. In particularly, Magellan's QAPI would be improved by detailing access standards, a list of performance metrics and how they are calculated, discussion on measurable objectives in the PIPs, documentation standards, and performance measures used as contractual requirements or quality incentives for providers. It would also improve with a discussion of measure goals, for example, why an acceptable level for provider audits is 70%.	Magellan	Partially Addressed	The PIPs section of the SFY2024 report includes quantitative values relevant to each project. Additionally, the performance measures demonstrate specific, quantifiable outcomes. However, additional sections of the QAPI report, including the priority goals, access standards, documentation standards, and over/under utilization measurements would all be improved with increased application of quantifiable goals and metrics.
Protocol 4. Validation of Network Adequacy				
15	**Recommendation for Magellan**: Detail specific provider recruitment, education, and support interventions and strategies in appropriate internal policies. It is important that Magellan clearly document the specific network improvement activities it is undertaking in order to capture the value of such initiatives through outcome measures and outcome comparisons over time. Magellan could detail these specific activities in their Network	Magellan	Partially Addressed	Magellan's documentation outlined provider outreach efforts, but did not explain the details of the outreach efforts or the rationale behind them.

#	SFY 2023 Recommendation	Responsibility	Findings	Comments
	Adequacy Framework or Network Development Plan to speak more directly to the manner through which they are addressing the needs and goals identified in those documents.			
16	**Recommendation for Magellan**: Adjust provider network reports to reflect the actual caseloads of providers and include average provider to participant ratios. Magellan considers each request for services and provider caseloads weekly through committee meetings. As reported during the virtual on-site meetings, Magellan reviews the caseload of each provider and assigns participants seeking services with providers that demonstrate capacity, regardless of the participant and/or provider's location. This effectively allows Magellan to be constantly aware of any evolving network needs, but this practice and its results are not clear through Magellan's network adequacy reports. Magellan would better demonstrate its adherence to its network standards and the ability of participants to access services by developing a report that shows provider caseloads, provider to participant ratios, and reasonable physical access to a provider for participants receiving services from that provider.	Magellan	Not Addressed	Magellan's caseload reports do not feature quantitative measures to demonstrate compliance with contractual requirements. They are not meaningful demonstrations of network adequacy.
17	**Recommendation for Magellan**: Develop targeted measures to assess access to all HFWA services and track progress towards related goals accordingly. Magellan is undergoing efforts to improve provider education on all HFWA services, encouraging inclusion of additional services on participants' plans of care.	Magellan	Not Addressed	Magellan did not expand their measures to demonstrate network adequacy for all provider types beyond what was previously leveraged.

#	SFY 2023 Recommendation	Responsibility	Findings	Comments
	During the virtual on-site meetings, Magellan noted their intent to develop clearer measures to assess access and network adequacy for Youth Support Partners, Family Support Services, and Respite. They mentioned interest in measures such as participants with a service on their plan of care compared to the number of participants receiving that service. Magellan's network development goals and strategies would benefit from Magellan constructing more detailed measures that accompany their provider outreach efforts and speak to network growth progress and meaningful access to the full suite of HFWA services.			

Worksheet 1.1. Review the Selected PIP Topic

PIP Topic: Improving the Prior Authorization Process for the High Fidelity Wraparound Program_____

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			The PIP topic was selected through the PIP workgroup's professional experience and input. While participants and their families did not cite concerns with Plan of Care authorization, providers largely expressed challenges in receiving prior authorizations. The PIP workgroup also tied several downstream impacts such as continuity of service delivery and subsequent participant outcomes to the prior authorization process.
1.2 Did selection of the PIP topic consider performance on the CMS Child and Adult Core Set measures?		X		The documentation Magellan submitted did not feature any information related to the CMS Child and Adult Core Set measures.
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 PIP topic relied mostly on providers' input, since providers cited challenges in the prior authorization process. Magellan did solicit information from participants, but participant feedback did not note challenging experiences with the authorization process.

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		The PIP topic does not target a specific priority area identified by HHS and / or CMS, as it targets a general administrative procedure. However, the CME program itself is aligned with CMS' focus on behavioral health initiatives, so the PIP topic can be said to indirectly align with a CMS priority.
1.6 Overall assessment: In the comments section, note any recommendations for improving the PIP topic.				None

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Worksheet 1.2. Review the PIP Aim Statement

PIP Aim Statement

1) Will the introduction of changes in the High Fidelity Wraparound Plan of Care review process (documents required for the prior authorization at the initial Plan of Care submission versus documents that can be submitted after the authorization) and provider communications result in a lower rate of service non-authorizations for the Wyoming Care Management Entity youth ages 4- 20 years old with a Serious Emotional Disturbance (SED diagnosis) who are enrolled during Standard Fiscal Year (SFY) 2024?

   Measure #1: Numerator: Number of non-authorizations issued.
   Denominator: Number of Plans of Care submitted.

2) 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 of the Plan of Care versus documents that can be submitted after the authorization) 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 #2: Numerator: Number of authorizations issued.
   Denominator: Number of Plans of Care submitted.

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			Both PIP aim statements specify a target population of "Wyoming Care Management Entity youth ages 4- 20 years old with a Serious Emotional Disturbance (SED diagnosis) who are enrolled during Standard Fiscal Year (SFY) 2024." The improvement strategy for both PIPs was described as "documents required for the prior authorization at the initial submission of the Plan of Care versus documents that can be submitted after the authorization." The PIP time period was not specified in the aim statements beyond SFY 2024.
2.2 Did the PIP aim statement clearly specify the population for the PIP?	X			Both PIP aim statements specify a target population of "Wyoming Care Management Entity youth ages 4- 20 years old with a Serious Emotional Disturbance (SED diagnosis) who are enrolled during Standard Fiscal Year (SFY) 2024."
2.3 Did the PIP aim statement clearly specify the time period for the PIP?	X			The PIP time period was not specified in the aim statements beyond SFY 2024.
2.4 Was the PIP aim statement concise?	X			
2.5 Was the PIP aim statement answerable?	X			The aim statement was answerable via data analyses.
2.6 Was the PIP aim statement measurable?	X			The aim statement was measurable. There was not any mention of controlling for confounding variables or considerations surround confounding variables.
2.7 Overall assessment: In the comments section, note any				None

Question	Yes	No	NA	Comments
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			
3.2 Was the entire MCP population included in the PIP?	X			
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			
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		The WY Wraparound program has a relatively small enrolled population, so it was not necessary to sample the population.
3.5 Overall assessment: In the comments section, note any recommendations for identifying the project population.				None

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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	The PIP addresses the entire MCP population.
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	The PIP addresses the entire MCP population.
4.3 Did the sample contain a sufficient number of enrollees taking into account non-response?			X	The PIP addresses the entire MCP population.
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	The PIP addresses the entire MCP population.
4.5 Were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field.			X	The PIP addresses the entire MCP population.
4.6 Overall assessment: In the comments section, note any recommendations for improving the sampling method.				None; Sampling was not used.

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Worksheet 1.5. Review the Selected PIP Variables and Performance Measures

Selected PIP Variables and Performance Measures:

_____

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 variables directly assess successful and unsuccessful plan of care authorizations. The period assessed is the fiscal year.
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?	X			The performance measures assess Plan of Care authorizations which are well described as central to a successful care delivery process and participant experience.
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			The performance measures' data are pulled directly from the Electronic Health Record.
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 are based on authorization requests and directly assessing authorizations.

Question	Yes	No	NA	Comments
5.5 Did the performance measures: • Monitor the performance of MCPs at a point in time? • Track MCP performance over time? • Compare performance among MCPs over time? • Inform the selection and evaluation of quality improvement activities?	X			Non-authorization data is collected weekly. Authorization data is collected monthly. Data for both measures is also reviewed annually.
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	There is no reference to CMS data sets or measures in the PIP documentation and the performance measures directly assess the process the PIP targets.
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			
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		Magellan used participant and provider satisfaction surveys to assess opportunities for improvement within their program, but the measures to assess PIP success do not include similar surveys. Also, participant surveys did not note the prior authorization process as a concern. As such, performance measures based on participant satisfaction would not demonstrate successful process improvements.
5.9 Did the measures include a strategy to ensure inter-rater reliability (if applicable)?			X	The measures are based on objective data pulled directly from the health record.

Question	Yes	No	NA	Comments
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			Magellan detailed the process through which successful and efficient prior authorization processes affect participant outcomes. Magellan leverages clinical experience as well as peer-reviewed literature and published national best practices.
5.10 Overall assessment: In the comments section, note any recommendations for improving the selected PIP variables and performance measures.				None

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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			The measure data is collected through an established and logical set of code and pulled directly from the Electronic Health Record.
6.2 Did the PIP design specify the frequency of data collection? If yes, what was the frequency (for example, semi-annually)?	X			The PIP documentation states that data will be collected weekly and monthly.
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 PIP documentation specifies the data source as the Electronic Health Record.
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 clearly defines the data elements to be collected through the code provided for the data pull.
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		No data analysis plan is provided for the PIP. Magellan expanded upon their data analysis process during the virtual on-site meetings.
6.6 Did the data collection instruments allow for consistent and accurate data collection over the time periods studied?	X			
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 was not used in the PIP for the performance measures.
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.				None

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 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?		X		EHR data was used as the sole source for performance measures. Data was validated by a senior clinical analyst. Comparability across systems was not assessed, as all data is coming from the same electronic system.

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			Data collection personnel are not listed. The PIP does cite that team members involved in the PIP have "a variety of backgrounds including master's level licensed clinicians, Lean Six Sigma certification, statistics and data analysis subject matter experts, and delivery of HFWA services subject matter experts." While the PIP documentation does not list data collection and analysis personnel, Magellan provided a list of personnel with their qualifications following the virtual on-site meetings.

Question	Yes	No	NA	Comments
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	Medical record review was not conducted. While the medical record was marked as the applicable data source, only administrative data is used to assess the PIP.
6.17 For medical record review, were guidelines for obtaining and recording the data developed? • A glossary of terms for each project should be developed before data collection begins to ensure consistent interpretation among and between data collection staff • Data collection staff should have clear, written instructions, including an overview of the PIP, how to complete each section of the form or instrument, and general guidance on how to handle situations not covered by the instructions. This is particularly important when multiple reviewers are collecting data			X	Medical record review was not conducted.

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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	No data analysis plan was presented. Magellan provided a description of their data analysis process during the virtual on-site interviews.
7.2 Did the analysis include baseline and repeat measurements of project outcomes?	X			
7.3 Did the analysis assess the statistical significance of any differences between the initial and repeat measurements?	X			
7.4 Did the analysis account for factors that may influence the comparability of initial and repeat measurements?		X		The PIP documentation did not note any consideration of confounding variables or comparability between baseline and repeat measurements. The analysis does note that "the exact intervention that may have caused this decrease cannot be directly correlated. The decrease in the number of documents required at the authorization request could be surmised to have had an effect but cannot be entirely confirmed. This will need further review and monitoring as the project moves into SFY 2025." Magellan noted during the virtual on-site interviews that they plan to conduct further analyses on the factors influencing the outcomes. The analyses they plan to conduct and next steps for those analyses were not clear or determined.
7.5 Did the analysis account for factors that may threaten the internal or external validity of the findings?		X		The PIP documentation did not note any consideration of confounding variables or comparability between baseline and repeat measurements.
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 PIP documentation only discussed trends across the entire enrolled population.

Question	Yes	No	NA	Comments
7.7 Were PIP results and findings presented in a concise and easily understood manner?	X			
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 discusses a need for better links between outcomes and interventions. It mentions potential discrepancy in data and a need to review data collection processes for reliability and validity. The PIP also notes that changes to key processes should occur in SFY 2025, so the interventions have not been fully implemented. Magellan notes that they plan to conduct continued analyses of provider feedback to identify barriers and interventions with the best potential for improvement.
7.9 Overall assessment: In the comments section, note any recommendations for improving the analysis and interpretation of PIP results				Noted data discrepancies would best be explored to improve the PIP. It would also be beneficial to develop intermediate measures to assess the effectiveness of specific interventions, since there are several interventions employed.

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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			
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			Magellan indicated primary and secondary drivers contributing to access challenges in the prior authorization process and designed interventions to address those drivers – notable improvement from previous year. The interventions were not designed based on data analyses, but were designed based on provider feedback and open-field responses in provider surveys.
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			
8.4 Was the strategy culturally and linguistically appropriate?[2]	X			

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

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

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)?		X		Magellan noted in their PIP narrative that further analyses will be conducted to address confounding variables and assess the impact of such variables on interventions and their correlated outcomes.
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 PIP documentation assesses the statistical significance of changes. It notes that there was no way to determine the correlation of the performance measures with the interventions and that Magellan plans to work to address this in the next year of the PIP.
8.7 Overall assessment: In the comments section, note any recommendations for improving the implementation strategies.				The EQRO recommends that Magellan conduct analyses to determine any external situations that may be influencing the measures and explain those confounders in the documentation.

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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?	X			
9.2 Was there any quantitative evidence of improvement in processes or outcomes of care?		X		The performance measure related to the volume of authorized plans of care demonstrated improvement, but the PIP documentation notes that there was no way to determine if that improvement was due to the interventions or which intervention would have contributed to the improvement.
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		The PIP documentation notes that there was no way to determine if the interventions were the cause of the performance.
9.4 Is there statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention?	X			The statistical analysis conducted did demonstrate a statistically significant improvement in performance measure 2, but it was not clear if that change was the result of any particular intervention. There was also statistical significance in the change demonstrated in performance measure 1, but the change was away from the goal.
9.5 Was sustained improvement demonstrated through repeated measurements over time?		X		Sustained improvement was not demonstrated over time.
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.				The EQRO recommends that Magellan examine the causes for contradictory trends in the measures and discuss assessments of the PIP's effectiveness thoroughly in the documentation.

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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 PIP methodology involves interventions built to improve the efficiency and effectiveness of the prior authorization process. The PIP methodology does not, however, examine any confounding variables that may influence the PIP's measures. Further, the PIP design does not feature any analyses that examine why non-authorizations may have increased.
Rating 2: EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	The PIP data measures showed increases in non-authorizations, the opposite trend the PIP intended. However, the PIP measures did demonstrate a marked increase in continuous authorizations. While this was a positive improvement, the documentation noted that the Magellan team was unable to determine if the improvement was a direct result of the PIP's interventions or which interventions may have contributed..

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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 the introduction of changes in the High Fidelity Wraparound Plan of Care review process (documents required for the prior authorization at the initial Plan of Care submission versus documents that can be submitted after the authorization) and provider communications result in a lower rate of service non-authorizations for the Wyoming Care Management Entity youth ages 4- 20 years old with a Serious Emotional Disturbance (SED diagnosis) who are enrolled during Standard Fiscal Year (SFY) 2024?

   Measure #1: Numerator: Number of non-authorizations issued.
   Denominator: Number of Plans of Care submitted.

2) 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 of the Plan of Care versus documents that can be submitted after the authorization) 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 #2: Numerator: Number of authorizations issued.
   Denominator: Number of Plans of Care submitted.

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:

Target population description, such as duals, LTSS or pregnant women (please specify): All youth enrolled in the WY High Fidelity Wraparound CME program.

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)

- Streamlined the number of documents required for the Plan of Care submission
- Magellan CME worked with WDH to consider a reimbursement increase for providers
- Provider Surveys concerning Pre and Post to the PA process, External Quality Improvement Committee

• Monthly Provider Calls, weekly training calls • Development of Provider Manual • Development of rating scale within the Clinical Review Tool • Reminders sent to providers 30 days prior to the POC being due for review.
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)

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

Performance measures (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent remeasurement year (if applicable)**	**Most recent remeasurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No)** **Specify P-value**
Rate of service non-authorizations for WY CME youth enrolled during SFY 2024: Number of non-authorizations issued / Number of Plans of Care submitted	SFY 2023	4.8% (out of 1,254 Plans of Care submitted)	☐ Not applicable—PIP is in planning or implementation phase, results not available	7.19% (out of 1,140 Plans of Care submitted)	☐ Yes ☒ No	☒ Yes ☐ No Specify P-value: .0205 ☐ <.01 ☒ <.05 Other (specify):
Rate of continuous authorizations for WY CME youth enrolled during SFY 2024. Number of authorizations issued / Number of Plans of Care submitted.	SFY 2023	75.35% (out of 1,254 Plans of Care submitted)	☐ Not applicable—PIP is in planning or implementation phase, results not available	81.05% (out of 1,140 Plans of Care submitted)	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: .0001 ☒ <.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
			☐ 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

EQRO recommendations for improvement of PIP:

- Assess, consider, and document the impact of any potential confounding variables on the PIP measures.
- Assess why non-authorizations may have increased and discuss the analysis in the PIP documentations.
- Develop interventions to address potential causes for the increase in non-authorizations.
- Differentiate between how improvement in continuous authorizations accompanied by a greater volume of non-authorizations speaks to the overall success of the PIP.
- Describe how the interventions were developed in the PIP documentation.
- Include the individuals involved in the PIP measure data collection and evaluation process and their background in the PIP documentation.
- Consider including questions about the PIP interventions in provider surveys to collect data on provider response as another mechanism to assess and demonstrate PIP success.
- Address inconsistencies in reported data collection and analysis cadences in the PIP documentation.

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Worksheet 1.1. Review the Selected PIP Topic

PIP Topic _Increase the Number of 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.)	X			The PIP documentation does not note how the PIP topic was selected.
1.2 Did selection of the PIP topic consider performance on the CMS Child and Adult Core Set measures?		X		The PIP documentation does not make any reference of the CMS Child and Adult Core Set measures.
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 PIP documentation notes that input was collected from participants through the grievance process, Member Advisory Group, WFI-EZ survey and the Member Experience Survey. The documentation does not note what feedback was considered or how it was considered. The PIP documentation notes that Magellan sought out provider input through avenues such as individual calls with providers and monthly provider calls. The documentation does not note what feedback has been offered from providers or how their input was leveraged in PIP design or topic selection.

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 is for a managed care program that only services youth with severe behavioral health challenges.
1.5 Did the PIP topic align with priority areas identified by HHS and/or CMS?		X		Increasing the provider network does not directly align with HHS and CMS' priority areas. However, the WY High Fidelity Wraparound Program for youth behavioral health services does align with the CMS behavioral health priority area.
1.6 Overall assessment: In the comments section, note any recommendations for improving the PIP topic.				None

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Worksheet 1.2. Review the PIP Aim Statement

PIP Aim Statement

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 the Network for the 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?	X			The PIP aim statement identifies the PIP strategy as "targeted improvement, training, and support." The PIP aim statements specify the target population as Family Care Coordinators and Respite providers in the Wyoming HFWA program. The aim statements specify the PIP time period as SFY 2024.
2.2 Did the PIP aim statement clearly specify the population for the PIP?	X			The PIP aim statements specify the target population as Family Care Coordinators and Respite providers in the Wyoming HFWA program.
2.3 Did the PIP aim statement clearly specify the time period for the PIP?	X			The aim statements specify the PIP time period as SFY 2024.
2.4 Was the PIP aim statement concise?	X			
2.5 Was the PIP aim statement answerable?	X			
2.6 Was the PIP aim statement measurable?	X			
2.7 Overall assessment: In the comments section, note any recommendations for improving the PIP aim statement.				None

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Worksheet 1.3. Review the Identified PIP Population

PIP Population

All WY CME enrolled youths with a full month of enrollment, ages 4-20 during the measurement period.

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

Question	Yes	No	NA	Comments
3.1 Was the project population clearly defined in terms of the identified study question (e.g., age, length of the study population's enrollment, diagnoses, procedures, other characteristics)? • The required length of time will vary depending on the PIP topic and performance measures	X			The PIP aims to address the provider population for all WY CME enrolled youths. The PIP does not specify a time period beyond SFY 2024.
3.2 Was the entire MCP population included in the PIP?	X			
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			The data collection process and PIP interventions only assess the number of providers, but the providers serve the entire MCP population.
3.4 Was a sample used? (If yes, use Worksheet 1.4 to review sampling methods). • If the data will be collected manually (such as through medical record review), sampling may be necessary		X		Sampling was not used.
3.5 Overall assessment: In the comments section, note any recommendations for identifying the project population.				None

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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	
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	
4.3 Did the sample contain a sufficient number of enrollees taking into account non-response?			X	
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	
4.5 Were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field.			X	
4.6 Overall assessment: In the comments section, note any recommendations for improving the sampling method.				None

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Worksheet 1.5. Review the Selected PIP Variables and Performance Measures

Selected PIP Variables and Performance Measures:

_____

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 are raw provider counts examined monthly, quarterly, and annually.
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?	X			
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			
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 are just provider counts. There are not any analytics involved in their design.

Question	Yes	No	NA	Comments
5.5 Did the performance measures: • Monitor the performance of MCPs at a point in time? • Track MCP performance over time? • Compare performance among MCPs over time? • Inform the selection and evaluation of quality improvement activities?	X			The performance measures assess provider enrollment over time and at several points in time.
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 PIP documentation does not make any reference to any formal data sets or 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)?		X		Magellan only used the raw number of providers as measures.
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 did not capture any changes in enrollee satisfaction.
5.9 Did the measures include a strategy to ensure inter-rater reliability (if applicable)?			X	The measures are a raw count and not subject to any rating bias.

Question	Yes	No	NA	Comments
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	Process measures were not used.
5.10 Overall assessment: In the comments section, note any recommendations for improving the selected PIP variables and performance measures.				The EQRO recommends that Magellan leverage measures that consider additional context to assess the effectiveness of the PIP.

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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			
6.2 Did the PIP design specify the frequency of data collection? If yes, what was the frequency (for example, semi-annually)?	X			The PIP noted that data was to be collected 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 PIP notes that data is collected from a Network Information System that is populated with data that a network analyst adds to the system whenever a provider applies to enroll in the network.
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 design only calls for provider counts to be collected.
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 PIP includes a detailed description of the data to be collected and assessed. It also details the data validation plan.
6.6 Did the data collection instruments allow for consistent and accurate data collection over the time periods studied?	X			
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.				Magellan noted some inconsistencies in their data collected, but a full description of the inconsistencies' impact is necessary to assess the quality of the data and the PIP's effectiveness.

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 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?	X			Provider enrollment data was validated by a network analyst. Only one system was used for data collection and pulling.

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		Data collection personnel are not listed. The PIP does cite that team members involved in the PIP have "a variety of backgrounds including master's level licensed clinicians, Lean Six Sigma certification, statistics and data analysis subject matter experts, and delivery of HFWA services subject matter experts."
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	Medical records were not reviewed.

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			X	Medical records were not reviewed.

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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			
7.2 Did the analysis include baseline and repeat measurements of project outcomes?	X			
7.3 Did the analysis assess the statistical significance of any differences between the initial and repeat measurements?		X		The analysis does not include any statistical measures or statistical significance tests. The PIP only uses raw provider counts as performance measures.
7.4 Did the analysis account for factors that may influence the comparability of initial and repeat measurements?	X			The analysis discussed potential discrepancies in the baseline measurement due to provider agencies failing to inform Magellan when a provider leaves the agency, leading to potentially inflated provider counts prior to discovering and address this trend during re-measurement year 1.
7.5 Did the analysis account for factors that may threaten the internal or external validity of the findings?	X			The analysis discussed potential discrepancies in the baseline measurement due to provider agencies failing to inform Magellan when a provider leaves the agency, leading to potentially inflated provider counts prior to discovering and address this trend during re-measurement year 1.
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 PIP does not look at regional provider enrollment or anything beyond general MCP provider enrollment.
7.7 Were PIP results and findings presented in a concise and easily understood manner?	X			
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	X			

Question	Yes	No	NA	Comments
lessons learned and opportunities for improvement				
7.9 Overall assessment: In the comments section, note any recommendations for improving the analysis and interpretation of PIP results				The EQRO recommends that Magellan discuss data discrepancies and their impact on the PIP's assessment in the documentation.

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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		The PIP documentation lists primary and secondary drivers of challenges related to network adequacy. However, the PIP documentation does not feature any evidence or rationale behind the interventions leveraged to address the primary and secondary drivers.
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			
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	X			

[3] 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?[4]		X		The PIP documentation stats that the strategy had no cultural or linguistic elements that needed to be addressed. However, this does not account for WDH's concerns in meeting the needs of Native American participants.
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		The strategy does not discuss confounding variables.
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 PIP discusses the results of the re-measurement and reasons for not meeting plan goals. It also discusses future efforts to better meet those goals.
8.7 Overall assessment: In the comments section, note any recommendations for improving the implementation strategies.				The EQRO recommends that the PIP documentation discuss confounding variables, Magellan's outreach initiatives to Native American communities, and the evidence / rationale driving the interventions designed to address identified challenges.

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[4] 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			
9.2 Was there any quantitative evidence of improvement in processes or outcomes of care?	X			Measure 1 showed a negative trend. Measure 2 showed minimal improvement.
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	The PIP did not demonstrate clear improvement in the measures used.
9.4 Is there statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention?		X		Statistical analyses were not included in the PIP design.
9.5 Was sustained improvement demonstrated through repeated measurements over time?		X		Performance varied by month and quarter.
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.				None

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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	Magellan was unable to directly link outcome measures with the interventions described in the PIP documentation. Magellan also only used raw provider counts in their PIP measurements instead of more robust statistical measures. Further, Magellan was not able to define the number of providers that would adequately meet their program's needs or why their goals were set as they were.
Rating 2: EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	The PIP measures showed significant fluctuation in provider enrollment that could not meaningfully demonstrate improvement.

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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 Providers in the WY CME 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 the Network for the 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 respite providers active the Network for the 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: 20 years old and younger.
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 conference with current WY providers and stakeholders (focus on Natrona County). • Leverage current provider contacts throughout the state to recruit new providers. • Information in provider and member newsletter concerning recruiting for High Fidelity Wraparound providers and respite providers. • Updated High Fidelity informational brochures and one specifically about the Respite services. Brochures will be distributed by current network providers to stakeholders in the WY community. • Engagement with providers during Tuesdays at 2 (a weekly training call with providers and CME staff) and ad hoc provider calls about respite roles with Network manager. • Summit virtual conference held with current WY providers throughout the state as well as stakeholders (focus for Laramie county)

- "Collaborative Connections" provider conference held in Casper, WY.
- Distributed HFWA brochures and posters to providers to use in their office and to distribute in their communities for other stakeholders and families to raise awareness of the program.
- WDH approved increase in unit reimbursement rates for providers.

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)

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	SFY 2023	64	☐ Not applicable—PIP is in planning or implementation phase, results not available	52	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): No statistical test used.
Number of Respite providers	SFY 2023	1	☐ Not applicable—PIP is in planning or implementation phase, results not available	3	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): No statistical test used.
			☐ 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

The PIP was not able to link interventions with changes in performance measures. Magellan also could not define the rationale behind the quantitative goals made for the PIP. The PIP does not feature measures subject to assessments for statistical significance. Further, the PIP measures showed regression from the goals.

EQRO recommendations for improvement of PIP:

- Track reasons for provider enrollment and disenrollment.
- Develop statistical measures to assess the PIP besides raw provider counts.
- Define rationale driving the measure goals (i.e., how does Magellan determine the number of providers necessary to improve the network in a capacity that is meaningful to members and potential members).
- Define how demand for providers is assessed.
- Clearly discuss in the PIP narrative how new provider recruitment is intended to be driven by events with current providers.
- Provide data collection and analysis personnel and backgrounds in the PIP documentation.
- Determine methods to assess the effectiveness of individual interventions in making progress towards the PIP's goals.
- In the PIP documentation, detail the outreach efforts Magellan is undertaking to improve coordination with Indian Health Service providers and increase Native American provider enrollment to meet the needs of Native American enrolled youth.

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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.)			X	Topic selection was the result of reflection on FY17 performance for implementation of improvement programs in FY18. Available measures were vetted through a balanced scorecard measure. The PIP is included in Magellan's SOW, so it is required by WDH.
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 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.	X			The strategy was built to address opportunity for improvement for providers identified in the Wyoming FY2017 Fourth Quarter report. Measures identified for improvement were engagement (>60 days), and implementation (>180 days). Magellan included specific input from both enrollees and providers in selecting this PIP topic.
1.4 Did the PIP topic address care of special populations or high priority services, such as: • Children with special health care needs • Adults with physical disabilities • Children or adults with behavioral health issues • People with intellectual and developmental disabilities • People with dual eligibility who use long-term services and supports (LTSS) • Preventive care • Acute and chronic care • High-volume or high-risk services • Care received from specialized centers (e.g., burn, transplant, cardiac surgery) • Continuity or coordination of care from multiple providers and over multiple episodes • Appeals and grievances • Access to and availability of care	X			The PIP listed the population served as "All WY CME enrolled youths". CME enrolled youths are Medicaid-covered youth (4-20 years of age) experiencing serious emotional disturbance/serious mental illness (SED/SMI).

Question	Yes	No	NA	Comments
1.5 Did the PIP topic align with priority areas identified by HHS and/or CMS?	X			The Engagement and Implementation PIP aligns with the CMS Aims and Priorities Outcomes and Alignment as well as Access for All and Engagement. Additionally, the PIP topic selection used the Triple Aim approach (adopted from the Institute of Medicine) to identify gaps.
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. 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 2024?
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 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?	X			The PIP aim statement identified enrollment and implementation as target measures, change in authorization process as the strategy, and SFY 2024 as the time period.
2.2 Did the PIP aim statement clearly specify the population for the PIP?	X			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?	X			The PIP aim statement clearly identified the time period as SFY 2024.
2.4 Was the PIP aim statement concise?	X			The aim statements are two clear and concise sentences / questions.
2.5 Was the PIP aim statement answerable?	X			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?	X			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.				

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Worksheet 1.3. Review the Identified PIP Population

PIP Population _____

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 definition includes active eligibility, diagnosis, age, timeframe, and discharge date.
3.2 Was the entire MCP population included in the PIP?	X			
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 was collected from the Fidelity HER for all 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		X		Sampling was not used.
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. Engagement: percent of youth and families not reaching engagement threshold (>60 days) (Does the change in authorization process improve the percent of Wyoming Care Management Entity youth (ages 4-20 years old who were discharged during the measurement periods), and their families reach engagement threshold (>60 days) for SFY 2022?)

   Numerator: "Count of youth < 60 days (about 2 months) of HFWA ("not engaged")."
   Denominator: "Count of discharged youth HFWA"

2. Implementation: percent of you and families reaching implementation threshold (>180 days) (Does the change in authorization process improve the percent of Wyoming Care Management Entity youth (ages 4-20 years old who were discharged during the measurement periods), and their families reach implementation threshold (>180 days) for SFY 2022?)

   Numerator: "Count of youth > 180 days (about 6 months) of HFWA ("implemented")."
   Denominator: "Count of discharged youth HFWA."

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 engagement threshold (>60 days) and implementation threshold (>180 days) achievement during SFY 2024 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?	X			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)?	X			The measures are analyzed using claims data and EHR data for SFY 2024, 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		X		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?	X			The performance measures were viewed over a specified period of time (SFY 2024). 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?		X		Magellan did not consider or use 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)?			X	N/A - Magellan did not use existing measures to develop this PIP.

Question	Yes	No	NA	Comments
5.8 Did the measures capture changes in enrollee satisfaction or experience of care? • Although enrollee satisfaction/experience is an important outcome of care in clinical areas, improvement in satisfaction should not be the only measured outcome of a clinical project. Some improvement in health or functional status should also be addressed • For projects in nonclinical areas (such as addressing access or availability of services), measurement of health or functional status is preferred		X		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.
5.9 Did the measures include a strategy to ensure inter-rater reliability (if applicable)?		X		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		X		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.				

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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			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)?	X			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		X		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)	X			The following categories of data are collected: Member data such as Youth ID, Youth Last Name, Youth First Name, and Medicaid number Enrollment data 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?		X		The data analysis plan did not include details for how the EHR data will analyzed or validated.
6.6 Did the data collection instruments allow for consistent and accurate data collection over the time periods studied?	X			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?		X		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.				

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			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?			X	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?			X	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?			X	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)?			X	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?		X		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	X			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

Question	Yes	No	NA	Comments
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				relevant training and qualifications to conduct assessment of the EHR data. Following the on-site interviews, Magellan provided additional information on data personnel.
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		There was no discussion of inter-rated or intra-rater reliability discussed in submitted documentation.
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			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?	X			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?	X			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?		X		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. As noted in previous years, "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?		X		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?		X		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		X		Magellan only compared results to previous year's performance and baseline.

Question	Yes	No	NA	Comments
performance of a single entity, such as an MCP, over time				
7.7 Were PIP results and findings presented in a concise and easily understood manner?	X			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	X			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				

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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		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	X			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[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	X			Magellan did state in the submitted documentation that it used the quality practice of PDSA for PIP development.

[5] 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?[6]	X			Magellan did state that, "No cultural or linguistic concerns were noted during the planning or intervention stages" of the PIP.
8.5 Was the implementation of the strategy designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes (e.g., patient risk factors, Medicaid program changes, provider education, clinic policies or practices)?	X			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?		X		Although Magellan previously addressed the success of the PIP and follow-up activities, in this year's documentation there was no such discussion. There was an statistical analysis to the validity of the results, which were found not to be statistically valid, but not further discussion was provided.
8.7 Overall assessment: In the comments section, note any recommendations for improving the implementation strategies.				

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

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

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

Question	Yes	No	NA	Comments
9.1 Was the same methodology used for baseline and repeat measurements?	X			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." "For SFY 2023, a review of the Provider Scorecard baseline goals based on the aggregate performance of the providers indicates that for engagement, results ranged from 10% to 16% over time. For implementation, results ranged from 62% to 70%. The workgroup reviewed the initial baselines and determined that would change the Engagement baseline back to <16% which was the original baseline number and the new baseline for the Implementation metric would be placed at 70% which is the baseline for the Provider Scorecard implementation metric."
9.2 Was there any quantitative evidence of improvement in processes or outcomes of care?	X			Both measures reported continued changes from baseline after six years of the intervention, but the changes varied substantially from year to year. Measure 1 (goal <16%): The percent of youth and families not reaching engagement threshold at baseline was 16.43%. By 2024, the rate was 14.73%, a difference of only 1.7%. Measure 2 (goal 70%): The rate of Implementation increased from

Question	Yes	No	NA	Comments
				58.90% a baseline to 61.63% in 2024, an increase of 2.73%.
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			Although reported improvement has been minimal in past years, there was more progress made this year (Measure1: 14.73% to 12.5%; Measure 2: 64.21% to 69.89%). The trend has continued to be favorable and continued towards the identified goals even if the results were not found to be statistically significant.
9.4 Is there statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention?		X		Although Fischer's Exact t-tests were conducted to evaluate statistical significance, results for both measures were not found to be statistically significant for SFY 2024 results compared to SFY 2021.
9.5 Was sustained improvement demonstrated through repeated measurements over time?	X			Both measures have seen continued changes from baseline but have yet to meet their respective goals after six years of the intervention. Measure 1 (goal 10%): The percent of youth and families not reaching engagement threshold at baseline was 16.43%. By 2024, the rate was 14.73%%, a difference of only 3.93%. Measure 2 (goal 70%): The rate of Implementation increased from 58.90% a baseline to 61.63% in 2024, an increase of 2.73%.
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 methodology was sound but other statistical tests would have better suited the analysis conducted.
Rating 2: EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	The changes were not evaluated to be statistically significant. Further, the quantifiable measures showed substantial fluctuation from year to year. As such, there is limited confidence that the PIP showed evidence of sustained improvement.

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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: 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 2024? 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 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: ages 4-20 years old
Target population description, such as duals, LTSS or pregnant women (please specify): Medicaid-covered youth (4-20 years of age) experiencing serious emotional disturbance/serious mental illness (SED/SMI)
Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

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

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)
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 2024 ☐ Not applicable—PIP is in planning or implementation phase, results not available	N=258; Rate=14.73%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: .7914 ☐ <.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 2024 ☐ Not applicable—PIP is in planning or implementation phase, results not available	N=258; Rate=61.63%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: .5023 ☐ <.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): 6th remeasurement year

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: The methodology could have been improved with a more appropriate statistical test and consistency in comparison goals. The PIP measurements also did not demonstrate consistent or statistically significant improvement.

EQRO recommendations for improvement of PIP: The PIP is now completed, as this was the final remeasurement year.

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 2024 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	53.8%
Goal Not Met	15.4%
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	60.9%
No	17.4%
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	100.0%
Partially	0.0%
No	0.0%
Total	100.0%

Appendix E: Protocol 2 - Operational Requirements Review Tool

SFY24 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%	273.00	270.00	284.00	277.00	1104.00	Goal Met	Yes	Yes	Yes	Yes	
					Ops 8-17A D	Number of standard requests for authorization		300.00	275.00	287.00	278.00	1140.00						
					Ops 8-17A R	Calculated N/D		91%	98%	99%	100%	97%						
					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			No extended standard auths in SFY24
					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			No expedited auths in SFY24
					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			No extended expedited auths in SFY24
					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%	53.00	37.00	55.00	44.00	189.00	Goal Met	Yes	Yes	Yes	Yes	
					Ops 8-19D	Data showing compliance with this requirement shall be included in the quarterly data report.		53.00	37.00	55.00	44.00	189.00						
					Ops 8-19R	Calculated N/D		100%	100%	100%	100%	100%						
3	HFWA	Ops 8-25	**Grievances** Provide enrollee grievance, appeal, and information about the right to a State fair hearings process to enrollees and designated representatives to voice expressions of dissatisfaction. This process shall be documented in the Policies and Procedures, Member Handbook, and Provider Handbook and communicated to enrollees and providers, as directed by the Agency. Enrollee grievances may be filled orally or in writing at any time. The Contractor must also ensure that individuals making decisions regarding enrollee grievances and appeals are free of conflict, were not involved in any previous level of review or decision-making, have appropriate clinical expertise for treatment, if applicable, and must consider all submitted documents and information, considered at any level of the enrollee grievance and appeal process.	An appeal must be filed by an enrollee within sixty (60) calendar days from the date on the adverse benefit determination notice. An enrollee may file a grievance with the CME at any time. The Contractor must present a proposed resolution to the issue reported within ninety (90) calendar days from the date the Contractor receives the enrollee grievance or appeal. If the Contractor's proposed resolution is not accepted by the individual or entity acting on their behalf, the Contractor has thirty (30) calendar days to review and respond to the enrollee grievance or appeal. After exhausting the enrollee grievance and appeal process with the Contractor, the enrollee must have no less than ninety (90) calendar days the date of the Contractor's final notice of resolution to request an Agency fair hearing. Contractor must resolve enrollee grievances and provide notice according to the enrollee's health condition, no more than ninety (90) calendar days from grievance receipt.	Ops 8-25N	Contractor must resolve enrollee grievances and provide notice according to the enrollee's health condition, no more than ninety (90) calendar days from grievance receipt.	100%	1.00	0.00	0.00	0.00	1.00	Not Applicable	Not Applicable	Yes	Yes	Yes	Ops 8-26, became Ops 8-25 No data in SFY24
					Ops 8-25D	# of Grievances		1.00	0.00	0.00	0.00	1.00						
					Ops 8-25R	Calculated N/D		100%	0%	0%	0%	100%						
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 24 align with OP 8-30 No data in SFY24
					Ops 8-28D	# of Appeals		0.00	0.00	0.00	0.00	0.00						
					Ops 8-28R	Calculated N/D		0%	0%	0%	0%	0%						
5	HFWA	Ops 8-29	**Grievances & Appeals** In the event the Contractor makes an adverse action notification regarding an enrollee or if the action is a denial of payment, written notice of the adverse action notification must be mailed to the enrollee on the date of determination. All notices of adverse action must, at a minimum, explain the determination, reasons for the determination, right to retrieve applicable and related copies of documents and records of the grievance, the right and process to appeal or request State fair hearing. Notices must also include information regarding the expedition of the right to appeal, and the continuation of benefits. ME network providers do not have the right to file a grievance on behalf of themselves due to any adverse benefit determination regarding am enrollee they serve.	Appeals can be filed orally or in writing by the enrollee or an authorized representative, including the provider, within sixty (60) calendar days from the date on the adverse action notice. If the Contractor's review results in an adverse action, the Contractor must provide a thirty (30) calendar day advance notification to the enrollee and the enrollee's Family Care Coordinator prior to implementing a change in program eligibility and/or service amount, duration or frequency. The Contractor must mail the notice of adverse action notification at least ten (10) business days before the date of action, when the action is a termination, suspension, or reduction of previously authorized Medicaid covered services. If the Agency has facts indicating that action should be taken because of probable fraud by the enrollee, and the facts have been verified, if possible, through secondary sources, the Contractor must mail the notice of adverse action notification within five (5) business days prior to the date of action.	Ops 8-29N	Appeals can be filed orally or in writing by the enrollee or an authorized representative, including the provider, within sixty (60) calendar days from the date on the adverse action notice.	98%	0.00	0.00	0.00	0.00	0.00	Not Applicable	Not Applicable	Yes	Yes	Yes	The Reported Measure and Findings for SFY 24 align with OP 8-31 No data in SFY24
					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%						

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						
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	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 24 align with OP 8-33 No data in SFY24
					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	Not Applicable	Not Applicable	Yes	Yes	Yes	The Reported Measure and Findings for SFY 24 align with OP 8-33 No data in SFY24
					Ops 8-31D	# of Grievances		0.00	0.00	0.00	0.00	0.00						
					Ops 8-31R	Calculated N/D		0%	0%	0%	0%	0%						
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%	154.00	94.00	42.00	34.00	324.00	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-3D	# of member referrals		155.00	105.00	53.00	35.00	348.00						
					EM 9-3R	Calculated N/D		99%	90%	79%	97%	93%						
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 9-4	# 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%	236.00	174.00	133.00	119.00	662.00	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		193%	158%	57%	46%	91%						
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%	21	52	40.00	72.00	185	Goal Not Met	No	Yes	Yes	Yes	
					EM 9-5D	# of applications		21	52	40.00	75.00	188						
					EM 9-5R	Calculated N/D		100%	100%	100%	96%	98%						
11	Operations	EM 9-6	Triage all completed applications to the Agency that meet the Children's Mental Health Waiver (CMHW) criteria to the Agency for processing. Authorize providers upon receipt of Agency approval for services.`	Send all CMHW referrals to the Agency within two (2) business days of discovery.	EM 9-6N	Send all CMHW referrals to the Agency within two (2) business days of discovery.	100%	24.00	14.00	13.00	19.00	70.00	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-6D	# of referrals		24.00	14.00	13.00	19.00	70.00						
					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%	60.00	80.00	48.00	69.00	257.00	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-7D	# of new enrollees		65.00	80.00	58.00	74.00	277.00						
					EM 9-7R	Calculated N/D		92%	100%	83%	93%	93%						
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;	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%	3.00	2.00	0.00	1.00	6.00						
					EM 9-9D	# of members with a 30 day advance notice of termination.		3.00	2.00	0.00	1.00	6.00						

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						
			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).		EM 9-9R	Calculated N/D		100%	100%	0%	100%	100%	Goal Met	Yes	Yes	Yes	Yes	
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%	122.00	128.00	118.00	104.00	472.00	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-12D	# of members with a CASII or ECSII assessment.		122.00	128.00	118.00	104.00	472.00						
					EM 9-12R	Calculated N/D		100%	100%	100%	100%	100%						
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%	62.00	79.00	58.00	74.00	273.00	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-15D	# of new enrollees.		62.00	79.00	58.00	74.00	273.00						
					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%	45.00	37.00	41.00	43.00	166.00	Goal Not Met	No	Yes	Yes	Yes	
					EM 9-16D	# of new enrollees.		82.00	62.00	79.00	50.00	273.00						
					EM 9-16R	Calculated N/D		55%	60%	52%	86%	61%						
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%	289	267	273	282	1111	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-17D	# of POCs emailed.		289	267	273	282	1111						
					EM 9-17R	Calculated N/D		100%	100%	100%	100%	100%						
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%	567	552	548	524	2191	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-20D	# of youths.		631	580	558	536	2305						
					EM 9-20R	Calculated N/D		90%	95%	98%	98%	95%						
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%	175	167	167	166	675	Goal Not Met	No	Yes	Yes	Yes	
					EM 9-22D	# of enrollees with required readiness assessments due.		220	207	203	203	833						
					EM 9-22R	Calculated N/D		80%	81%	82%	82%	81%						
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%	135	134	136	145	550	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-23D	# of enrollees with a FCC Authorizations.		141	141	141	154	577						
					EM 9-23R	Calculated N/D		96%	95%	96%	94%	95%						
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%	1	1	0	1	3	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-24D	# of members with respite authorization.		1	0	0	1	2						
					EM 9-24R	Calculated N/D		100%	0%	0%	100%	150%						
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%	0	0	0	0	0	Goal Not Met	No	Yes	Yes	Yes	
					EM 9-29D	# new enrollees		0	0	0	0	0						
					EM 9-29R	Calculated N/D		0%	0%	0%	0%	0%						

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	SFY2024 YTD
Operations Reporting							
Ops 8-17A N	Number of standard auth decisions within timeframe (14 calendar days)		273.00	270.00	284.00	277.00	1104.00
Ops 8-17A D	Number of standard requests for authorization		300.00	275.00	287.00	278.00	1140.00
Ops 8-17A R	Calculated N/D	95%	91.00%	98.18%	98.95%	99.64%	96.84%
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.		53.00	37.00	55.00	44.00	189.00
Ops 8-19D	Data showing compliance with this requirement shall be included in the quarterly data report.		53.00	37.00	55.00	44.00	189.00
Ops 8-19R	Calculated N/D	98%	100.00%	100.00%	100.00%	100.00%	100.00%
Grievances							
Ops 8-25N	Contractor must resolve enrollee grievances and provide notice according to the enrollee's health condition, no more than ninety (90) calendar days from grievance receipt.		1.00	0.00	0.00	0.00	1.00
Ops 8-25D	# of Grievances		1.00	0.00	0.00	0.00	1.00
Ops 8-25R	Calculated N/D	100%	100.00%	0.00%	0.00%	0.00%	100.00%
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. Data		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%

Appendix E: Protocol 2 - Operational Requirements Review Tool

OP	Performance Measure Description	Magellan Goals	Q1	Q2	Q3	Q4	SFY2024 YTD
Enrollee Eligibility and Enrollment							
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 days.		154.00	94.00	42.00	34.00	324.00
EM 9-3D	# of member referrals		155.00	105.00	53.00	35.00	348.00
EM 9-3R	Calculated N/D	90%	99.35%	89.52%	79.25%	97.14%	93.10%
Assist families with the application or admission process for children and youth							
EM 9-4	# of member referrals, The Contractor must report on the number of children and youth referred,		236.00	174.00	133.00	119.00	662.00
EM 9-4D	# of member referrals		122.00	110.00	232.00	261.00	725.00
EM 9-4R	Calculated N/D	90%	193.44%	158.18%	57.33%	45.59%	91.31%
Process all applications							
EM 9-5N	Process all enrollee applications within three (3) business days once application information is		21.00	52.00	40.00	72.00	185.00
EM 9-5D	# of applications		21.00	52.00	40.00	75.00	188.00
EM 9-5R	Calculated N/D	100%	100.00%	100.00%	100.00%	96.00%	98.40%
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.		24.00	14.00	13.00	19.00	70.00
EM 9-6D	# of referrals		24.00	14.00	13.00	19.00	70.00
EM 9-6R	Calculated N/D	100%	100.00%	100.00%	100.00%	100.00%	100.00%
Youth and/or the families of admission to the CME							
EM 9-7N	# of new enrollees that were notified of enrollment within two (2) business days of the final eligibility		60.00	80.00	48.00	69.00	257.00
EM 9-7D	# of new enrollees		65.00	80.00	58.00	74.00	277.00
EM 9-7R	Calculated N/D	90%	92.31%	100.00%	82.76%	93.24%	92.78%
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.		3.00	2.00	0.00	1.00	6.00
EM 9-9D	# of members with a 30 day advance notice of termination.		3.00	2.00	0.00	1.00	6.00
EM 9-9R	Calculated N/D	95%	100.00%	100.00%	0.00%	100.00%	100.00%
Review all evaluations, including the CASII and ECSII, for completeness							
EM 9-12N	# of members with a CASII or ECSII that has been signed by a qualified medical health professional. This includes electronic and hardcopy assessments.		122.00	128.00	118.00	104.00	472.00
EM 9-12D	# of members with a CASII or ECSII assessment.		122.00	128.00	118.00	104.00	472.00
EM 9-12R	Calculated N/D	95%	100.00%	100.00%	100.00%	100.00%	100.00%
Member Handbook to all new enrollees and their guardians.							
EM 9-15N	# of new enrollees that have received a member handbook.		62.00	79.00	58.00	74.00	273.00
EM 9-15D	# of new enrollees.		62.00	79.00	58.00	74.00	273.00
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.		45.00	37.00	41.00	43.00	166.00
EM 9-16D	# of new enrollees.		82.00	62.00	79.00	50.00	273.00
EM 9-16R	Calculated N/D	95%	54.88%	59.68%	51.90%	86.00%	60.81%
Authorize POCs							
EM 9-17N	# of POCs reviewed, the Contractor shall review and process one hundred percent (100%) of all POCs submitted.		289.00	267.00	273.00	282.00	1111.00

Appendix E: Protocol 2 - Operational Requirements Review Tool

OP	Performance Measure Description	Magellan Goals	Q1	Q2	Q3	Q4	SFY2024 YTD
EM 9-17D	# of POCs emailed.		289.00	267.00	273.00	282.00	1111.00
EM 9-17R	Calculated N/D	100%	100.00%	100.00%	100.00%	100.00%	100.00%
FCC & Contact with Parent and Youth twice a month in a quarter							
EM 9-20N	Minimum of two progress notes documenting FCC contacts per month for youth and/or caregiver.		567.00	552.00	548.00	524.00	2191.00
EM 9-20D	# of youths.		631.00	580.00	558.00	536.00	2305.00
EM 9-20R	Calculated N/D	95%	89.86%	95.17%	98.21%	97.76%	95.05%
Routine readiness assessments based on the pre-approved Transition Readiness Scale							
EM 9-22N	# of assessment within 3 months of the previous assessment.		175.00	167.00	167.00	166.00	675.00
EM 9-22D	# of enrollees with required readiness assessments due.		220.00	207.00	203.00	203.00	833.00
EM 9-22R	Calculated N/D	90%	79.55%	80.68%	82.27%	81.77%	81.03%
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.		135.00	134.00	136.00	145.00	550.00
EM 9-23D	# of enrollees with a FCC Authorizations.		141.00	141.00	141.00	154.00	577.00
EM 9-23R	Calculated N/D	95%	95.74%	95.04%	96.45%	94.16%	95.32%
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.		1.00	1.00	0.00	1.00	3.00
EM 9-24D	# of members with respite authorization.		1.00	0.00	0.00	1.00	2.00
EM 9-24R	Calculated N/D	100%	100.00%	0.00%	0.00%	100.00%	150.00%
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.		0.00	0.00	0.00	0.00	0.00
EM 9-29D	# new enrollees		0.00	0.00	0.00	0.00	0.00
EM 9-29R	Calculated N/D	95%	0.00%	0.00%	0.00%	0.00%	0.00%
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.		246.00	222.00	213.00	232.00	913.00
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.		246.00	222.00	213.00	232.00	913.00
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	5.00	5.00	8.00	6.00	N/A
OUT 13-1D	# of youth enrolled with the CME Contractor.	N/A	132.00	144.00	150.00	149.00	N/A

Appendix E: Protocol 2 - Operational Requirements Review Tool

OP	Performance Measure Description	Magellan Goals	Q1	Q2	Q3	Q4	SFY2024 YTD
OUT 13-1R	Calculated N/D	N/A	3.79%	3.47%	5.33%	4.03%	4.2%
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	7.30	10.00	8.87	9.16	8.8325
OUT 13-2_2	# of youth enrolled with the CME Contractor.	N/A	132.00	144.00	150.00	149.00	N/A
Recidivism							
OUT 13-3N	# of youth enrolled in HLOC (PRTF)	N/A	5.00	5.00	8.00	6.00	N/A
OUT 13-3D	# of youth enrolled with the CME Contractor.	N/A	132.00	144.00	150.00	149.00	N/A
OUT 13-3R	Calculated N/D	N/A	3.79%	3.47%	5.33%	4.03%	4.2%
Recidivism (LOC) at six (6)							
OUT 13-4N	# of graduated youth admitted to HLOC w/in 6mths. (PRTF)	N/A	0.00	0.00	0.00	1.00	N/A
OUT 13-4D	# of youth graduated from the CME.	N/A	17.00	19.00	17.00	25.00	N/A
OUT 13-4R	Calculated N/D	N/A	0.00%	0.00%	0.00%	4.00%	1.0%
Primary Care Practitioner Access (EPSDT)							
OUT 13-5N	# of CME enrolled youth with an identified Primary Care Practitioner.	N/A	62.00	79.00	58.00	71.00	N/A
OUT 13-5D	# of youth enrolled in the CME.	N/A	62.00	79.00	58.00	74.00	N/A
OUT 13-5R	Calculated N/D	N/A	100.00%	100.00%	100.00%	95.95%	98.99%
Cost Savings							
OUT 13-6N	total Medicaid cost (WYCME)	N/A	$ 709,769.22	$ 673,349.88	$ 520,379.85	$ 368,070.51	N/A
OUT 13-6D	# of youth enrolled in CME	N/A	132.00	144.00	150.00	149.00	N/A
OUT 13-6A	Average cost of CME youth	N/A	$ 5,377.04	$ 4,676.04	$ 3,469.20	$ 2,470.27	N/A
OUT 13-6RON	Total Medicaid cost (other)	N/A	$ 477,392.01	$ 575,366.75	$ 509,671.67	$ 544,314.11	N/A
OUT 13-6ROD	# of non-HFWA youths w PRTF	N/A	83.00	96.00	103.00	97.00	N/A
OUT 13-6ROA	Average cost of PRTF youth	N/A	$ 5,751.71	$ 5,993.40	$ 4,948.27	$ 5,611.49	$ 1,248.74
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	74.3%	79.9%	75.80%	78.30%	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	37.00	29.00	32.00	29.00	127.00
Family and Youth Participation at State-Level Advisory Meetings							
OUT 13-9N	# of Attendees Representing Families	N/A	7	36	14	44	N/A
OUT 13-9D	# of Enrollees	N/A	746	705	673	652	N/A
			0.94%	5.11%	2.08%	6.75%	3.72%
Family and Youth Participation in Communities							
OUT 13-10N	Family and Youth Participation in Communities	N/A	1	0	1	2	N/A
OUT 13-10D	# of Attendees Representing Families	N/A	746	705	673	652	N/A
OUT 13-10R	# of Enrollees	N/A	0.13%	0.00%	0.15%	0.00%	0.07%

Wyoming Department of Health - SFY 2024
External Quality Review Technical Report
Appendix F. Outcome Measures Review Tool

Outcomes Tool

No	2024 SOW Section	Outcome Name - SFY 2024	Outcome Requirement - SFY 2024	Outcome Performance Measure - SFY 2024	Outcome Performance Penalty - SFY 2024	Q1	Q2	Q3	Q4	Status of Goal	Findings and Comments
1	OUT 13-1	Out-of-Home (OOH) Placements	The Contractor must, report the number of OOH placements of Contractor youth OOH=Out of Home (PRTF, or Acute Psychiatric Stabilization)	Report quarterly for the previous quarter the Denominator - number of youth enrolled with the CME Contractor and the Numerator – number of CME youth in OOH placement.	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next reporting period (following quarter).	N: 5 D: 132 %: 3.8	N: 5 D: 144 %: 3.5	N: 8 D: 150 %: 5.3	N: 6 D: 149 %: 4.0	Meets Requirement	Magellan reported the number and percent of OOH placements on a quarterly basis.
2	OUT 13-2	Decreased Length of Stay (LOS) for Inpatient and Residential Treatment admissions for youth enrolled in the CME.	The Contractor must report the overall length of stays for inpatient psychiatric treatment (PRTF and Acute Psychiatric Stabilization) for youth enrolled in the CME.	Report quarterly for the previous quarter the Average LOS for CME enrolled youth in OOH placement. Average LOS is equal to the average of PRTF and acute psychiatric hospitalization stays.	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next reporting period (following quarter).	ALOS: 7.30 days CME Enrolled Youth: 132	ALOS: 10 days CME Enrolled Youth: 144	ALOS: 8.87 days CME Enrolled Youth: 150	ALOS: 9.16 days CME Enrolled Youth: 149	Meets Requirement	Magellan reported the average length of stay on a quarterly basis.
3	OUT 13-3	Recidivism	The Contractor must decrease the recidivism of youth served by the Contractor moving from a lower level of care to a higher level of care.	Report quarterly for the previous quarter the Denominator - number of youth enrolled with the Contractor and the Numerator - number of youth moved to a higher level of care while served by the Contractor. LOC hierarchy = PRTF level of care	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next reporting period (following quarter)	N: 5 D: 132 %: 3.8	N: 5 D: 144 %: 3.5	N: 8 D: 150 %: 5.3	N: 6 D: 149 %: 4.0	Meets Requirement	Magellan reported the number of youth who moved to a higher level of care on a quarterly basis.
4	OUT 13-4	Recidivism (LOC) at six (6) months post CME graduation	The Contractor must report recidivism of youth served by the Contractor and who graduated from the CME program as having met goals, who are moving from a lower LOC to a higher LOC within six (6) months of graduation from the CME.	Report annually quarterly on the previous quarter in the following fiscal year no earlier than the end of the third quarter to assure any higher LOC claims are available for inclusion, the Denominator - number of youth graduated from the CME and the Numerator - number of graduated youth moved to a higher level of care (PRTF) within six (6) months of graduation from the CME.	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next reporting annual period (following year).	N: 0 D: 17 %: 0	N: 0 D: 19 %: 0	N: 0 D: 17 %: 0	N: 1 D: 25 %: 4	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: 62 D: 62 %: 100	N: 79 D: 79 %: 100	N: 58 D: 58 %: 100	N: 71 D: 74 %: 95.95	Meets Requirement	Magellan reported on EPSDT Compliance / PCP identification on a quarterly basis.

No	2024 SOW Section	Outcome Name - SFY 2024	Outcome Requirement - SFY 2024	Outcome Performance Measure - SFY 2024	Outcome Performance Penalty - SFY 2024	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.): $5,377.04 Avg. cost of PRTF youth (6 mo.): $5,751.71	Avg. cost of CME youth (6 mo.): $4,676.04 Avg. cost of PRTF youth (6 mo.): $5,993.40	Avg. cost of CME youth (6 mo.): $3,469.20 Avg. cost of PRTF youth (6 mo.): $4,948.27	Avg. cost of CME youth (6 mo.): $2,470.27 Avg. cost of PRTF youth (6 mo.): $5,611.49	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 and the decreased PMPM will continue until the next reporting period	74.3%	79.9%	75.8%	78.3%	Meets Requirement	Magellan reported fidelity to the HFWA model as measured by the Wraparound Fidelity Index (WFI-EZ) on a monthly basis.
8	OUT 13-8		The Contractor must report the number of WFI-EZ surveys received to capture a valid and representative sample of the experiences of enrollees served.	Report quarterly the number of WFI- EZ surveys received during the quarterly period compared to the same quarter in the previous year.	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by one quarter of one percent (0.25%) and the decreased PMPM will continue until the next reporting period (following quarter).	# of Surveys (average) : 82	# of Surveys (average): 66	# of Surveys (average): 60	# of Surveys (average): 39	Meets Requirement	Magellan reported the number of WFI-EZ surveys administered on a monthly basis.
9	OUT 13-9	Family and Youth Participation at State-level Advisory Committees	The Contractor must work with Agency to identify and invite family and youth to participate on State- level Advisory Committees.	Report quarterly for the previous quarter the Denominator - number of state-level Advisory attendees who represent family and youth enrollees and the Numerator - number of CME enrollees.	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%). The decreased PMPM will continue until the next reporting period	N: 7 D: 746 %: 0.94%	N: 36 D: 705 %: 5.11	N: 14 D: 673 %: 2.08	N: 44 D: 652 %: 6.75	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: 1 D: 746 %: 0.13	N: 0 D: 705 %: 0	N: 1 D: 673 %: 0.15	N: 2 D: 652 %: 0.31	Meets Requirement	Magellan reported on the Family and Youth Participation in Communities across on a quarterly basis.

Appendix G: Protocol 3 - Compliance Review Tool

Wyoming Department of Health (WDH), Care Management Entity (CME) Program

Appendix G: External Quality Review (EQR) Protocol 3 Document Request Crosswalk

#	Federal regulation source(s)	Medicaid agency policy/ regulation information needed to determine MCP compliance	SFY2024 Contract Language	Potentially Applicable MCP Documents	Document(s) Submitted (To Be Completed by Magellan)	Location within Document(s) of Language Demonstrating Compliance (To Be Completed by Magellan)	Documents Reviewed	Findings from Document Review	Questions / Required Follow-Up	Reviewer Determination
EX1	EXAMPLE 1	CMS Language	Language from SFY2024 SOW that aligns with CMS Language	Types of documentation that may be applicable to CMS Language per CMS guidance.	1) First Document Name 2) Second Document Name	1) Page Number(s) in First Document 2) Page Number(s) in Second Document				
EX2	EXAMPLE 2	•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]	Medicaid/CHIP enrollment and disenrollment policies and procedures (ES)	1) Magellan 2024 Disenrollment Policy 2) 2024 Member Handbook	1) pg. 5 2) pgs. 32, 46-47				
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)	1) P3.61. Quality Improvement Program QI.105.18 Policy; 2) P3.61. SFY2024 WY CME Quality Improvement Program Description Final; 3) P3.61. P3.68. SFY2024.WY CME QI_WorkPlan Final 4) P3.61.SFY2024 Magellan WY CME Quality Annual Program Evaluation	2) pgs.7,9-10,13-14,16-20 4) pgs 7-9,23,24	1) P3.61. Quality Improvement Program QI.105.18 Policy; 2) P3.61. SFY2024 WY CME Quality Improvement Program Description Final; 3) P3.61. P3.68. SFY2024.WY CME QI_WorkPlan Final 4) P3.61.SFY2024.Magellan WY CME Quality Annual Program Evaluation	All general and appropriate parameters are included in this document related to quality activities. However, evidence of Wyoming-specific input is limited to the QIC committee.	How does WY Magellan staff provide input on the annual review and edits? It appears the primary path of input is the QIC Committee, can you provide additional detail as to how they inform quality updates?	Fully 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]		1) P3.62 and P3.63.WY CME Quality Issues Management Final; 2) P3.62 and P3.63.WY CME Standardized Data Validation Plan for Performance Improvement Projects Final; 3) P3.62. P3.68.SFY2024. Annual.Report.Committee.Data.File P3.62.WY CME Data Validation-Verification Plan 5) P3.62.SFY2024 WY CME Quality Improvement Program Description 6) P3.62.Quality Improvement Program QI.105.18 Policy	4) 6) pgs 3-4,6-7	1) P3.62 and P3.63.WY CME Quality Issues Management Final; 2) P3.62 and P3.63.WY CME Standardized Data Validation Plan for Performance Improvement Projects Final; 3) P3.62. P3.68.SFY2024. Annual.Report.Committee.Data.File 4) P3.62.WY CME Data Validation-Verification Plan 5) P3.62.SFY2024 WY CME Quality	Magellan policy describes the establishment of the QAPI program and accompanying documentation of PIPs with targets and measures. The SFY2024 QAPI was included in this review, including three PIPs.		Fully Met
63		The state's specifications for how the MCP should identify, measure and report performance measures required per paragraph (c) of this section.	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]		1) P3.62 and P3.63.WY CME Quality Issues Management Final; 2) P3.62 and P3.63.WY CME Standardized Data Validation Plan for Performance Improvement Projects Final; 3) Improving the Prior Authorization Process PIP SFY 2024 4) Increase the Number of Providers in the WY Care Management Entity SFY 2024	3) See document in P1.1 4) See document in P1.1	1) P3.62 and P3.63.WY CME Quality Issues Management Final; 2) P3.62 and P3.63.WY CME Standardized Data Validation Plan for Performance Improvement Projects Final; 3) Improving the Prior Authorization Process PIP SFY 2024 4) Increase the Number of Providers in the WY Care Management Entity SFY 2024 *Addition: P.1.2 Quality Improvement Activity	Three PIPs appear reported to the State in SFY2024, including as part of the QAPI. The three PIPs include Increase the Number of Providers in the Wyoming Care Management Entity Network, Improving the Prior Authorization Process for the High Fidelity Wraparound Program, and Engagement and Implementation Improvement. However, significant, sustained improvement was not found across the three PIPs.	What are Magellan's plans to ensure more significant, positive impact of PIPs in upcoming years?	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]		1) P3.64.Medicaid Service Authorization Determination - CO.MCD.244.14; P3.64.WY CME HFWA Administrative Nonauthorization Procedure; P3.64.WY CME HFWA Clinical Nonauthorization Procedure; P3.64. P3.65.WY CME HFWA Concurrent Review Procedure; 5) P3.64. WY CME Minimum Contact Note Documentation Quality Check 2024; P3.64.SFY2024 Magellan WY CME Quality Annual Program Evaluation; 7) P3. 64.WY CME HFWA Enrollment Procedure; 8) P3. 64.WY CME Medicaid Eligibility Verification Procedure 9) P3.64. Medicaid Service Authorization Determination-CO.MCD.244.09-2024.WY.HFWA.AA FINAL 10) P3.64 WY CME Provider Record Documentation Review Procedure Final	2) 3) 4) 6) pgs 58-61 10) See document in P3.65	1) P3.64.Medicaid Service Authorization Determination - CO.MCD.244.14; 2) P3.64.WY CME HFWA Administrative Nonauthorization Procedure; 3) P3.64.WY CME HFWA Clinical Nonauthorization Procedure; 4) P3.64. P3.65.WY CME HFWA Concurrent Review Procedure; 5) P3.64. WY CME Minimum Contact Note Documentation Quality Check 2024; 6) P3.64.SFY2024 Magellan WY CME Quality Annual Program Evaluation; 7) P3. 64.WY CME HFWA Enrollment	The SFY2024 QAPI demonstrates a formal section dedicated to the evaluation of over and/or under utilization. This section demonstrates utilization analysis based on the minimum of two provider contacts per month. Additionally, the QAPI committee reviews service utilization quarterly. However, there is no evidence of member-specific service analysis or application of service trends to provider standards, which would provide a more comprehensive view of over and under utilization.	Are there any ongoing efforts to identify member-specific over or under utilization of services?	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]		1) P3. 65. WY CME Provider Record Documentation Review Procedure Final_; P3. 65.WY CME HFWA Annual Assessment Review Procedure; 3) P3.64. P3.65.WY CME HFWA Concurrent Review Procedure	2)	1) P3. 65. WY CME Provider Record Documentation Review Procedure Final_; 2) P3. 65.WY CME HFWA Annual Assessment Review, and Provider Record Documentation Review Procedure. All three policies reflect an attention to appropriateness of services, clinical eligibility for HFWA, and documentation quality maintenance. However, there is no reference to special health care needs and coordination or consideration of necessary collaboration to meet unique member needs.	Magellan provided three policies related to concurrent review for prior authorization, the HFWA Annual Assessment Review, and Provider Record Documentation Review Procedure. All three policies reflect an attention to appropriateness of services, clinical eligibility for HFWA, and documentation quality maintenance. However, there is no reference to special health care needs and coordination or consideration of necessary collaboration to meet unique member needs.	Our review identified limited reference to unique policies or provider parameters for meeting special health needs of specific members. How do CME providers ensure adequate collaboration and consideration of any special health needs or considerations? (i.e., physical health conditions, juvenile justice involvement, etc.) Are these activities noted in formal policy?	Not 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		Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
67		The state's requirements for the MCP's participation in efforts by the State to prevent, detect, report, investigate and remediate critical incidents, that occur within the delivery of LTSS as well as to track and trend results in order to make systems improvements, if applicable	Not Applicable		Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
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)	1) P3.61. P3.68. SFY2024.WY CME QI_WorkPlan Final; 2) P3.62. P3.68.SFY2024. Annual.Report.Committee.Data.File 3) SFY2024 Magellan WY CME Quality Annual Program Evaluation	3) pgs 9-24;58-61 (See document in P3.74)	1) P3.61. P3.68. SFY2024.WY CME QI_WorkPlan Final; 2) P3.62. P3.68.SFY2024. Annual.Report.Committee.Data.File 3) SFY2024 Magellan WY CME Quality Annual Program Evaluation	The QAPI report for SFY2024 detailed performance outcomes related to health status/outcomes, access/availability of care, use of service/utilization, health plan/provider characteristics, and beneficiary characteristics. The Annual Report Committee Data File provided additional data related to health plan financial cost and health outcomes. To improve upon current collection, service utilization and health plan stability analytics would be useful.	How does Magellan track health plan stability for the CME program in Wyoming?	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		Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
70		Information on whether the MCP calculates the performance measure and reports to the state or whether the MCP provides data to the state, which then calculates the PM.	Data on performance measures is reported to the Agency quarterly or as otherwise listed in the contractual requirements negotiated between the Agency and Contractor. The quarterly reports to the Agency aid in the identification of opportunities for quality improvement and the assessment of Contractor effectiveness. [SOW pg. 9]		1) P3.70. SFY2024 Q3.Enrollee.Management.Committee.Data.File; P3.70. SFY2024 Q3.General Operations C.Waiver.Committee.Data.File; P3.70. SFY2024 Q3.General.Operations.Committee.Data; P3.70. SFY2024 Q3.PM.OUT.Committee.Data.File; P3.70. SFY2024.Q1.Enrollee.Management.Committee.Data.File; P3.70. SFY2024.Q1.General Operations C.Waiver.Committee.Data.File; P3.70. SFY2024.Q1.General.Operations.Committee.Data; P3.70.SFY2024 Q2.PM.OUT.Committee.Data.File; P3.70.SFY2024 Q2.Enrollee.Management.Committee.Data.File; P3.70.SFY2024 Q2.General Operations C.Waiver.Committee.Data.File; P3.70.SFY2024 Q2.General.Operations.Committee.Data; P3.70.SFY2024.Q1.PM.OUT.Committee.Data.File	2) 3) 4) 5) 6) 7) 8) 9) 10) 11) 12)	1) P3.70. SFY2024 Q3.Enrollee.Management.Committee.Data.File; 2) P3.70. SFY2024 Q3.General Operations C Waiver.Committee.Data.File; 3) P3.70. SFY2024 Q3.General.Operations.Committee.Data; 4) P3.70. SFY2024 Q3.PM.OUT.Committee.Data.File; 5) P3.70. SFY2024.Q1.Enrollee.Management.Committee.Data.File; 6) P3.70. SFY2024.Q1.General Operations C Waiver.Committee.Data.File; P3.70.	Quarterly reports for Q1 and Q2 are provided and demonstrate regular reporting on performance metrics. Q3 and Q4 reports were not included for validation. Additionally, quarterly reports reflect data tables with an accompanying graph. There is not any additional narrative, recommendations, or strategic insight accompanying the data values.	Is there accompanying analysis or commentary is provided to the State alongside the quarterly data reports?	Partially 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)	1) Improving the Prior Authorization Process PIP SFY 2024 2) Increase the Number of Providers in the WY Care Management Entity SFY 2024	1) See document in P1.1 2) See document in P1.1	1) Improving the Prior Authorization Process PIP SFY 2024 2) Increase the Number of Providers in the WY Care Management Entity SFY 2024 *Addition: P.1.2 Quality Improvement Activity	Detailed reports of all PIP activities were delivered to the state during SFY2024. These reports include objective quality indicators for performance, interventions implemented with evaluation of impact, and planning commentary for the upcoming year. However, none of the three PIP activities demonstrated significant improvement, sustained over time.		Partially 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]		1) Improving the Prior Authorization Process PIP SFY 2024 2) Increase the Number of Providers in the WY Care Management Entity SFY 2024	1) See document in P1.1 2) See document in P1.1	1) Improving the Prior Authorization Process PIP SFY 2024 2) Increase the Number of Providers in the WY Care Management Entity SFY 2024	Detailed reports of all PIP activities were delivered to the state during SFY2024. These reports include objective quality indicators for performance, interventions implemented with evaluation of impact, and planning commentary for the upcoming year. However, none of the three PIP activities demonstrated significant improvement, sustained over time.		Partially 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		Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	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)	1) P3.74.SFY2024 Magellan WY CME Quality Annual Program Evaluation 2) SFY 2024 Annual Reports	1) pgs 23-34 2) Annual Reports in Protocol 2.6	1) P3.74.SFY2024 Magellan WY CME Quality Annual Program Evaluation 2) SFY 2024 Annual Reports	Annual reports from the CME provider reflect regular tracking of performance outcomes, analysis of PIPs, and initiatives directed at quality improvement.		Fully Met

Worksheet 4.1. State Network Adequacy Standards to be Validated

Instructions: Worksheet 4.1 guides the state and the EQRO to identify the network adequacy standards that the EQRO will need to validate. In the table below, the EQRO should list the quantitative network adequacy standards to be validated under this protocol. If covered under the state's managed care contracts, the validation standards should include adult and pediatric primary care, OB/GYN, adult and pediatric behavioral health, adult and pediatric specialist, hospital, pharmacy, pediatric dental, and LTSS providers. The validation standards should also include additional provider types (e.g., medication-assisted treatment providers for opioid use disorder), or specialists, as defined by the state, that follow the state's network adequacy standards. The state and the EQRO should add rows as necessary to the table to capture all state network adequacy standards that will be validated. Definitions for this activity include:

- **Network adequacy standard:** A quantitative parameter that states establish to set expectations for contracted managed care plans' provider networks. For example, a state may set a network adequacy standard that all enrollees have access to a primary care provider (PCP) within 30 miles or 30 minutes of their home.
- **Applicable provider types**: All provider types to which the network adequacy standard applies.
- **Applicable plan types**: All plan types (such as Medicaid, CHIP, LTSS, and dental plans) to which the network adequacy standard applies.
- **Applicable regions**: All regions to which the network adequacy standard applies. Typically, regions are categorized as urban, rural and frontier. In Activity 1, Step 1, the state and EQRO should clarify how regions are defined. When standards differ by region (for example, if the state's distance standard between a beneficiary home and primary care provider is 30 miles in urban areas and 50 miles in rural areas), they should be listed in separate rows in the table below.
- **Data and documentation submitted by MCPs**: All data and documentation MCPs must submit to demonstrate compliance with the network adequacy standard. In parentheses, please note the frequency with which this data and documentation is submitted (e.g., annually, quarterly, monthly).

Network adequacy standard	Applicable provider types	Applicable plan types	Applicable regions	Data and documentation submitted by MCPs (frequency)
Enrollees must have access to a primary care provider office within 30 minutes or 30 miles of their residence	*Primary care (family medicine physicians, internal medicine physicians, OBGYNs, pediatricians, nurse practitioners, physician assistants)*	*Medicaid, CHIP*	*Statewide*	*Beneficiary enrollment files (monthly)* *Provider network data files (quarterly)*
(PM 10-1 & PM 10-2) Magellan must develop a sufficient network of providers to ensure access to services and supports to all participants.	Family Care Coordinators, Family and Youth Peer Support and Advocacy, and Respite providers.	Medicaid	Statewide	Geomaps - Quarterly
(PM 10-4) Training shall be completed for each provider within ninety (90)	Family Care Coordinators, Family and Youth	Medicaid	Statewide	Committee Data File - Quarterly

calendar days of the start of the training for ninety-five percent (95%) of network providers.	Peer Support and Advocacy, and Respite providers.			
(PM 10-8) All network providers must be available during their defined business hours equal to those offered to commercial enrollees.	Family Care Coordinators, Family and Youth Peer Support and Advocacy, and Respite providers.	Medicaid	Statewide	None
(PM 10-11) Magellan must implement a regional approach to its provider network as approved by WDH.	Family Care Coordinators, Family and Youth Peer Support and Advocacy, and Respite providers.	Medicaid	Statewide	Network Development Plan – Annual Geomaps - Quarterly
(PM 10-13) Maximum caseload of 10 members for each provider.	Standard Family Care Coordinator.	Medicaid	Statewide	Caseload Reports – Weekly
(PM 10-13) Maximum caseload of 15 members for each provider.	Family Care Coordinators that have completed advanced “Tier 2” trainings.	Medicaid	Statewide	Caseload Reports – Weekly
(PM 10-13) Maximum caseload of 25 members for each provider.	Youth and Family Support Partners.	Medicaid	Statewide	Caseload Reports – Weekly

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Worksheet 4.2. Network Adequacy Indicators to be Validated

Instructions: Worksheet 4.2 guides the state and the EQRO to define the network adequacy indicators that the EQRO will need to validate. To start, the EQRO should fill in the first column of the table below with the network adequacy standards identified in Activity 1, Step 2 (Worksheet 4.1). The state and the EQRO should then identify and define the indicator(s) that will be validated, listing each indicator in its own row and adding rows as necessary. A separate worksheet should be completed to define the indicators that will be validated for each MCP, taking into account the standards that apply to each plan type. Definitions for this activity include:

- **Network adequacy standard:** A quantitative parameter that states establish to set expectations for contracted managed care plans' provider networks. For example, a state may set a network adequacy standard that all enrollees have access to a primary care provider (PCP) within 30 miles or 30 minutes of their home.
- **Network adequacy indicator**: The metric(s) used to assess adherence to the quantitative network adequacy standard required by the state. For example, the network adequacy indicator for a network adequacy standard that all enrollees have access to a primary care provider (PCP) within 30 miles or 30 minutes of their home could be the proportion of enrollees who have access to a primary care provider within 30 miles or 30 minutes from their home.
- **Definition of network adequacy indicator:** A clear description of the network adequacy indicator, including criteria for calculating the numerator and denominator. The definition should address specific methodological issues that impact indicator calculations. For example, for time and distance indicators, the definition should specify whether distance is measured "as the crow flies" or using driving distances. The definition should also identify the provider types to which the indicator applies.

Managed Care Plan (MCP) name: Magellan

Network adequacy standard	Network adequacy indicator	Definition of network adequacy indicator
Beneficiaries must have access to a primary care provider office within 30 minutes or 30 miles of their residence	*Proportion of beneficiaries who have a primary care provider accepting new Medicaid patients within 30 minutes or 30 miles of their residence*	*Numerator: Number of beneficiaries for which one or more of the following is true:* • *An in-network provider office is a 30-minute drive or less from their residence (according to mapping software)* • *An in-network provider office is 30 miles or less by road from of their home (according to mapping software)* *Denominator: All Medicaid and CHIP beneficiaries except those enrolled only in LTSS plans*
(PM 10-1 & PM 10-2) Magellan must develop a sufficient network of providers to ensure access to services and supports to all participants.	None in SOW – Defined by Magellan through caseload reviews.	Magellan describes the sufficient access as not fielding any concerns from members regarding access to providers. Magellan assesses member needs during weekly staff meetings. Magellan produces weekly caseload report that only features a list of members and the Family Care Coordinators assigned to them.
(PM 10-4) Training shall be completed for each provider within ninety (90) calendar days of the start of the training for ninety-five percent (95%) of network providers.	Proportion of providers that complete trainings within 90 calendar days of the start of training.	Numerator: "All providers shall complete and successful pass the certification process prior to providing any CME service." Denominator: "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."
(PM 10-8) All network providers must be available	Manual reviews of "assigned hours" as they	Assessed manually without a quantitative measure.

during their defined business hours equal to those offered to commercial enrollees.	align with the working hours indicated in providers' Medicaid applications.	
(PM 10-11) Magellan must implement a regional approach to its provider network as approved by WDH.	8 regions with associated counties	Region 1 – Albany, Goshen, Laramie, and Platte Counties Region 2 – Converse, Niobrara, and Natrona Counties Region 3 – Campbell, Crook, Johnson, Sheridan, and Weston Counties Region 4 – Big Horn, Hot Springs, Park, and Washakie Counties Region 5 – Fremont County (excluding the Reservation) Region 6 – Carbon, Sweetwater, and Uinta Counties Region 7 – Lincoln, Sublette, and Teton Counties Region 8 – Wind River Reservation
(PM 10-13) Maximum caseload of 10 members for each Family Care Coordinator that have only completed Tier 1 trainings.	List of members and their assigned provider(s)	Magellan produces weekly caseload report that only features a list of members and the Family Care Coordinators assigned to them. There are not quantitative values delivered to WDH to demonstrate adherence to the standard. There is also no information on completed trainings in the caseload report.
(PM 10-13) Maximum caseload of 15 members for Family Care Coordinators that have completed Tier 2 trainings.	List of members and their assigned provider(s)	Magellan produces weekly caseload report that only features a list of members and the Family Care Coordinators assigned to them. There are not quantitative values delivered to WDH to demonstrate adherence to the standard.
(PM 10-13) Maximum caseload of 25 members for each Youth and Family Support Partner provider.	List of members and their assigned provider(s)	Magellan produces weekly caseload report that only features a list of members and the Family Care Coordinators assigned to them. There are not quantitative values delivered to WDH to demonstrate adherence to the standard.

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Worksheet 4.3. Data Sources for Network Adequacy Validation

Instructions: For each network adequacy indicator identified in Activity 1, Step 2 (Worksheet 4.2), Worksheet 4.3 lists the network adequacy indicators used to measure the MCPs' compliance with the network adequacy standards established by the state and guides the EQRO to identify all data sources needed to validate a network adequacy indicator. To start, the EQRO should fill in the first column of the table below with the network adequacy indicators identified in Worksheet 4.2, adding rows as necessary. If multiple data sources will be used to validate a given indicator, each data source should be listed in a separate row. The EQRO should then fill in the remaining columns with information about the data source. Definitions for this activity include:

- **Network adequacy indicator**: The metric(s) used to assess adherence to the quantitative network adequacy standard required by the state. For example, the network adequacy indicator may be that enrollees have access to a primary care provider within 30 miles or 30 minutes from their home. The table below should include all network adequacy indicators identified in Worksheet 4.2.
- **Data source:** The type of data needed to validate a network adequacy indicator. When multiple data sources are used to validate a given indicator, each data source should be listed in a separate row. For example, if validation of time and distance indicators requires both provider network and beneficiary enrollment files, each data source should be listed separately. The year(s) of data should also be listed.
- **Data format and software:** File format for the data source and any digital software needed to access or analyze this file format. Additionally, the EQRO should note if it will need to convert this data to other file formats, and if so, any potential challenges that may occur.
- **Variables for network adequacy validation:** All variables within the data source that are needed to complete the validation activity. The EQRO should consider how to utilize different variables for beneficiary datasets and provider datasets.
- **State standards for data accuracy, timeliness, and completion**: If applicable, any standards set by the state related to data accuracy and completeness. Typically, this applies to data that MCPs collect and submit to the state.
- **Challenges and notes:** Any potential challenges the EQRO could encounter in accessing and using the data source, and any additional information that provides context for data validation of the given indicator. If applicable, this column could include hyperlink(s) to the data source or related materials to facilitate validation of the given indicator.

Managed Care Plan (MCP) name: *Magellan*

Network adequacy indicator	Data source and year(s) of data	Data format and analysis software; note if conversion required	Variables for network adequacy validation	State standards for accuracy, timeliness, and completion	Challenges and notes
Proportion of beneficiaries who have a primary care provider office within 30 minutes or 30 miles of their residence	*Beneficiary enrollment files*	*Comma Separated Value (CSV)*	*Beneficiary address, beneficiary date of birth, beneficiary plan type*	*State requires MCPs to submit updated and accurate beneficiary enrollment files monthly*	*State and MCP have noted that in urban regions a significant proportion of beneficiaries rely on public transit, rather than driving*

Network adequacy indicator	Data source and year(s) of data	Data format and analysis software; note if conversion required	Variables for network adequacy validation	State standards for accuracy, timeliness, and completion	Challenges and notes
Proportion of beneficiaries who have a primary care provider office within 30 minutes or 30 miles of their residence	*Provider network data files*	*Comma Separated Value (CSV)*	*Provider address, provider type*	*State requires MCPs to submitted updated and accurate provider network data files quarterly. The state flags and rejects data in which provider type is not specified.*	*State and MCP have noted challenges keeping provider network data up-to-date; provider network data also does not include information about accommodations for beneficiaries with physical disabilities or low English proficiency*
None in SOW – Defined by Magellan through caseload reviews.	None	N/A	N/A	N/A	Magellan does not provide quantitative measures to demonstrate adequate access or measurable goals to define adequate access.
Proportion of providers that complete trainings within 90 calendar days of the start of training.	SFY 2024 Committee Data File Q3 SFY 2024 Committee Data File	Excel file	Numerator: "All providers shall complete and successful pass the certification process prior to providing any CME service." Denominator: "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."	State requires Magellan to deliver the Committee Data file quarterly and annually.	None

Network adequacy indicator	Data source and year(s) of data	Data format and analysis software; note if conversion required	Variables for network adequacy validation	State standards for accuracy, timeliness, and completion	Challenges and notes
Manual review of "assigned hours" as they align with the working hours indicated in providers Medicaid application.	None	N/A	N/A	N/A	None Noted
8 regions with associated counties	SFY 2024 Network Development Plan	PDF	List of regions and their counties Number of providers active in each region.	None	Providers often deliver services via telehealth so they are counted for several counties.
List of members and their assigned provider(s)	6/7/2024 Weekly Caseload Report	PDF	List of members and the names of their Family Care Coordinator Name	None	The Caseload Report does not feature any quantitative values or context to demonstrate compliance.
List of members and their assigned provider(s)	6/7/2024 Weekly Caseload Report	PDF	List of members and the names of their Family Care Coordinator Name	None	None
List of members and their assigned provider(s)	None	None	None	None	None

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Worksheet 4.4. Network Adequacy Data Concerns Identified in Review of ISCA

Instructions: Worksheet 4.4 guides the EQRO in identifying any data concerns it has identified in its review of an MCP's Information System Capacity Assessment (ISCA). The EQRO should first determine whether the MCP has completed an ISCA review within the past two years. If the MCP has not conducted an ISCA within the previous two years, the EQRO must conduct one consistent with the processes discussed in Appendix A. If the MCP has completed an ISCA review within the past two years, the EQRO should review the findings and identify any concerns related to data sources that will be used in the network adequacy validation.

The EQRO should fill in the first column of the table below with data sources identified in Activity 2, Step 1 (Worksheet 4.3) that are covered in the ISCA. If the EQRO identifies concerns related to a given data source in its review of ISCA findings, the EQRO should fill in the remaining columns to describe the concern and potential workarounds. If no data concerns are identified for a given data source, the EQRO should enter "Not identified" in the second column.

Managed Care Plan (MCP) name: *Magellan*

Data source	Data concern	Type (check boxes)						Potential solutions or workarounds
		Data capture	Data processing	Data integration	Data storage	Data reporting	Other	
Provider network data files	*Provider network data files may be inaccurate due to providers entering and leaving networks, or changes in provider information, such as address*	X				X		*The EQRO will validate a sample of providers through phone calls or on-site visits to determine if the provider still participates in the network, if the location is accurate, and if the provider is accepting new Medicaid patients.*
None	None							None

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Worksheet 4.5. Assessment of Network Adequacy Data Sources not Reviewed in the ISCA

Instructions: Worksheet 4.5 guides the EQRO in assessing the integrity of any systems that collect, store, and process network adequacy data not addressed in the ISCA. The EQRO should identify any data source(s) identified in Activity 2, Step 1 (Worksheet 4.3) that were not reviewed in the ISCA. This may include MCP data sources not covered in the ISCA, data from non-MCP entities, and primary data the EQRO plans to collect for the purpose of the network adequacy validation. For each data source, the EQRO should complete the table below to assess the integrity of the system that collects, stores, and processes the data. The EQRO should conduct follow-up interviews as needed to supplement its understanding of the information systems and processes.

Managed Care Plan (MCP) name: _Magellan_____

Name of data source	Committee Data File
What system is used to collect this data?	Fidelity EHR, SQL, Quest Analytic Suite
What system is used to store this data?	Enterprise Data Warehouse
How frequently are the data collected and updated?	Weekly, Monthly, Quarterly, Annually
What software systems and/or programming languages are used to analyze this data?	SQL, SQL server, Cognos
Which staff are involved in collecting and storing this data, and what is their level of training?	Senior Manager, Clinical Analytics – BS in IT and 25 years of data analytics experience Manager, Clinical Analytics – MS in IT Systems and Management and 11 years of data analytics experience Clinical Analyst – BS in Information Management and 15 years as a data analyst Network Management Analyst – BS in Business Administration, BA in Psychology, and 4 years of experience as HFWA provider Quality Director – MA in Psychology, Licensed Clinical Social Worker, Lean Six Sigma Green Belt, and 20 years in Quality roles.
Are there adequate staffing resources to collect and analyze data? Specifically, does the MCP employ enough data analysts and do they have adequate time to perform necessary analytics?	Yes
Which staff are involved in analyzing and reporting this data, and what is their level of training?	Senior Manager, Clinical Analytics; Manager, Clinical Analytics; Clinical Analyst; Network Management Analyst; Quality Director
What errors may occur in the process of collecting, storing, and analyzing the data?	Incomplete data from claims at the time of data reporting, leading to changing values over time.
What systems are in place to prevent and fix errors that occur in the process of collecting, storing, and analyzing the data?	Data validation reviews at irregular intervals
What proportion of the data are missing or incomplete on key data elements?	Related to network adequacy indicators as described in the WDH-Magellan contract - 0
What systems are in place to prevent missing or incomplete data?	None
Data concerns relevant to network adequacy validation	A lack of measures to demonstrate network adequacy

Potential solutions or workarounds to address data concerns	Build additional data measures to demonstrate network adequacy and add contributory data to regular data pulls
Name of data source	SFY 2024 Network Development Plan
What system is used to collect this data?	Fidelity EHR, SQL, Quest Analytic Suite
What system is used to store this data?	Enterprise Data Warehouse
How frequently are the data collected and updated?	Weekly, Monthly, Quarterly, Annually
What software systems and/or programming languages are used to analyze this data?	SQL, SQL server, Cognos, Quest Analytic Suite
Which staff are involved in collecting and storing this data, and what is their level of training?	Senior Manager, Clinical Analytics – BS in IT and 25 years of data analytics experience Manager, Clinical Analytics – MS in IT Systems and Management and 11 years of data analytics experience Clinical Analyst – BS in Information Management and 15 years as a data analyst Network Management Analyst – BS in Business Administration, BA in Psychology, and 4 years of experience as HFWA provider Quality Director – MA in Psychology, Licensed Clinical Social Worker, Lean Six Sigma Green Belt, and 20 years in Quality roles.
Are there adequate staffing resources to collect and analyze data? Specifically, does the MCP employ enough data analysts and do they have adequate time to perform necessary analytics?	Yes
Which staff are involved in analyzing and reporting this data, and what is their level of training?	Senior Manager, Clinical Analytics; Manager, Clinical Analytics; Clinical Analyst; Network Management Analyst; Quality Director
What errors may occur in the process of collecting, storing, and analyzing the data?	Providers are often counted several times in maps demonstrating provider counts in each region due to telehealth delivery across regions.
What systems are in place to prevent and fix errors that occur in the process of collecting, storing, and analyzing the data?	None
What proportion of the data are missing or incomplete on key data elements?	Related to network adequacy indicators as described in the WDH-Magellan contract – only caseload ratios
What systems are in place to prevent missing or incomplete data?	None
Data concerns relevant to network adequacy validation	The Network Development Plan is a report, not a data source. Due to a lack of network adequacy requirements and related measures in current operations and contractual agreements between WDH and Magellan, raw data sources and network adequacy measure able to demonstrate compliance were not reported to WDH or provided for the EQR.
Potential solutions or workarounds to address data concerns	Develop quantifiable network adequacy standards and measures reported at a regular cadence as part of the Committee Data File.

Name of data source	Weekly Caseload Report
What system is used to collect this data?	Fidelity EHR
What system is used to store this data?	Fidelity EHR
How frequently are the data collected and updated?	Weekly
What software systems and/or programming languages are used to analyze this data?	Fidelity EHR, SQL, SQL server, Cognos
Which staff are involved in collecting and storing this data, and what is their level of training?	Senior Manager, Clinical Analytics – BS in IT and 25 years of data analytics experience Manager, Clinical Analytics – MS in IT Systems and Management and 11 years of data analytics experience Clinical Analyst – BS in Information Management and 15 years as a data analyst Network Management Analyst – BS in Business Administration, BA in Psychology, and 4 years of experience as HFWA provider Quality Director – MA in Psychology, Licensed Clinical Social Worker, Lean Six Sigma Green Belt, and 20 years in Quality roles.
Are there adequate staffing resources to collect and analyze data? Specifically, does the MCP employ enough data analysts and do they have adequate time to perform necessary analytics?	Yes
Which staff are involved in analyzing and reporting this data, and what is their level of training?	Senior Manager, Clinical Analytics; Manager, Clinical Analytics; Clinical Analyst; Network Management Analyst; Quality Director
What errors may occur in the process of collecting, storing, and analyzing the data?	The reports provided do not feature quantitative values to demonstrate compliance with caseload limits. Completed trainings for providers are not listed and providers are often listed multiple times for the same participant. Provider types are not listed.
What systems are in place to prevent and fix errors that occur in the process of collecting, storing, and analyzing the data?	None
What proportion of the data are missing or incomplete on key data elements?	50%
What systems are in place to prevent missing or incomplete data?	None
Data concerns relevant to network adequacy validation	The reports provided do not feature quantitative values to demonstrate compliance with caseload limits. Completed trainings for providers are not listed and providers are often listed multiple times for the same participant. Provider types are not listed.
Potential solutions or workarounds to address data concerns	Provide quantitative caseload ratios for each provider along with a field demonstrating their completed training level. Provide

	aggregate caseload ratio measures across providers of the same training levels. Delineate by provider types.

Worksheet 4.6. Assessment of MCP Network Adequacy Data, Methods, and Results

Instructions: Worksheet 4.6 guides the EQRO in evaluating and assessing the data and methods used by MCPs to calculate results generated for each network adequacy indicator. This worksheet also guides the EQRO in generating a validation rating that reflects the EQRO's overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis and interpretation of the network adequacy indicator.

The EQRO should fill in the table below **for each network adequacy indicator** to be validated. The EQRO should respond to the questions below, and insert comments to explain "No" and "Not Applicable" responses. If an item is partially met, select "No" and explain in comments. For example, if data sources are available for some but not all indicators or for some but not all years, select "No" and explain in comments. If an item is "Not Applicable," please explain in comments.

Managed Care Plan (MCP) name: Magellan

Network Adequacy Indicator: Manual Caseload and Member Service Receipt Reviews

Question	Yes	No	Not Applicable	Comments
Assessment of data collection procedures				
Were all data sources (and year[s] of data) needed to calculate this indicator submitted by the MCP to the EQRO?		X		Magellan reported that their method of confirming compliance relied on periodic manual reviews. They used claims data and the provider directory for this review. While Magellan did provide a provider directory, the claims data referenced was not provided and the review process was not detailed.
For each data source, were all variables needed to calculate this indicator included?		X		There was no data available to review and no standard process that pulls from data to inform a quantitative indicator.
Are there any patterns in missing data that may affect the calculation of this indicator? (Note: This assessment should be based on a systematic assessment of the proportion of missing data for each variable.)		X		There was no data provided or used to reference in calculating the indicator. As such, no pattern could be assessed, because not standard reporting system was defined or used.
Do the MCP's data enable valid, reliable, and timely calculations of this indicator?		X		The data was not standardized or assessed through a standard process. The indicator was not provided as a quantitative measure reported to WDH.
Did the MCP's data collection instruments and systems allow for consistent and accurate data collection for this indicator over the time periods studied?		X		Data was not collected consistently or regulatory to inform proof of compliance.

Question	Yes	No	Not Applicable	Comments
During the time period included in the reporting cycle, have there been any changes in the MCP's data systems that might affect the accuracy or completeness of network adequacy data used to calculate this indicator (e.g., major upgrades, consolidations within the system, acquisitions/mergers with other MCPs)?			X	Since there was no quantitative measures used to demonstrate compliance, no data system changes were relevant to assess the validity of this indicator.
If encounter or utilization data were used to calculate this indicator, did providers submit data for all encounters?			X	Encounter and utilization data were not used.
If LTSS data were used to calculate this indicator, were all relevant LTSS provider services included (for example, through claims and encounter data, authorization systems, case management systems, or electronic visit verification [EVV] systems)?			X	LTSS data were not used.
If access and availability studies were conducted to calculate this indicator, does the MCP include all phone calls made in the denominator? This means phone calls that do not reach a provider office may be excluded from the denominator.			X	Access and availability studies were not conducted.
If access and availability studies were conducted to calculate this indicator, does the MCP have processes for addressing potential roadblocks in identification, such as lack of a Medicaid or CHIP ID or medical record number needed to speak with provider offices?			X	Access and availability studies were not conducted.
Assessment of MCP Network Adequacy Methods				
Are the methods selected by the MCP to calculate this indicator appropriate for the state		X		WDH does not have concerns with the indicator as presented. The state is also small enough that manual reviews are possible and appropriate, even if not sufficiently rigorous.
Are the methods selected by the MCP to calculate this indicator appropriate to the state Medicaid and CHIP population(s)?		X		
Are the methods selected by the MCP adequate to generate the data needed to calculate this indicator?		X		Magellan has not provided a quantitative measure for the data to inform, as compliance is was reported to only be assessed through manual reviews of data.

Question	Yes	No	Not Applicable	Comments
In calculating this indicator, does the MCP use a system for classifying provider types that matches the state's expectations and follows how the state defines a specialist?	X			
If applicable, does the MCP's approach for addressing telehealth match the state's expectations?	X			
If the MCP is sampling a subset of the Medicaid and/or CHIP population to calculate this indicator, did the sampling frame contain a complete, recent, and accurate list of the target population? A sampling frame is the list from which the sample is drawn. It includes the universe of members of the target population, typically Medicaid and CHIP beneficiaries and providers. The completeness, currency, and accuracy of the sampling frame are key to the representativeness of the sample.			X	The indicator did not involve sampling.
If the MCP is sampling a subset of the Medicaid and/or CHIP population to calculate this indicator, is the sample representative of the population?			X	The indicator did not involve sampling.
If the MCP is sampling a subset of the Medicaid and/or CHIP population to calculate this indicator, are sample sizes large enough to draw statistically significant conclusions?			X	The indicator did not involve sampling.
In calculating this indicator, were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field.			X	The indicator did not involve sampling.
If applicable to this indicator, does the MCP's approach for measuring distance (e.g., "as the crow flies" or using road distances) match the state's expectation?			X	The indicator did not measure distance.
If applicable to this indicator, does the MCP's approach for measuring time (e.g., during low traffic or high traffic time periods, using driving distance or public transit) match the state's expectation?			X	The indicator did not measure time to a provider.
If applicable to this indicator, does the MCP's approach to deriving provider-to-enrollee ratios or percentage of contracted providers accepting new patients match the state's expectation?		X		The data sources provided do not provide caseload ratios that would align with those required by WDH.

Question	Yes	No	Not Applicable	Comments
If applicable to this indicator, does the MCP's approach for determining the maximum wait time for an appointment match the state's expectation?			X	The indicator does not assess wait time.
Are the methods used to calculate this indicator rigorous and objective?		X		The indicator is assessed through manual reviews at unspecified periods and / or points in time. There are no rigorous or objective methods used to assess compliance with the standard.
Are the methods used to calculate this indicator unlikely to be subject to manipulation? If "no," please describe in the "comments" field.		X		There are no objective methods or rigorous protocols used to calculate the indicator. Compliance reviews are conducted via manual reviews and not reported to WDH.
Assessment of MCP network adequacy results				
In calculating this indicator, did the MCP produce valid results—that is, did the MCP measure what they intended to measure?		X		There are no clear measurements provided to WDH to demonstrate compliance.
In calculating this indicator, did the MCP produce accurate results—that is, did the MCP's calculated values reflect the true values?		X		There are no clear measurements provided to WDH to demonstrate compliance.
In calculating this indicator, did the MCP produce reliable results—that is, were the MCP's results reproducible and consistent?		X		There are no clear measurements provided to WDH to demonstrate compliance.
In calculating this indicator, did the MCP accurately interpret its results?		X		There are no clear measurements provided to WDH to demonstrate compliance.
Comments				
Please note any recommendations for improving the data collection procedures to calculate this indicator.				
Please note any recommendations for improving the sampling methods to calculate this indicator.				
Please note any recommendations for improving the analysis to calculate this indicator.				
Please note any recommendations for improving the results to calculate this indicator.				

Calculate validation score:

A. Total number of "Yes" responses	**2**

B. Total number of "No" responses	**15**
Score = A / (A + B) x 100	**11.8%**

Determine validation rating:

The "validation rating" refers to the EQRO's overall confidence that acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Validation score	Validation rating
90.0% or greater	High confidence
51.0% to 89.9%	Moderate confidence
10.0% to 49.9%	Low confidence
Less than 10%	No confidence

Summary:

Managed Care Plan (MCP) name: Magellan
Indicator: Manual Caseload and Member Provider Reviews
Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
Comments

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Network Adequacy Indicator: Proportion of providers that complete trainings within 90 calendar days of the start of training

Question	Yes	No	Not Applicable	Comments
Assessment of data collection procedures				
Were all data sources (and year[s] of data) needed to calculate this indicator submitted by the MCP to the EQRO?	X			
For each data source, were all variables needed to calculate this indicator included?	X			

Question	Yes	No	Not Applicable	Comments
Are there any patterns in missing data that may affect the calculation of this indicator? (Note: This assessment should be based on a systematic assessment of the proportion of missing data for each variable.)		X		Magellan did not provide the source data.
Do the MCP's data enable valid, reliable, and timely calculations of this indicator?		X		The indicator is not assessed at clear intervals, and the data did not align with the number of providers assessed.
Did the MCP's data collection instruments and systems allow for consistent and accurate data collection for this indicator over the time periods studied?	X			
During the time period included in the reporting cycle, have there been any changes in the MCP's data systems that might affect the accuracy or completeness of network adequacy data used to calculate this indicator (e.g., major upgrades, consolidations within the system, acquisitions/mergers with other MCPs)?			X	No changes were made in the data systems.
If encounter or utilization data were used to calculate this indicator, did providers submit data for all encounters?			X	Encounter and utilization data were not used for this indicator.
If LTSS data were used to calculate this indicator, were all relevant LTSS provider services included (for example, through claims and encounter data, authorization systems, case management systems, or electronic visit verification [EVV] systems)?			X	LTSS data were not used.
If access and availability studies were conducted to calculate this indicator, does the MCP include all phone calls made in the denominator? This means phone calls that do not reach a provider office may be excluded from the denominator.			X	Access and availability studies were not conducted.
If access and availability studies were conducted to calculate this indicator, does the MCP have processes for addressing potential roadblocks in identification, such as lack of a Medicaid or CHIP ID or medical record number needed to speak with provider offices?			X	Access and availability studies were not conducted.
Assessment of MCP Network Adequacy Methods				

Question	Yes	No	Not Applicable	Comments
Are the methods selected by the MCP to calculate this indicator appropriate for the state	X			
Are the methods selected by the MCP to calculate this indicator appropriate to the state Medicaid and CHIP population(s)?	X			
Are the methods selected by the MCP adequate to generate the data needed to calculate this indicator?		X		The numerator and denominator for the value do not align with the proportion noted in the measure description.
In calculating this indicator, does the MCP use a system for classifying provider types that matches the state's expectations and follows how the state defines a specialist?	X			
If applicable, does the MCP's approach for addressing telehealth match the state's expectations?			X	The measure does not relate to telehealth service delivery.
If the MCP is sampling a subset of the Medicaid and/or CHIP population to calculate this indicator, did the sampling frame contain a complete, recent, and accurate list of the target population? A sampling frame is the list from which the sample is drawn. It includes the universe of members of the target population, typically Medicaid and CHIP beneficiaries and providers. The completeness, currency, and accuracy of the sampling frame are key to the representativeness of the sample.			X	The indicator did not involve sampling.
If the MCP is sampling a subset of the Medicaid and/or CHIP population to calculate this indicator, is the sample representative of the population?			X	The indicator did not involve sampling.
If the MCP is sampling a subset of the Medicaid and/or CHIP population to calculate this indicator, are sample sizes large enough to draw statistically significant conclusions?			X	The indicator did not involve sampling.
In calculating this indicator, were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field.			X	The indicator did not involve sampling.
If applicable to this indicator, does the MCP's approach for measuring distance (e.g., "as the crow flies" or using road distances) match the state's expectation?			X	The indicator did not measure distance.

Question	Yes	No	Not Applicable	Comments
If applicable to this indicator, does the MCP's approach for measuring time (e.g., during low traffic or high traffic time periods, using driving distance or public transit) match the state's expectation?			X	The indicator did not measure time to a provider.
If applicable to this indicator, does the MCP's approach to deriving provider-to-enrollee ratios or percentage of contracted providers accepting new patients match the state's expectation?			X	The indicator does not assess ratios or percentage of contracted providers.
If applicable to this indicator, does the MCP's approach for determining the maximum wait time for an appointment match the state's expectation?			X	The indicator does not assess wait time.
Are the methods used to calculate this indicator rigorous and objective?	X			
Are the methods used to calculate this indicator unlikely to be subject to manipulation? If "no," please describe in the "comments" field.	X			
Assessment of MCP network adequacy results				
In calculating this indicator, did the MCP produce valid results—that is, did the MCP measure what they intended to measure?		X		The numerator and denominator listed in the committee data file to not align with the proportion expressed in the measure description.
In calculating this indicator, did the MCP produce accurate results—that is, did the MCP's calculated values reflect the true values?		X		The numerator and denominator listed in the committee data file to not align with the proportion expressed in the measure description.
In calculating this indicator, did the MCP produce reliable results—that is, were the MCP's results reproducible and consistent?		X		The numerator and denominator listed in the committee data file to not align with the proportion expressed in the measure description.
In calculating this indicator, did the MCP accurately interpret its results?		X		The numerator and denominator listed in the committee data file to not align with the proportion expressed in the measure description.
Comments				
Please note any recommendations for improving the data collection procedures to calculate this indicator.				

Question	Yes	No	Not Applicable	Comments
Please note any recommendations for improving the sampling methods to calculate this indicator.				
Please note any recommendations for improving the analysis to calculate this indicator.				
Please note any recommendations for improving the results to calculate this indicator.				

Calculate validation score:

A. Total number of "Yes" responses	**8**
B. Total number of "No" responses	**7**
Score = A / (A + B) x 100	**53.3%**

Determine validation rating:

The "validation rating" refers to the EQRO's overall confidence that acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Validation score	Validation rating
90.0% or greater	High confidence
51.0% to 89.9%	Moderate confidence
10.0% to 49.9%	Low confidence
Less than 10%	No confidence

Summary:

Managed Care Plan (MCP) name: Magellan
Indicator: Proportion of providers that complete trainings within 90 calendar days of the start of training
Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
Comments

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.

Network Adequacy Indicator: Manual review of "assigned hours" as they align with the working hours indicated in providers' Medicaid applications

Question	Yes	No	Not Applicable	Comments
Assessment of data collection procedures				
Were all data sources (and year[s] of data) needed to calculate this indicator submitted by the MCP to the EQRO?		X		Magellan reported that their method of confirming compliance relied on periodic manual reviews. They used claims data and the provider directory for this review. While Magellan did provide a provider directory, the claims data referenced was not provided and the review process was not detailed.
For each data source, were all variables needed to calculate this indicator included?		X		There was no data available to review and no standard process that pulls from data to inform a quantitative indicator.
Are there any patterns in missing data that may affect the calculation of this indicator? (Note: This assessment should be based on a systematic assessment of the proportion of missing data for each variable.)		X		There was no data provided or used to reference in calculating the indicator. As such, no pattern could be assessed, because not standard reporting system was defined or used.
Do the MCP's data enable valid, reliable, and timely calculations of this indicator?		X		The data was not standardized or assessed through a standard process. The indicator was not provided as a quantitative measure reported to WDH.
Did the MCP's data collection instruments and systems allow for consistent and accurate data collection for this indicator over the time periods studied?		X		Data was not collected consistently or regulatory to inform proof of compliance.
During the time period included in the reporting cycle, have there been any changes in the MCP's data systems that might affect the accuracy or completeness of network adequacy data used to calculate this indicator (e.g., major upgrades, consolidations within the system, acquisitions/mergers with other MCPs)?			X	Since there was no quantitative measures used to demonstrate compliance, no data system changes were relevant to assess the validity of this indicator.
If encounter or utilization data were used to calculate this indicator, did providers submit data for all encounters?			X	Encounter and utilization data were not used.
If LTSS data were used to calculate this indicator, were all relevant LTSS provider services included (for example, through claims and encounter data, authorization systems, case management systems, or electronic visit verification [EVV] systems)?			X	LTSS data were not used.

Question	Yes	No	Not Applicable	Comments
If access and availability studies were conducted to calculate this indicator, does the MCP include all phone calls made in the denominator? This means phone calls that do not reach a provider office may be excluded from the denominator.			X	Access and availability studies were not conducted.
If access and availability studies were conducted to calculate this indicator, does the MCP have processes for addressing potential roadblocks in identification, such as lack of a Medicaid or CHIP ID or medical record number needed to speak with provider offices?			X	Access and availability studies were not conducted.
Assessment of MCP Network Adequacy Methods				
Are the methods selected by the MCP to calculate this indicator appropriate for the state	X			WDH does not have concerns with the indicator as presented. The state is also small enough that manual reviews are possible and appropriate, even if not sufficiently rigorous.
Are the methods selected by the MCP to calculate this indicator appropriate to the state Medicaid and CHIP population(s)?	X			
Are the methods selected by the MCP adequate to generate the data needed to calculate this indicator?		X		Magellan has not provided a quantitative measure for the data to inform, as compliance is was reported to only be assessed through manual reviews of data.
In calculating this indicator, does the MCP use a system for classifying provider types that matches the state's expectations and follows how the state defines a specialist?	X			
If applicable, does the MCP's approach for addressing telehealth match the state's expectations?	X			
If the MCP is sampling a subset of the Medicaid and/or CHIP population to calculate this indicator, did the sampling frame contain a complete, recent, and accurate list of the target population? A sampling frame is the list from which the sample is drawn. It includes the universe of members of the target population, typically Medicaid and CHIP beneficiaries and providers. The completeness, currency, and accuracy of the sampling frame are key to the representativeness of the sample.			X	The indicator did not involve sampling.

Question	Yes	No	Not Applicable	Comments
If the MCP is sampling a subset of the Medicaid and/or CHIP population to calculate this indicator, is the sample representative of the population?			X	The indicator did not involve sampling.
If the MCP is sampling a subset of the Medicaid and/or CHIP population to calculate this indicator, are sample sizes large enough to draw statistically significant conclusions?			X	The indicator did not involve sampling.
In calculating this indicator, were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field.			X	The indicator did not involve sampling.
If applicable to this indicator, does the MCP's approach for measuring distance (e.g., "as the crow flies" or using road distances) match the state's expectation?			X	The indicator did not measure distance.
If applicable to this indicator, does the MCP's approach for measuring time (e.g., during low traffic or high traffic time periods, using driving distance or public transit) match the state's expectation?			X	The indicator did not measure time to a provider.
If applicable to this indicator, does the MCP's approach to deriving provider-to-enrollee ratios or percentage of contracted providers accepting new patients match the state's expectation?			X	The indicator does not assess ratios or percentage of contracted providers.
If applicable to this indicator, does the MCP's approach for determining the maximum wait time for an appointment match the state's expectation?			X	The indicator does not assess wait time.
Are the methods used to calculate this indicator rigorous and objective?		X		The indicator is assessed through manual reviews at unspecified periods and / or points in time. There are no rigorous or objective methods used to assess compliance with the standard.
Are the methods used to calculate this indicator unlikely to be subject to manipulation? If "no," please describe in the "comments" field.		X		There are no objective methods or rigorous protocols used to calculate the indicator. Compliance reviews are conducted via manual reviews and not reported to WDH.
Assessment of MCP network adequacy results				
In calculating this indicator, did the MCP produce valid results—that is, did the MCP measure what they intended to measure?		X		There are no clear measurements provided to WDH to demonstrate compliance.

Question	Yes	No	Not Applicable	Comments
In calculating this indicator, did the MCP produce accurate results—that is, did the MCP's calculated values reflect the true values?		X		There are no clear measurements provided to WDH to demonstrate compliance.
In calculating this indicator, did the MCP produce reliable results—that is, were the MCP's results reproducible and consistent?		X		There are no clear measurements provided to WDH to demonstrate compliance.
In calculating this indicator, did the MCP accurately interpret its results?		X		There are no clear measurements provided to WDH to demonstrate compliance.
Comments				
Please note any recommendations for improving the data collection procedures to calculate this indicator.				
Please note any recommendations for improving the sampling methods to calculate this indicator.				
Please note any recommendations for improving the analysis to calculate this indicator.				
Please note any recommendations for improving the results to calculate this indicator.				

Calculate validation score:

A. Total number of "Yes" responses	**4**
B. Total number of "No" responses	**12**
Score = A / (A + B) x 100	**25%**

Determine validation rating:

The "validation rating" refers to the EQRO's overall confidence that acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Validation score	Validation rating
90.0% or greater	High confidence
51.0% to 89.9%	Moderate confidence
10.0% to 49.9%	Low confidence
Less than 10%	No confidence

Summary:

Managed Care Plan (MCP) name: Magellan

Indicator: Manual review of "assigned hours" as they align with the working hours indicated in providers' Medicaid applications
Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
Comments

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.

Network Adequacy Indicator: 8 regions with associated counties

Question	Yes	No	Not Applicable	Comments
Assessment of data collection procedures				
Were all data sources (and year[s] of data) needed to calculate this indicator submitted by the MCP to the EQRO?	X			
For each data source, were all variables needed to calculate this indicator included?	X			
Are there any patterns in missing data that may affect the calculation of this indicator? (Note: This assessment should be based on a systematic assessment of the proportion of missing data for each variable.)		X		Magellan's number of providers does not align across the data sources provided (i.e., Geomaps, SFY 2024 Network Development Plan). The Geomaps also do not account for providers that deliver services in several regions when denoting the number of providers active in each regions.
Do the MCP's data enable valid, reliable, and timely calculations of this indicator?		X		Magellan's number of providers does not align across the data sources provided (i.e., Geomaps, SFY 2024 Network Development Plan). The Geomaps also do not account for providers that deliver services in several regions when denoting the number of providers active in each regions.

Question	Yes	No	Not Applicable	Comments
Did the MCP's data collection instruments and systems allow for consistent and accurate data collection for this indicator over the time periods studied?		X		Magellan's number of providers does not align across the data sources provided (i.e., Geomaps, SFY 2024 Network Development Plan). The Geomaps also do not account for providers that deliver services in several regions when denoting the number of providers active in each regions. Magellan reported that provider counts were not reflective of those providing services due to agencies not reporting when providers leave their agency. This discrepancy has since been remedied.
During the time period included in the reporting cycle, have there been any changes in the MCP's data systems that might affect the accuracy or completeness of network adequacy data used to calculate this indicator (e.g., major upgrades, consolidations within the system, acquisitions/mergers with other MCPs)?		X		Magellan reported that provider counts were not reflective of those providing services due to agencies not reporting when providers leave their agency. This discrepancy has since been remedied.
If encounter or utilization data were used to calculate this indicator, did providers submit data for all encounters?			X	Encounter and utilization data were not used.
If LTSS data were used to calculate this indicator, were all relevant LTSS provider services included (for example, through claims and encounter data, authorization systems, case management systems, or electronic visit verification [EVV] systems)?			X	LTSS data were not used.
If access and availability studies were conducted to calculate this indicator, does the MCP include all phone calls made in the denominator? This means phone calls that do not reach a provider office may be excluded from the denominator.			X	Access and availability studies were not conducted.
If access and availability studies were conducted to calculate this indicator, does the MCP have processes for addressing potential roadblocks in identification, such as lack of a Medicaid or CHIP ID or medical record number needed to speak with provider offices?			X	Access and availability studies were not conducted.
Assessment of MCP Network Adequacy Methods				

Question	Yes	No	Not Applicable	Comments
Are the methods selected by the MCP to calculate this indicator appropriate for the state	X			
Are the methods selected by the MCP to calculate this indicator appropriate to the state Medicaid and CHIP population(s)?	X			
Are the methods selected by the MCP adequate to generate the data needed to calculate this indicator?		X		The data shows inconsistencies and the Geomap values do not account for providers that deliver services in more than one region.
In calculating this indicator, does the MCP use a system for classifying provider types that matches the state's expectations and follows how the state defines a specialist?	X			
If applicable, does the MCP's approach for addressing telehealth match the state's expectations?		X		The geomap values do not consider if an provider delivers telehealth services in several regions when considering regional access to services. As such, providers are counted multiple times in several regions.
If the MCP is sampling a subset of the Medicaid and/or CHIP population to calculate this indicator, did the sampling frame contain a complete, recent, and accurate list of the target population? A sampling frame is the list from which the sample is drawn. It includes the universe of members of the target population, typically Medicaid and CHIP beneficiaries and providers. The completeness, currency, and accuracy of the sampling frame are key to the representativeness of the sample.			X	The indicator did not involve sampling.
If the MCP is sampling a subset of the Medicaid and/or CHIP population to calculate this indicator, is the sample representative of the population?			X	The indicator did not involve sampling.
If the MCP is sampling a subset of the Medicaid and/or CHIP population to calculate this indicator, are sample sizes large enough to draw statistically significant conclusions?			X	The indicator did not involve sampling.
In calculating this indicator, were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field.			X	The indicator did not involve sampling.

Question	Yes	No	Not Applicable	Comments
If applicable to this indicator, does the MCP's approach for measuring distance (e.g., "as the crow flies" or using road distances) match the state's expectation?			X	The indicator did not measure distance.
If applicable to this indicator, does the MCP's approach for measuring time (e.g., during low traffic or high traffic time periods, using driving distance or public transit) match the state's expectation?			X	The indicator did not measure time to a provider.
If applicable to this indicator, does the MCP's approach to deriving provider-to-enrollee ratios or percentage of contracted providers accepting new patients match the state's expectation?			X	The indicator does not assess ratios or percentage of contracted providers.
If applicable to this indicator, does the MCP's approach for determining the maximum wait time for an appointment match the state's expectation?			X	The indicator does not assess wait time.
Are the methods used to calculate this indicator rigorous and objective?	X			
Are the methods used to calculate this indicator unlikely to be subject to manipulation? If "no," please describe in the "comments" field.	X			
Assessment of MCP network adequacy results				
In calculating this indicator, did the MCP produce valid results—that is, did the MCP measure what they intended to measure?		X		Magellan's number of providers does not align across the data sources provided (i.e., Geomaps, SFY 2024 Network Development Plan). The Geomaps also do not account for providers that deliver services in several regions when denoting the number of providers active in each regions. Magellan reported that provider counts were not reflective of those providing services due to agencies not reporting when providers leave their agency. This discrepancy has since been remedied.

Question	Yes	No	Not Applicable	Comments
In calculating this indicator, did the MCP produce accurate results—that is, did the MCP's calculated values reflect the true values?		X		Magellan's number of providers does not align across the data sources provided (i.e., Geomaps, SFY 2024 Network Development Plan). The Geomaps also do not account for providers that deliver services in several regions when denoting the number of providers active in each regions. Magellan reported that provider counts were not reflective of those providing services due to agencies not reporting when providers leave their agency. This discrepancy has since been remedied.
In calculating this indicator, did the MCP produce reliable results—that is, were the MCP's results reproducible and consistent?		X		Magellan's number of providers does not align across the data sources provided (i.e., Geomaps, SFY 2024 Network Development Plan). The Geomaps also do not account for providers that deliver services in several regions when denoting the number of providers active in each regions. Magellan reported that provider counts were not reflective of those providing services due to agencies not reporting when providers leave their agency. This discrepancy has since been remedied.
In calculating this indicator, did the MCP accurately interpret its results?		X		Magellan's number of providers does not align across the data sources provided (i.e., Geomaps, SFY 2024 Network Development Plan). The Geomaps also do not account for providers that deliver services in several regions when denoting the number of providers active in each regions. Magellan reported that provider counts were not reflective of those providing services due to agencies not reporting when providers leave their agency. This discrepancy has since been remedied.
Comments				
Please note any recommendations for improving the data collection procedures to calculate this indicator.				
Please note any recommendations for improving the sampling methods to calculate this indicator.				

Question	Yes	No	Not Applicable	Comments
Please note any recommendations for improving the analysis to calculate this indicator.				
Please note any recommendations for improving the results to calculate this indicator.				

Calculate validation score:

A. Total number of "Yes" responses	**7**
B. Total number of "No" responses	**10**
Score = A / (A + B) x 100	**41.3%**

Determine validation rating:

The "validation rating" refers to the EQRO's overall confidence that acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Validation score	Validation rating
90.0% or greater	High confidence
51.0% to 89.9%	Moderate confidence
10.0% to 49.9%	Low confidence
Less than 10%	No confidence

Summary:

Managed Care Plan (MCP) name: Magellan
Indicator: 8 regions with associated counties
Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
Comments

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.

Network Adequacy Indicator: List of members and their assigned provider(s)

Question	Yes	No	Not Applicable	Comments
Assessment of data collection procedures				
Were all data sources (and year[s] of data) needed to calculate this indicator submitted by the MCP to the EQRO?		X		Numbers for provider caseloads were not provided and alignment with several agencies were not provided.
For each data source, were all variables needed to calculate this indicator included?		X		Reasons for providers aligned to several agencies were not provided.
Are there any patterns in missing data that may affect the calculation of this indicator? (Note: This assessment should be based on a systematic assessment of the proportion of missing data for each variable.)		X		The absence of providers being aligned to several agencies was not provided. The type of providers was not provided (per Magellan's contract with WDH, caseload limits are imposed on FCCs, YSPs, and FSPs)
Do the MCP's data enable valid, reliable, and timely calculations of this indicator?		X		The caseload ratios are not calculated per the documents submitted by Magellan.
Did the MCP's data collection instruments and systems allow for consistent and accurate data collection for this indicator over the time periods studied?	X			
During the time period included in the reporting cycle, have there been any changes in the MCP's data systems that might affect the accuracy or completeness of network adequacy data used to calculate this indicator (e.g., major upgrades, consolidations within the system, acquisitions/mergers with other MCPs)?			X	There were no changes in the data systems reported.
If encounter or utilization data were used to calculate this indicator, did providers submit data for all encounters?			X	Encounter and utilization data were not used.
If LTSS data were used to calculate this indicator, were all relevant LTSS provider services included (for example, through claims and encounter data, authorization systems, case management systems, or electronic visit verification [EVV] systems)?			X	LTSS data were not used.
If access and availability studies were conducted to calculate this indicator, does the MCP include all phone calls made in the denominator? This means phone calls that do not reach a provider office may be excluded from the denominator.			X	Access and availability studies were not conducted.

Question	Yes	No	Not Applicable	Comments
If access and availability studies were conducted to calculate this indicator, does the MCP have processes for addressing potential roadblocks in identification, such as lack of a Medicaid or CHIP ID or medical record number needed to speak with provider offices?			X	Access and availability studies were not conducted.
Assessment of MCP Network Adequacy Methods				
Are the methods selected by the MCP to calculate this indicator appropriate for the state		X		The indicator does not provide the quantitative caseload ratios that providers are required to limit themselves to per Magellan's contract with WDH. There are also no ways to differentiate between providers that have completed Tier 1 and Tier 2 trainings in the report provided.
Are the methods selected by the MCP to calculate this indicator appropriate to the state Medicaid and CHIP population(s)?		X		The indicator does not provide the quantitative caseload ratios that providers are required to limit themselves to per Magellan's contract with WDH. There are also no ways to differentiate between providers that have completed Tier 1 and Tier 2 trainings in the report provided.
Are the methods selected by the MCP adequate to generate the data needed to calculate this indicator?		X		The indicator does not provide the quantitative caseload ratios that providers are required to limit themselves to per Magellan's contract with WDH. There are also no ways to differentiate between providers that have completed Tier 1 and Tier 2 trainings in the report provided.
In calculating this indicator, does the MCP use a system for classifying provider types that matches the state's expectations and follows how the state defines a specialist?		X		The caseload report provided either does not include YSPs and FSPs or it does not differentiate between those YSPs, FSPs, and FCCs.
If applicable, does the MCP's approach for addressing telehealth match the state's expectations?	X			

Question	Yes	No	Not Applicable	Comments
If the MCP is sampling a subset of the Medicaid and/or CHIP population to calculate this indicator, did the sampling frame contain a complete, recent, and accurate list of the target population? A sampling frame is the list from which the sample is drawn. It includes the universe of members of the target population, typically Medicaid and CHIP beneficiaries and providers. The completeness, currency, and accuracy of the sampling frame are key to the representativeness of the sample.			X	The indicator did not involve sampling.
If the MCP is sampling a subset of the Medicaid and/or CHIP population to calculate this indicator, is the sample representative of the population?			X	The indicator did not involve sampling.
If the MCP is sampling a subset of the Medicaid and/or CHIP population to calculate this indicator, are sample sizes large enough to draw statistically significant conclusions?			X	The indicator did not involve sampling.
In calculating this indicator, were valid sampling techniques used to protect against bias? Specify the type of sampling used in the “comments” field.			X	The indicator did not involve sampling.
If applicable to this indicator, does the MCP’s approach for measuring distance (e.g., “as the crow flies” or using road distances) match the state’s expectation?			X	The indicator did not measure distance.
If applicable to this indicator, does the MCP’s approach for measuring time (e.g., during low traffic or high traffic time periods, using driving distance or public transit) match the state’s expectation?			X	The indicator did not measure time to a provider.
If applicable to this indicator, does the MCP’s approach to deriving provider-to-enrollee ratios or percentage of contracted providers accepting new patients match the state’s expectation?		X		The indicator does not provide the quantitative caseload ratios that providers are required to limit themselves to per Magellan’s contract with WDH. There are also no ways to differentiate between providers that have completed Tier 1 and Tier 2 trainings in the report provided.
If applicable to this indicator, does the MCP’s approach for determining the maximum wait time for an appointment match the state’s expectation?			X	The indicator does not assess wait time.

Question	Yes	No	Not Applicable	Comments
Are the methods used to calculate this indicator rigorous and objective?		X		Magellan reported that they manually assess provider capacity during weekly meetings, but there are not quantitative measures provided to WDH. As such, there are no clear caseload values provided to WDH.
Are the methods used to calculate this indicator unlikely to be subject to manipulation? If "no," please describe in the "comments" field.		X		There is no objective quantitative measure used to assess compliance. As such, determinations of compliance are not presentable by the report Magellan provides, so attestations of compliance may be subject to manipulation.
Assessment of MCP network adequacy results				
In calculating this indicator, did the MCP produce valid results—that is, did the MCP measure what they intended to measure?		X		The indicator does not provide the quantitative caseload ratios that providers are required to limit themselves to per Magellan's contract with WDH. There are also no ways to differentiate between providers that have completed Tier 1 and Tier 2 trainings in the report provided.
In calculating this indicator, did the MCP produce accurate results—that is, did the MCP's calculated values reflect the true values?		X		The indicator does not provide the quantitative caseload ratios that providers are required to limit themselves to per Magellan's contract with WDH. There are also no ways to differentiate between providers that have completed Tier 1 and Tier 2 trainings in the report provided.
In calculating this indicator, did the MCP produce reliable results—that is, were the MCP's results reproducible and consistent?		X		The indicator does not provide the quantitative caseload ratios that providers are required to limit themselves to per Magellan's contract with WDH. There are also no ways to differentiate between providers that have completed Tier 1 and Tier 2 trainings in the report provided.
In calculating this indicator, did the MCP accurately interpret its results?		X		The indicator does not provide the quantitative caseload ratios that providers are required to limit themselves to per Magellan's contract with WDH. There are also no ways to differentiate between providers that have completed Tier 1 and Tier 2 trainings in the report provided.
Comments				
Please note any recommendations for improving the data collection procedures to calculate this indicator.				

Question	Yes	No	Not Applicable	Comments
Please note any recommendations for improving the sampling methods to calculate this indicator.				
Please note any recommendations for improving the analysis to calculate this indicator.				
Please note any recommendations for improving the results to calculate this indicator.				

Calculate validation score:

A. Total number of "Yes" responses	**2**
B. Total number of "No" responses	**15**
Score = A / (A + B) x 100	**11.8%**

Determine validation rating:

The "validation rating" refers to the EQRO's overall confidence that acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Validation score	Validation rating
90.0% or greater	High confidence
51.0% to 89.9%	Moderate confidence
10.0% to 49.9%	Low confidence
Less than 10%	No confidence

Summary:

Managed Care Plan (MCP) name: Magellan
Indicator: List of members and their assigned provider(s)
Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
Comments

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

Worksheet 4.7. Summary of Network Adequacy Validation Findings

Instructions: Worksheet 4.7 guides the EQRO in summarizing its validation findings. The EQRO should complete this worksheet separately for each MCP. To start, the EQRO should fill in the first column of the table below with the network adequacy indicators identified in Activity 1, Step 2 (Worksheet 4.2). The EQRO should then note whether the MCP addressed the network adequacy indicator in its network adequacy assessment activities. For indicators addressed by the MCP, the EQRO should provide the validation rating generated in Activity 4, Step 3 (Worksheet 4.6), noting if any indicators could not be validated due to missing data or other issues. The EQRO may provide any additional context needed in the "comments" field. The EQRO should add additional rows as needed to include all network adequacy indicators. Definitions for this worksheet include:

- **Network adequacy indicator**: The metric(s) used to assess adherence to the quantitative network adequacy standard required by the state. For example, the network adequacy indicator may be the proportion of enrollees who have access to a primary care provider within 30 miles or 30 minutes from their home, or provider-to-enrollee ratio. The table below should include all network adequacy indicators identified in Activity 1, Step 2 (Worksheet 4.2).
- **Validation rating:** The rating, calculated in Activity 4, Step 3 (Worksheet 4.6) that refers to the EQRO's overall confidence that acceptable methodology was used for all phases of design, data collection, data analysis, and interpretation of network adequacy monitoring activities.

Managed Care Plan (MCP) name: Magellan

Network adequacy indicator	Did the MCP address this indicator in its network adequacy monitoring activities?	Validation rating	Comments
Manual Caseload and Member Service Receipt Reviews	☐ Addressed ☐ Missing	☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	11.8%
Proportion of providers that complete trainings within 90 calendar days of the start of training	☐ Addressed ☐ Missing	☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	53.3%
Manual review of "assigned hours" as they align with the working hours indicated in providers' Medicaid applications	☐ Addressed ☐ Missing	☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	25%
8 regions with associated counties and providers per region	☐ Addressed ☐ Missing	☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	41.3%

Network adequacy indicator	Did the MCP address this indicator in its network adequacy monitoring activities?	Validation rating	Comments
List of members and their assigned provider(s) (intended to demonstrate caseload ratios).	☐ Addressed ☐ Missing	☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☐ Could not be validated	11.8%

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Worksheet 4.8. Recommendations to Improve MCP Assessment of Network Adequacy

Instructions: Worksheet 4.8 provides a template for the EQRO to refer back to EQRO recommendations from past EQR technical reports (where applicable), review MCP progress in responding to those recommendations, and provide recommendations based on the current network adequacy validation cycle. The recommendations should be specific and actionable to support improvement of the MCP's assessment of network adequacy.

Managed Care Plan (MCP) name: Magellan
Prior Recommendation Year (if applicable): SFY 2023
EQRO Prior Recommendations (if applicable): 1) Detail specific provider recruitment, education, and support interventions and strategies in appropriate internal policies. 2) Adjust provider network reports to reflect the actual caseloads of providers and include average provider to participant ratios. 3) Develop targeted measures to assess access to all HFWA services and track progress towards related goals accordingly.
Summary of MCP Response to Prior Recommendations (if applicable): 1) Magellan built out their network development plans to identify regional need for providers and detailed the barriers they have found to provider recruitment and interventions to improve provider recruitment. 2) No changes were made. 3) No changes were made.
EQRO Assessment of Degree to which MCP Effectively Addressed the Recommendations (if applicable): 1) Addressed 2) Not Addressed 3) Not Addressed
Current Recommendation Year: SFY 2024
EQRO Current Recommendations for MCP Assessment of Network Adequacy: 1) **Magellan:** Incorporate caseload ratio calculations as regular measures reported to WDH to demonstrate compliance with contractual requirements. 2) **Magellan:** Improve caseload report documentation to provide WDH with meaningful context regarding service delivery types, caseload ratios by provider, tier 1 and tier 2 training completion status, reasoning for variable provider-agency alignment. 3) **WDH:** Develop formal and measurable standards in the contract between Magellan and WDH. 4) **WDH:** Develop clear and quantifiable indicators to assess compliance with standards established in recommendation 3, above, and incorporate those indicators in the contract between Magellan and WDH. 5) **Magellan:** Establish meaningful and demonstrable measures by which to determine what "adequate access" to services is defined as and can be demonstrated by. 6) **Magellan:** Develop a mechanism to assess and define demand for services / providers by current and potential members.

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Appendix I: Quality Strategy Findings and Recommendations

Introduction

As part of the SFY 2024 External Quality Review, the EQRO team also considered the Wyoming Care Management Entity (CME) program's alignment with the six core goals of the program's active Quality Strategy. The six goals outlined in the Quality Strategy include:

1. Reduce rate of admissions to inpatient psychiatric treatment facilities.
2. Reduce frequency of readmissions to inpatient psychiatric treatment facilities.
3. Reduce length of stay in inpatient and residential psychiatric treatment facilities.
4. Reduce overall Medicaid cost of care for enrolled youth.
5. Improve child and family integration into home and community life.
6. Assist enrolled youth in cultivating family partnerships and natural supports.

On an annual basis, the EQRO team considers program progress towards the six outlined goals through review of specific metrics collected to evaluate program outcomes. The metrics are part of the Wyoming CME Scope of Work, agreed upon between the State and contractor, and delivered on both a quarterly and annual basis. To understand the program direction during SFY2024, metric outcomes from SFY2023 are displayed as the baseline year for statewide performance. As part of the SFY2024 Quality Strategy analysis, the EQRO team also presents proposed targets for the State to consider as progress goals.

Of note, in the presentation of metrics for the Quality Strategy, the EQRO team did take into consideration the Protocol 2 findings in SFY 2024. Namely, the EQRO team considered the contractor metric reporting inconsistencies identified throughout the year. In coordination with the State, for the purpose of the Quality Strategy evaluation, the values presented in the below table are based on contractor-collected data, but the metrics are recalculated by the EQRO team for improved accuracy and understanding of performance. Finally, accompanying the performance targets are EQRO team suggestions for program quality priorities and activities aligned with the Quality Strategy and full evaluation upcoming in SFY 2025.

Table 1. Quality Strategy Findings, Performance Targets, and Recommendations

EQR Findings	Associated Quality Strategy Objective	Statewide Performance Baseline (SFY 2023)	Statewide Performance (SFY 2024)	Suggested SFY 2025 Statewide Performance Target for Objective with EQRO Explanation
Goal 1: Reduce rate of admissions to inpatient psychiatric treatment facilities.				
The average rate of Out-of-Home (OOH) Placements for CME Youth in SFY 2024 is 4.2%. This is a 147% increase in the average rate of OOH Placements from SFY 2023 to SFY 2024. **Note**: During EQR interviews, the contractor confirmed that the average rate of Out-of-Home (OOH) Placements and the average rate of CME youth moving from a lower level of care to a higher level of care are the same values based on their data collection and metric calculation practices.	1. Decrease OOH placements of CME youth.	1.7%	4.2%	**2.0%** The SFY 2024 increase in the average rate of OOH placements for CME Youth demonstrates movement in the opposite direction of Goal 1. As such, it is the EQRO team's recommendation that the Wyoming CME program prioritizes reduction of OOH placements in SFY 2025. Additionally, WDH should consider stratification of OOH Placement calculations to understand more specifically where members are being placed, such as PRTFs, acute psychiatric units, or other treatment settings. Based on SFY 2023 performance, the EQRO team believes 2.0% is an achievable goal for this metric.
Goal 2: Reduce frequency of readmissions to inpatient psychiatric treatment facilities.				
The average rate of CME youth moving from a lower level of care to a higher level of care in SFY 2024 is 4.2%. This is a 147% increase in the average rate of CME youth moving from a lower level of care to a higher level of care from SFY 2023 to SFY 2024. **Note:** During EQR interviews, the contractor confirmed that the average rate of Out-of-Home (OOH) Placements and the average rate of CME youth moving from a lower level of care to a higher level of care are the same values based on their data collection and metric calculation practices.	3. Decrease recidivism of CME youth moving from a lower level of care to a higher level of care.	1.7%	4.2%	**2.0%** Like the above row, recent values for the average rate of CME youth moving from a lower level of care to a higher level of care are moving in the opposite direction of Goal 2. As such, it is the EQRO team's recommendation that the Wyoming CME program prioritizes reducing OOH placements and working to reduce the number of CME youth in need of higher level of care in SFY 2025. Based on SFY 2023 performance, the EQRO team believes 2.0% is an achievable goal for this metric.
The average rate of youth who graduated from the CME program and moved into a higher level of care within 6 months is 1.3% in SFY 2024.	4. Decrease recidivism of youth who graduated from the CME program having met their goals and who are moving from a lower level of	1.2%	1.3%	**1.0%** This metric outcome should be decreasing as progress towards Goal 2 is made, making 1.0% an

This is a slight, 8% increase from the baseline year.	care to a higher level of care within six months of graduation from the CME program.			incremental goal in a positive direction for quality improvement.
Goal 3: Reduce length of stay in inpatient and residential psychiatric treatment facilities.				
The average length of stay (LOS) for inpatient and residential treatment admissions for youth enrolled in the CME Program was 8.8 days in SFY 2024. The average length of stay value decreased by approximately one day, showing some positive improvement for this metric in line with Goal 3.	2. Decrease LOS for inpatient and residential treatment admissions for youth enrolled in the CME program.	9.82 days	8.8 days	**7 days** To continue a decrease in average length of stay (LOS) in line with Goal 3 progress, the EQRO team would recommend a target of 7 days for average length of stay (LOS) in SFY 2025. Clinically, that aligns with short-term, acute psychiatric hospitalizations. Of note, the EQRO team would also recommend clarifying the exact placement type(s) considered as part of this metric.
Goal 4: Reduce overall Medicaid cost of care for enrolled youth.				
The average difference between Medicaid costs for CME youth and non-CME enrolled youth was $1,608.14 in SFY 2024. The annual trends for this value appear to be progressing towards reduced Medicaid cost of care for CME enrolled youth.	6. Decrease Medicaid costs compared to the target eligible population of non-CME enrolled youth with PRTF stays.	$3,990.14	$1,608.14	**$1,200.00** To progress towards reduced Medicaid cost of care for enrolled youth, $1,200.00 is a recommended goal for continued, incremental decrease in cost. Of note, the metric documentation for this goal appears to a comparison of cost for all CME enrolled youth and all non-CME youth with a PTRF stay. This may be a disparate comparison, and the metric used for Goal 4 should be further considered by the State for intended measurement.
Goal 5: Improve child and family integration into home and community life. **Goal 6:** Assist enrolled youth in cultivating family partnerships and natural supports.				
The average rate of CME youth with identified primary care practitioners was 98.9% in SFY 2024. This metric appears to continue to increase towards a large majority of identification.	5. Increase compliance with EPSDT / increase number of CME youth who have an identified primary care practitioner.	96.4%	98.9%	**99%** It appears achievable for the Wyoming CME program to continue with a vast majority of primary care practitioners identified for CME youth. Because this metric has remained close to 100% completion for multiple years, it is a recommendation that the next step in quality improvement could be to explore the frequency of well-child appointments or annual check-ups for CME youth.
The total number of WFI-EZ surveys received in SFY 2024 was 127. Without a total	8. Increase participation with the WFI-EZ, as measured by the	216	127	**200**

number of distributed surveys, it is difficult to understand the context for this reported value as it relates to performance in SFY 2024. However, in comparison with SFY 2023, this appears to be a decrease, and negative change, in WFI-EZ survey collection.	number of WFI-EZ surveys received.			Considering the 216 WFI-EZ surveys received in SFY 2023, it appears achievable for the CME program to collect 200 or more surveys in SFY 2025. Of note, it would be recommended that this metric be adjusted to include consideration of the total distributed WFI-EZ surveys on an annual basis to better understand efficacy and quality of the process.
The average rate of families and youth participating in State-level Advisory Committees was 3.6% in SFY 2024. This is a modest, positive increase in participation from SFY 2023 to SFY 2024.	9. Increase family and youth participation at State-level Advisory Committees.	2.3%	3.6%	**5%** To continue progress towards increased CME youth and family participation in State-level Advisory Committees, in line with Goal 6, the recommended goal for SFY 2025 is 5%.
The average rate of families and youth participating in communities was 0.1% in SFY 2024. From SFY 2023 to SFY 2024, there was a significant drop in CME family and youth participation in communities. It is unclear what preceded this change, but this is a negative metric report with consideration to both Goals 5 and 6.	10. Increase family and youth participation in communities (e.g., community advisory boards, support groups, other stakeholder meetings).	63.3%	0.1%	**25%** It is recommended that the State evaluate the drastic drop in CME family and youth participation in communities in SFY 2024. Moreover, it is recommended the CME program work towards a 25% goal for community participation and clarify how this metric is defined and applied to assess Goals 5 and 6.

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

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

#	Finding	Strength or Needed Improvement	Domain
Protocol 1. Validation of Performance Improvement Projects			
1	Documentation maintained for PIPs aligns directly with CMS requirements.	Strength	Quality
2	Magellan's 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 considerably improved aspects of their documentation based on previous years' EQR recommendations.	Strength	Quality
4	Magellan's PIP designs do not account for confounding variables that may contribute to performance measures.	Needed Improvement	Quality
5	Despite previous PIPs showing limited sustained and statistically significant improvement, current PIPs do not objectively evaluate specific improvement activities from the previous year.	Needed Improvement	Quality
6	Magellan Network PIP does not leverage robust statistical measures to determine the PIP's effectiveness.	Needed Improvement	Quality
7	Magellan's Network PIP does not leverage objective analytic rationale for the PIP's performance measure goals.	Needed Improvement	Quality
Protocol 2. Validation of Performance Measures			
8	Clinical and technical teams are knowledgeable, engaged, and invested.	Strength	Quality; Timeliness; Access to Care
9	Documentation describing measure result creation.	Strength	Quality

#	Finding	Strength or Needed Improvement	Domain
10	Measure creation staff are cross-trained.	Strength	Quality
11	Contract and business requirement documents (BRD) require more clarity to adequately inform calculations.	Needed Improvement	Quality
12	Annual measure calculation may require final calculation rather than sum, or average, of prior quarters.	Needed Improvement	Quality
Protocol 3. Compliance with Medicaid Managed Care Regulations			
13	Magellan's Quality Assessment and Performance Improvement (QAPI) Report is complete and organized. All general and appropriate parameters are included in the document related to quality activities.	Strength	Quality
14	Magellan's team holds regular, formal team and external meetings to consider quality improvement progress for the WY CME program.	Strength	Quality
15	The QAPI goals and focus areas are general and repeated across years, reflecting limited adjustment year to year based on Wyoming program-specific needs. The objectives are also not measurable and do not reflect a period for achievement.	Needed Improvement	Quality
16	Over/under utilization tracked metrics are limited, high-level and provider prescribed. There does not appear to be a mechanism to assess utilization based on member needs or acuity.	Needed Improvement	Quality
17	The Magellan team presented limited examples of program readiness to meet member special health care needs.	Needed Improvement	Quality
Protocol 4. Validation of Network Adequacy			
18	Magellan has made significant improvements in developing and documenting their targeted provider outreach and recruitment efforts.	Strength	Quality
19	Magellan has continued to grow and develop the WY CME provider network to meet the needs of program enrollees.	Strength	Timeliness; Access to Care

#	Finding	Strength or Needed Improvement	Domain
20	Magellan's weekly caseload reports do not clearly demonstrate compliance with provider caseload requirements.	Needed Improvement	Quality; Timeliness; Access to Care
21	WDH's contract with Magellan largely delegates network adequacy standard setting and reporting to Magellan instead to providing standards and reporting measures required by WDH.	Needed Improvement	Quality; Timeliness; Access to Care
22	Magellan and WDH do not have a definition or formal measures to determine what constitutes adequate access to services.	Needed Improvement	Quality; Timeliness; Access to Care
23	Magellan does not have a process to define demand for services that inform network needs and goals.	Needed Improvement	Timeliness; Access to Care