Wyoming Department of Health Care Management Entity Program SFY 2025 External Quality Review

Appendices

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Document Contents

Appendix A: Abbreviations and Acronyms

AI/AN – American Indian and Alaska Native

ALOS – Average Length of Stay

BRD – Business Requirements Document

CASII – Child and Adolescent Service Intensity Instrument

CDF – Committee Data File

CFR – Code of Federal Regulations

CHIP – Children's Health Insurance Program

CHIPRA – Children's Health Insurance Program Reauthorization Act

CMS – Centers for Medicare & Medicaid Services

CME – Care Management Entity

CMHW – Community Mental Health Waiver

CFT – Child and Family Team

ECSII – Early Childhood Service Intensity Instrument

EHR – Electronic Health Record

EPSDT – Early and Periodic Screening, Diagnostic, and Treatment

EQR – External Quality Review

EQRO – External Quality Review Organization

FCC – Family Care Coordinator

FFS – Fee-for-Service

FSP – Family Support Partner

HFWA – High-Fidelity Wraparound

IHI – Institute for Healthcare Improvement

ISCA – Information Systems Capabilities Assessment

LOC – Level of Care

LOS – Length of Stay

LTSS – Long-Term Services and Supports

MAG – Member Advisory Group

MCE – Managed Care Entity

MCO – Managed Care Organization

MCP – Managed Care Plan

OOH – Out of Home

OP – Operational Requirement

PA – Prior Authorization

PA PIP – Prior Authorization Performance Improvement Project

PAHP – Prepaid Ambulatory Health Plan

PIHP – Prepaid Inpatient Health Plan

PCCM – Primary Care Case Management

PDSA – Plan-Do-Study-Act

PIP – Performance Improvement Project

PM – Performance Measure

POC – Plan of Care

PRTF – Psychiatric Residential Treatment Facility

QAPI – Quality Assessment and Performance Improvement

QIA – Quality Improvement Activity

QIC – Quality Improvement Committee

SAMHSA – Substance Abuse and Mental Health Services Administration

SHCN – Special Health Care Needs

SED – Serious Emotional Disturbance

SFY – State Fiscal Year

SLAC – State-level Advisory Committee

SOW – Statement of Work

SPMI – Serious and Persistent Mental Illness

SQL – Structured Query Language

TCM – Targeted Case Management

WDH – Wyoming Department of Health

WFI-EZ – Wraparound Fidelity Index - Easy

WY – Wyoming

YSP – Youth Support Partner

Appendix B: Status of SFY 2024 Recommendations

Table 1. Status of SFY 2024 Recommendations

#	SFY 2024 Recommendation	Responsibility	Findings	Comments
Protocol 1. Validation of Performance Improvement Projects				
1.	**Recommendation for Magellan**: Assess contributory elements to the PIPs' performance measures and leverage additional performance measures to directly assess the interventions' effectiveness. During the virtual on-site meetings, Magellan's team noted that they plan to examine their interventions and determine if there are other factors contributing to the PIPs' performance measures. Magellan would benefit from including this assessment in their PIP documentation. The PIPs could also be improved by designing performance measures to directly assess the interventions and isolate the interventions' impacts from external elements.	Magellan	Partially Addressed	Magellan did discuss possible confounding variables in their submitted documentation but there was no analysis of their impact, nor were they included in the evaluation or consideration of the selection of the performance measures.
2.	**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	Fully Addressed	Magellan regularly evaluated the progress of the PIPs, and a notable example of reviewing their impact and progress was the PA PIP. Magellan noticed that progress was falling short of expectations, so they reviewed the entire process. Magellan identified a new process and requirements and presented them to WDH for approval. It led to the early termination of the PIP.
3.	**Recommendation for Magellan:** Develop performance measures with greater context and meaning, moving	Magellan	Not Addressed	While raw provider counts are helpful and demonstrate growth,

#	SFY 2024 Recommendation	Responsibility	Findings	Comments
	away from provider counts as the PIP's performance measure. The PIP would be improved by using raw provider counts as a component of the PIP's performance measures but not using the provider counts as the performance measure itself. Magellan may choose to do so by using percent change in provider counts as a performance measure or tie provider counts to member to provider ratios or regional access to local providers.			supplementing them with measures that distinguish recruitment, retention, and capacity relative to demand would allow the State to better assess whether network growth is translating into timely access, reduced service delays, and avoidance of higher downstream utilization and costs. On their own, raw counts do not provide a complete picture.
4.	**Recommendation for Magellan:** Develop objective, analytical rationale for the PIP's performance measure goals. The Network PIP would be improved by tying the PIP's performance measures to clear rationale based on a demonstrated need. Magellan may consider conducting an analysis to determine current and potential demand for services across Wyoming and basing network goals on that analysis. They may consider a regional / local access approach to the network goals. Tying performance measure goals to demonstrated needs would add credibility to the PIP and allow Magellan to better showcase their interventions' effectiveness and benefit to the program.	Magellan	Partially Addressed	Magellan did discuss the different strategies to better incorporate and prepare newly enrolled vs. currently enrolled providers. A single combined performance measure was used to evaluate both groups of currently enrolled and new providers. A performance target of the percentage of new or currently enrolled providers was not considered. Neither was the consideration of providers actively providing services vs. just being enrolled with the program.
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	WDH	Fully Addressed	Technical specification 'OUT 13 - 2 Enrollee Management' updated August 2025 to include reference to updated global

#	SFY 2024 Recommendation	Responsibility	Findings	Comments
	exact inclusions and exclusions required for each measure. • Consider updating the criteria for Measure OUT 13-2 to calculate the total number for PRTF and/or Acute Psychiatric admission days for youth enrolled greater than or equal to 6 months in the reporting period over the number of youth enrolled greater than or equal to 6 months and having a PRTF and/or Acute Psychiatric stay during this time. • Consider updating the criteria for Measure OUT 13-4 to calculate the total number of youth who graduated from the CME in the in the 6 months prior to the end of the measure quarter and moved to a higher level of care (Psychiatric Residential Treatment Facility) during that time over the number of youth who graduated from the CME in the 6 months prior to the end of the measure quarter. • Consider updating the criteria for Measure OUT 13-5 to calculate the total number of newly enrolled in the reporting quarter and having an identified PCP over the number of youth newly enrolled in the reporting quarter.			report query. In November 2025, query updated to use an eligibility date six months prior to beginning of each fiscal quarter and new metric for total cost of non-CME youth with PRTF stays.
6.	**Recommendation for WDH:** Review each measure where the final annual amount is simply a sum of the four quarters, or in 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	WDH	Fully Addressed	Committee Data File appears to continue calculating and displaying year end values as the sum of the four prior quarters Tab 'Outcomes & Provider Management' column 'AB' includes a year-end total for measures OUT 13-1 through OUT 13-7.

#	SFY 2024 Recommendation	Responsibility	Findings	Comments
	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.			
7.	**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 calculation is an understated or overstated value. For some measures, such as OUT 13-4, Magellan is currently calculating the annual value as the average of the quarterly averages, and this does not allow for proper weighting and de-duplication. For a measure such as OUT 13-5, the CDF reflects the annual count as 'Sum of Quarters', but rather than a manual calculation, this should be a new SFY query after the close of the fourth quarter, even though the end results may be more or less than the sum of the quarters.	Magellan	Fully Addressed	Committee Data File appears to continue calculating and displaying year end values as the sum of the four prior quarters. Tab 'Outcomes & Provider Management' column 'AB' includes a year-end total for measures OUT 13-1 through OUT 13-7.
Protocol 3. Compliance with Medicaid Managed Care Regulations				
8.	**Recommendation for Magellan:** QAPI prioritized goals should directly reflect yearly changes and needs of the WY CME program and include quantifiable metrics to track progress. The Magellan team can improve the QAPI report by updating the priority goals based on annual findings and outcomes of the WY CME program. The QAPI plan and related activities for	Magellan	N/A	This Protocol 3 recommendation was made in SFY 2024 as part of the evaluation of QAPI. The QAPI section of Protocol 3 was not assessed in SFY 2025; therefore, progress towards this

#	SFY 2024 Recommendation	Responsibility	Findings	Comments
	a given year should be tied to the most significant gaps in quality or outcomes. To determine such needs, goals from year to year should be connected to key metrics and quantifiable outcomes that demonstrate what is changing, positively or negatively, in regard to program outcomes over time. Applying additional objective, quantitative measures to performance will improve the validity of the QAPI and evaluation.			recommendation was also not assessed.
9.	**Recommendation for Magellan:** Magellan should expand their assessment of over/under utilization to include more quantifiable metrics and consideration of member acuity. Magellan's current approach to review of over/under utilization is multifaceted, with several different mechanisms to consider service utilization in the context of provider written Plans of Care. However, what is absent from the over/under utilization analysis presented in the QAPI report is consideration of whether or not the prescribed services in the Plan of Care are appropriate for that specific member in the first place, taking into account their specific acuity, diagnosed conditions, family circumstances, or other factors. The EQRO team recognizes this assessment may be a part of the Quality Department's Plan of Care reviews; however, those review findings are not a part of the QAPI report and are not quantified in reported metrics for the CME program. As such, there is no presented assessment of the appropriateness of assigned services, and subsequent utilization. To build upon the current over/under utilization analysis in the QAPI report, consideration of services pursued based on member acuity would strengthen the overall understanding of utilization across the CME program. Furthermore, the EQRO team would recommend incorporating additional quantifiable metrics to all for concrete analysis and tracking of utilization over time.	Magellan	Partially Addressed	Magellan did discuss a review of utilization, namely minimum contact in the documents submitted this year, but no mention of over- or underutilization analysis was included. While review of claims and minimum contacts met the requirements for Protocol 3 around Enrollee Rights and Responsibilities this year, it did not fully address the recommendation from last year that focused on the QAPI and the quality of services.

#	SFY 2024 Recommendation	Responsibility	Findings	Comments
10.	**Recommendation for Magellan:** Magellan should establish explicit policy and procedures to address special health care needs (SHCN) of CME youth members, with specific resources and mechanisms for providers to offer additional support as needed within the CME program. Magellan's current documentation does not acknowledge special health care needs, particularly outside of CME qualifying needs. To improve upon this gap, Magellan should develop specific policy and procedure for providers that establish expectations for meeting special health care needs for members. Once policy and procedures acknowledge the potential for special health care needs, the EQRO team would also recommend the Magellan team accompany this new documentation with specific resources and mechanisms for providers to ensure they are prepared to meet special health care needs that may be outside of qualifying diagnoses for the CME program.	Magellan	Partially Addressed	Magellan has established policies, procedures, and assessment mechanisms to identify and address SHCN for CME-eligible youth, including documented requirements for assessments, Plans of Care, and ongoing quality monitoring. However, explicit provider-facing policies and resources for addressing SHCN outside of CME-qualifying diagnoses are not clearly documented. As a result, while SHCN are addressed within CME eligibility, the recommendation to develop broader guidance and resources for providers remains only partially addressed.
Protocol 4. Validation of Network Adequacy				
11.	**Recommendation for Magellan:** Incorporate caseload ratio calculations as regular measures reported to WDH to demonstrate compliance with contractual requirements. Magellan's caseload report does not feature a quantitative measure to demonstrate provider caseloads at a glance. To demonstrate compliance with the caseload requirements in Magellan's contract with WDH, Magellan's caseload reports should demonstrate individual provider caseloads clearly as quantitative values. This will better demonstrate compliance with caseload standards to WDH through objective quantitative	Magellan	Partially Addressed	The Caseload report continues to be submitted every week; however, caseload summaries or ratios are neither evaluated nor included in the reporting. An indicator of provider training level is also not included so any evaluation or review of trends by training is not possible. During this year's EQR process it was reported by Magellan though that they only

#	SFY 2024 Recommendation	Responsibility	Findings	Comments
	indicators properly evaluated through the EQR Protocol 4 review tool.			assign youth to Tier 2 FCCs.
12.	**Recommendation for Magellan:** Develop aggregate caseload measures. Magellan's caseload report would benefit from demonstrating compliance with general caseload requirements through aggregate caseload measures. Magellan can pull together caseload averages by provider type and training level to provide average caseload measures and compare those measures to the established standards.	Magellan	Fully Addressed	The Caseload report is still submitted weekly, including the listing of youth and who their assigned providers are. There is also an indicator of provider type.
13.	**Recommendation for Magellan:** Provide caseload measures for additional periods beyond weekly. Currently, Magellan provides weekly caseload reports. Magellan would better demonstrate compliance by reporting additional caseload measures applied to average caseloads over additional periods such as monthly, quarterly, and/or annually.	Magellan	Not Addressed	The caseload report is still submitted weekly, but a more in-depth evaluation or detailed quantitative evaluation quarterly or annually is not completed.
14.	**Recommendation for Magellan:** Improve caseload report documentation to provide WDH with meaningful context. Magellan's caseload reports would be improved by denoting the provider type, explaining why providers delivering services to one member are listed with that member several times as affiliates of different agencies, and the providers' training levels.	Magellan	Not Addressed	Caseload report is still submitted weekly, but caseload summaries or ratios are not reported. An indicator of provider training level is also not included. During this year's EQR process it was reported by Magellan though that they only assign youth to Tier 2 FCCs.
15.	**Recommendation for WDH:** Develop formal and measurable network adequacy standards and indicators and incorporate them in WDH's contract with Magellan. To consistently measure compliance and adhere to well-informed network adequacy standards, WDH can incorporate specific network adequacy standards and indicators into their contract with Magellan. This will also	WDH	Fully Addressed	Although the new adequacy standards and indicators have been developed and are incorporated into the SFY 2026 SOW, they were not in place for this year's review. Magellan discussed how they are preparing to meet the

#	SFY 2024 Recommendation	Responsibility	Findings	Comments
	allow for direct compliance and quality assessments through EQR Protocol 4.			new standards during this year's EQR process.
16.	**Recommendation for WDH and Magellan:** Detail what qualifies as adequate access to services in the contract between WDH and Magellan. WDH and Magellan can work together to determine how adequate access can be defined in line with Magellan's administrative processes and professional understanding of network adequacy within WDH's program. Doing so would provide a foundation for WDH and Magellan to develop network adequacy standards in their contract based on a clear definition for adequate access to services.	WDH/Magellan	Not Addressed	Documentation demonstrates multiple approaches to network monitoring; however, it does not include analysis of service utilization relative to youth acuity or expected need. While such monitoring supports assessment of network performance, the absence of this analysis limits the documentation's ability to fully demonstrate that provider capacity meets varying service demand; grievances and complaints alone do not provide this assessment.
17.	**Recommendation for Magellan:** Develop a process and measures to assess and define current and potential members' demand for services / providers. Magellan can develop an analytic process to determine what number of providers the current member population and the future member population may require to experience full access to services that meet their needs. Developing a clear and objective assessment of member demand will allow for clear goal setting and improvement efforts.	Magellan	Not Addressed	There was not an evaluation of over- or underutilization of services or an expected utilization of services by acuity of a youth included in this year's submitted documents. Without an evaluation of appropriate utilization of services, the ability to appropriately assess the potential need of the youth if the enrolled population increases or decreases.

Worksheet 1.1. Review the Selected PIP Topic

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

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 vendor's 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. The proposed PIP was presented and approved by the State.
1.2 Did selection of the PIP topic consider performance on the CMS Child and Adult Core Set measures?		X		No, the documentation did not discuss the use or performance on any CMS Child or Adult Core Set measure.
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 attempt to solicit information from participants, but participant feedback did not address the youth or guardian's challenging experiences with the authorization process.
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) 2025 with an approved Plan of Care."

Question	Yes	No	NA	Comments
1.5 Did the PIP topic align with priority areas identified by HHS and/or CMS?		X		The PIP primarily focuses on an administrative aspect of the CME program operation, although a key step in the ability of the providers ability to provide care to the youth. The documentation did not specifically target a priority area identified by HHS and/or CMS, but the CME program is aligned with CMS's focus on behavioral health initiatives, especially those targeting at-risk youth.
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) 2025?

   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) 2025?

   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			Yes, both aim statements address a specific population, timeframe, and clear outcomes of improvement through implementation of the PIP. The targeted population for both aim statements was "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) 2025." The improvement strategy for both aim statements was "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." The time period for both aim statements was "Standard Fiscal Year (SFY) 2025."
2.2 Did the PIP aim statement clearly specify the population for the PIP?	X			The targeted population for both aim statements was "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) 2025."
2.3 Did the PIP aim statement clearly specify the time period for the PIP?	X			The time period for both aim statements was "Standard Fiscal Year (SFY) 2025."
2.4 Was the PIP aim statement concise?	X			
2.5 Was the PIP aim statement answerable?	X			Yes, both aim statements could be answerable through data analysis of the performance measure provided.
2.6 Was the PIP aim statement measurable?	X			Yes, both aim statements could be answerable through data analysis of the performance measure provided. Although there was no discussion around confounding variables.

Question	Yes	No	NA	Comments
2.7 Overall assessment: In the comments section, note any recommendations for improving the PIP aim statement.				As this was the second year of the PIP, an evaluation of confounding variables or additional improvement strategies that could be included should be included for next year if the PIP is maintained.

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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) who are enrolled during Standard Fiscal Year (SFY) 2025.

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			Although the time period of "enrolled during SFY 2025" is mentioned, no minimum amount of enrollment, e.g., months, was discussed. As it takes up to 90 days for a POC to be completed and approved, it may be beneficial to only include those youth with a minimum of 6 months of enrollment.
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		No sampling of youth or sampling methodology was used. The CME program total population is small in size so it would not be recommended to sample an even smaller subset.
3.5 Overall assessment: In the comments section, note any recommendations for identifying the project population.				Although the time period of "enrolled during SFY 2025" is mentioned, no minimum amount of enrollment, e.g., months, was discussed. As it takes up to 90 days for a POC to be completed and approved, it may be beneficial to only include those youth with a minimum of 6 months of enrollment.

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Worksheet 1.4. Review the Sampling Method

Overview of Sampling Method: None was utilized

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

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Worksheet 1.5. Review the Selected PIP Variables and Performance Measures

Selected PIP Variables and Performance Measures:

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) 2025?

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) 2025?

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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			Yes, for both measures the time period was SFY 2025.
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			Yes, the Plan of Care (POC) authorizations are a critical step in the provision of services to the youth.
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			Yes, for both measures, the data source is the Fidelity EHR case management system.

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			Yes, the performance measures assess the barriers to care as part of the administrative operations of the CME 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			Although the performance measures only evaluated a single MCP, they did assess the barriers to care over a year, rather than a point in time. They did evaluate the quality of care of services and Magellan's attempt to improve its' operations.
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		No, there was no discussion in the provided documentation that Magellan evaluated health outcomes or if a long-term impact addressing the provision of services would improve the outcomes of the youth enrolled.
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			Yes, the performance measures assess the barriers to care as part of the administrative operations of the CME program.
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 performance measures assess the provision of timely services and not the experience of care by the youth or their guardians.

Question	Yes	No	NA	Comments
5.9 Did the measures include a strategy to ensure inter-rater reliability (if applicable)?			X	The data source is the number of authorizations from the case management system so there is no need to evaluate inter-rater reliability.
5.9 If process measures were used, is there strong clinical evidence indicating that the process being measured is meaningfully associated with outcomes? • This determination should be based on published guidelines, including citations from randomized clinical trials, case control studies, or cohort studies • At a minimum, the PIP should be able to demonstrate a consensus among relevant practitioners with expertise in the defined area who attest to the importance of a given process	X			Magellan detailed the process through which successful and efficient prior authorization processes affect participant outcomes. Magellan leveraged clinical experience and feedback from their providers in the development of the PIP.
5.10 Overall assessment: In the comments section, note any recommendations for improving the selected PIP variables and performance measures.				Although there was no discussion in the provided documentation that Magellan evaluated health outcomes or if a long-term impact addressing the provision of services would improve the outcomes of the youth enrolled, since the PIP has been in place for two years, an evaluation of increased services, the youth's experience of care, or improved outcomes due to more regular delivery of care should be considered next year.

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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 was collected through an established and logical set of code and pulled directly from the Fidelity EHR case management system.
6.2 Did the PIP design specify the frequency of data collection? If yes, what was the frequency (for example, semi-annually)?	X			Yes, data is pulled weekly, monthly, quarterly, and annually.
6.3 Did the PIP design clearly specify the data sources? • Data sources may include: ○ Encounter and claims systems ○ Medical records ○ Case management or electronic visit verification systems ○ Tracking logs ○ Surveys ○ Provider and/or enrollee interviews	X			The data source is the Fidelity EHR case management system.
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			Yes, the documentation was very clear on the data plan.
6.6 Did the data collection instruments allow for consistent and accurate data collection over the time periods studied?	X			The established query with the code provided allowed for consistent reporting.
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	
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	
6.10 If primary care data was used, did primary care providers submit encounter or utilization data for all encounters?			X	
6.11 If specialty care data was used, did specialty care providers submit encounter or utilization data for all encounters?			X	
6.12 If ancillary data was used, did ancillary service providers submit encounter or utilization data for all services provided?			X	
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	
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		The Fidelity EHR system was used to collect data. However, the EQRO did not have sufficient documentation to determine if patient, clinical, service, or quality metrics were validated for accuracy. Comparability across systems was not assessed, as all data was exported from the Fidelity 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			Yes, the documentation provided the data collection and analysis staff along with their responsibilities and personnel background and qualifications.
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 reviews were not conducted. While the medical record was marked as the applicable data source, only administrative data, authorizations approved, is used to assess the PIP.

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 record reviews were not conducted. While the medical record was marked as the applicable data source, only administrative data, authorizations approved, is used to assess the PIP.

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Worksheet 1.7. Review Data Analysis and Interpretation of PIP Results

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

Question	Yes	No	NA	Comments
7.1 Was the analysis conducted in accordance with the data analysis plan?		X		Magellan does not describe why there was a reduction in the number of PA's or provide their validation findings both of which were included in their data analysis plan.
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			Documentation reported the Chi-square test of association results
7.4 Did the analysis account for factors that may influence the comparability of initial and repeat measurements?		X		Documentation did include a brief discussion of confounding variables but there was no evaluation on their impact or other factors that impacted repeat measurements.
7.5 Did the analysis account for factors that may threaten the internal or external validity of the findings?		X		
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		Although there is only one MCP in the State, there was no discussion whether any results were associated with policy or program impacts implemented by WDH.
7.7 Were PIP results and findings presented in a concise and easily understood manner?	X			The PIP documentation was clear and easy to follow including tables for results.
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			There was a discussion of lessons learned and feedback from the pilot group, but the responses were from 2023. There was no discussion of lessons learned or opportunities for improvement from SFY 2024 to 2025.
7.9 Overall assessment: In the comments section, note any recommendations for improving the analysis and interpretation of PIP results				Last year, it was noted that the PIP discussed a need for better links between outcomes and interventions. It mentioned potential discrepancy in data and a need to review data collection processes for reliability and validity. The PIP also noted that changes to key processes should occur in SFY 2025. Magellan noted that they plan to

Question	Yes	No	NA	Comments
				conduct continued analyses of provider feedback to identify barriers and interventions with the best potential for improvement. This discussion was not included this year, but it was noted that the PIP was terminated at the end of March 2025. A new PA model was to be implemented but the new model was not included.

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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 did describe their interventions, primary, and secondary drivers, which were focused on addressing provider feedback and improving the provision of care to the youth.
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		No, while there was a brief discussion of possible confounding variables, but the implementation strategy did not take these into account or were planned to address them.
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 included an assessment of statistical significance and stated there was no way to determine the correlation of the performance measures with the interventions. In the final discussion for this year's performance it was noted that the PIP was terminated at the end of March 2025 so there will not be an opportunity to improve.
8.7 Overall assessment: In the comments section, note any recommendations for improving the implementation strategies.				There was improvement for both measures this year, but there was no discussion or evaluation of the impact of confounding factors on the performance for either measure. Although the PIP was terminated early, the PIP documentation would have been strengthened a more robust discussion of the lessons learned from the PIP that will be incorporated into the new PA process.

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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			
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 did not address whether the improvement in performance was likely a result of the interventions. Also, with the early termination of the PIP, it would have been good to see a more complete evaluation of the impact of the interventions so that they could be incorporated into the new model.
9.4 Is there statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention?		X		Although statistical significance tests were included for both performance measures, neither performance showed statistically significant improvement.
9.5 Was sustained improvement demonstrated through repeated measurements over time?		X		Although there was improvement for one of the measures, with the early termination of the PIP, sustained improvement could not be evaluated.
9.6 Overall assessment: In the comments section, note any recommendations for improving the significance and sustainability of improvement as a result of the PIP.				Although there was improvement in one of the measures this year, neither being statistically significant, an evaluation of confounding variables and the full impact, if any, of the interventions had on the performance would have improved the documentation. This is especially relevant as the PIP was terminated early and any impact could have been incorporated into the new model.

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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 described interventions designed to improve the efficiency of the POC approval process. Yet, the PIP methodology did not evaluate the secondary drivers they identified as part of their methodology to determine impact on the interventions and performance outcomes. While the PIP include an analysis plan, it did include the method for data validation including the process for reviewing possible data inconsistencies.
Rating 2: EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	While the PIP performance measures demonstrated improvement from SFY 2024, they were not shown to be statistically significant. One of the two measures achieved Magellan's performance target while the other did not. Documentation submitted for review reflected a reduction in the number of plans of care reviewed from SFY 2024 to SFY 2025 without describing the factors contributing to this change. While both performance measures showed improvement from the prior measurement period, the results did not demonstrate statistically significant improvement, and one measure did not meet its established performance target. This rating is similar to last year's rating.

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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 for the High Fidelity Wraparound Program PIP

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: youth ages 4-20 years old with Serious Emotional Disturbance (SED) Diagnosis.

Target population description, such as duals, LTSS or pregnant women (please specify): 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) 2025.

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 2025: Number of non-authorizations issued / Number of Plans of Care submitted	SFY 2023	4.8% (out of 1,254 Plans of Care submitted)	SFY 2025 ☐ Not applicable—PIP is in planning or implementation phase, results not available	5.9% (50 out of 842 POCs submitted)	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Rate of continuous authorizations for WY CME youth enrolled during SFY 2025. Number of authorizations issued / Number of Plans of Care submitted.	SFY 2023	75.35% (out of 1,254 Plans of Care submitted)	SFY 2025 ☐ Not applicable—PIP is in planning or implementation phase, results not available	94.06% (792 out of 842 POCs submitted)	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First remeasurement ☒ Second remeasurement ☐ Other (specify):

Validation rating #1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results,

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

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

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

EQRO comments on validation ratings:

Rating 1: The PIP methodology described interventions designed to improve the efficiency of the POC approval process. Yet, the PIP methodology did not evaluate the secondary drivers they identified as part of their methodology to determine impact on the interventions and performance outcomes. While the PIP include an analysis plan, it did include the method for data validation including the process for reviewing possible data inconsistencies.

Rating 2: While the PIP performance measures demonstrated improvement from SFY 2024, they were not shown to be statistically significant. One of the two measures achieved Magellan's performance target while the other did not. Documentation submitted for review reflected a reduction in the number of plans of care reviewed from SFY 2024 to SFY 2025 without describing the factors contributing to this change. While both performance measures showed improvement from the prior measurement period, the results did not demonstrate statistically significant improvement, and one measure did not meet its established performance target. This rating is similar to last year's rating.

EQRO recommendations for improvement of PIP: Although there was improvement in one of the measures this year, neither being statistically significant, an evaluation of confounding variables and the full impact, if any, of the interventions had on the performance would have improved the documentation. This is especially relevant as the PIP was terminated early and any impact could have been incorporated into the new model.

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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 PIP

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			Unlike last year's PIP documentation, this year Magellan provided documentation to the impact of not having a robust provider network and the impact of providing services in a frontier state present.
1.2 Did selection of the PIP topic consider performance on the CMS Child and Adult Core Set measures?		X		No, the documentation did not discuss the use or performance on any CMS Child or Adult Core Set measure.
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			Although Magellan documented the use of provider submitted data and enrollment data, the PIP documentation discussed an initial pilot provider summit in 2023. Enrollee feedback was collected through their annual Member Experience Survey.
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 was implemented as part of a PAHP that only provides services for youth with Serious Emotional Disturbance (SED diagnosis).
1.5 Did the PIP topic align with priority areas identified by HHS and/or CMS?	X			Yes, the PIP topic of network adequacy aligns with CMS goals of expanding provider networks.
1.6 Overall assessment: In the comments section, note any recommendations for improving the PIP topic.				None

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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 1.2. Review the PIP Aim Statement

PIP Aim Statement:

1.) Will targeted recruitment, training and support by the CME concerning the HFWA program and provider roles with stakeholders throughout the state of Wyoming increase the number of Family Care Coordinators active the Network for the SFY 2025?

2.) Will targeted recruitment, training and support by the CME concerning HFWA program with stakeholders throughout the state of Wyoming increase the number of respite providers in the Network for the SFY 2025?

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			Yes, both aim statements address a specific population, timeframe, and clear outcomes of improvement through implementation of the PIP. The targeted population for the aim statements was "Family Care Coordinators and Respite providers in the Wyoming HFWA program." The improvement strategy for both aim statements was "targeted recruitment, training, and support by the CME." The time period for both aim statements was "Standard Fiscal Year (SFY) 2025."
2.2 Did the PIP aim statement clearly specify the population for the PIP?	X			The targeted population for the aim statements was "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 time period for both aim statements was "Standard Fiscal Year (SFY) 2025."
2.4 Was the PIP aim statement concise?	X			
2.5 Was the PIP aim statement answerable?	X			Yes, both aim statements should be answerable if the interventions are clearly defined
2.6 Was the PIP aim statement measurable?	X			Yes, both aim statements could be measurable with an increase in providers.
2.7 Overall assessment: In the comments section, note any recommendations for improving the PIP aim statement.				As this was the second year of the PIP, an evaluation of confounding variables or additional improvement strategies that should be included in the aim statement for next year if the PIP is maintained.

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Worksheet 1.3. Review the Identified PIP Population

PIP Population: Annual sum of Family Care Coordinators (FCC) and Respite Providers.

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			Although the PIP documentation identifies the population as annual sum or FCC and Respite providers, it does not clarify enrolled, those billing for services, or just new providers. During the onsite interviews, Magellan clarified that all providers are included.
3.2 Was the entire MCP population included in the PIP?		X		The PIP focused on increasing the number of FCC and Respite providers in their provider networks. All of the interventions were targeted on the providers and not the enrolled youth. While appropriate based on the topic of the PIP, since the youth of the CME were not targeted, the entire population was not included.
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 PIP focused only on the recruitment of providers and not the enrollees.
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		No sampling of youth or sampling methodology was used.
3.5 Overall assessment: In the comments section, note any recommendations for identifying the project population.				Although the PIP documentation identifies the population as the annual sum of FCC and Respite providers, during the onsite Magellan did clarify all providers, they didn't distinguish their aim statement or measures by enrolled providers, those billing for services, or just new providers. It is recommended clarifying the provider population and explaining why Magellan chose not to use unique counts of providers.

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Worksheet 1.4. Review the Sampling Method

Overview of Sampling Method: None was utilized

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

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Worksheet 1.5. Review the Selected PIP Variables and Performance Measures

Selected PIP Variables and Performance Measures:

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 2025?

2. Will targeted recruitment, training and support by the CME concerning HFWA program with stakeholders throughout the state of Wyoming increase the number of respite providers in the Network for the SFY 2025?

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			Yes, the measures are raw provider counts examined quarterly and annually. Rather than just the raw count of providers, the addition of new and maintained providers would be better sub measures.
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			Yes, without a robust provider network, the CME program cannot provide services.
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			Yes, the measures are raw provider counts examined quarterly and annually. Rather than just the raw count of providers, the addition of new and maintained providers would be better sub measures. The source of the data was the provider enrollment system.

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		The PIP measures rely solely on provider counts and do not incorporate analytic approaches typically used in health services research to assess whether provider growth is sufficient relative to service demand or network needs. While the PIP does not involve clinical care or outcome measures, the absence of analytic context limits the extent to which the measures support evaluation of the PIP's stated access-related aim beyond tracking counts alone.

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 measures are just sum counts of provider types on an annual basis compared to baseline year (2023).
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		No, there was no discussion in the provided documentation that Magellan evaluated health outcomes or if a long-term impact addressing the provision of services would improve the outcomes of the youth enrolled.
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		No, the measures are just a raw count of providers by provider type.
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		No, the measures are just a raw count of providers by provider type.

Question	Yes	No	NA	Comments
5.9 Did the measures include a strategy to ensure inter-rater reliability (if applicable)?			X	No, the measures are just a raw count of providers by provider type pulled from the enrollment system so there is no need for inter-rater reliability considerations.
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 measures are just a raw count of providers by provider type which are being considered as outcomes based on the intervention.
5.10 Overall assessment: In the comments section, note any recommendations for improving the selected PIP variables and performance measures.				Although the measures are raw, provider counts examined quarterly and annually the provider types were separated into separate measures this year. Rather than just the raw count of providers, the addition of new and maintained providers would be better sub measures. It is also recommended for a measure to evaluate a specific aspect of the intervention or component of the improvement strategy.

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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 PIP documentation stated they just pulled the annual sum of provider counts by provider type from their provider enrollment system.
6.2 Did the PIP design specify the frequency of data collection? If yes, what was the frequency (for example, semi-annually)?	X			Yes, data is pulled quarterly and annually.
6.3 Did the PIP design clearly specify the data sources? • Data sources may include: ○ Encounter and claims systems ○ Medical records ○ Case management or electronic visit verification systems ○ Tracking logs ○ Surveys ○ Provider and/or enrollee interviews	X			The data source is the provider enrollment system.
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			Yes, the design defined the data elements it planned to collect.
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		Yes, the documentation was very clear on the data plan. The interventions were defined however, they were not sufficiently reported or analyzed. The results include Rate or Results and Comparison Benchmark which are not defined in the submitted documentation which led to confusion as to which were the results and how the benchmarks were decided. Without the clear linkage from the data collection plan to the data analysis plan, it was difficult to evaluate the tracking of the performance year over year.
6.6 Did the data collection instruments allow for consistent and accurate data collection over the time periods studied?	X			Yes, Magellan pulled the provider counts from their provider enrollment data.
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	No qualitative data collection methods were 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.				For the performance measures the data analysis plan was appropriate although it is simple in design.

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	
6.10 If primary care data was used, did primary care providers submit encounter or utilization data for all encounters?			X	
6.11 If specialty care data was used, did specialty care providers submit encounter or utilization data for all encounters?			X	
6.12 If ancillary data was used, did ancillary service providers submit encounter or utilization data for all services provided?			X	
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	
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	

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			Yes, the documentation provided the data collection and analysis staff along with their responsibilities and personnel background and qualifications.
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 reviews were not conducted.

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 record reviews were 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		While the PIP documentation had a section titled data analysis plan, it lacked the criteria that CMS expects
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			Documentation reported that significance was tested with unpaired, two-tail t-test was completed.
7.4 Did the analysis account for factors that may influence the comparability of initial and repeat measurements?		X		Documentation did include a mention of confounding variables or factors that impacted repeat measurements in the submitted data analysis plan but there was no evaluation of the impact of the factors in the overall evaluation or how they impacted the outcomes.
7.5 Did the analysis account for factors that may threaten the internal or external validity of the findings?		X		
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		Although there is only one MCP in the State, there was no discussion whether any results were associated with policy or program impacts implemented by WDH.
7.7 Were PIP results and findings presented in a concise and easily understood manner?	X			The PIP documentation was clear and easy to follow including tables for results.
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			There was a discussion of lessons learned or opportunities for improvement from SFY 2024 to 2025.
7.9 Overall assessment: In the comments section, note any recommendations for improving the analysis and interpretation of PIP results				Last year, it was noted that the PIP discussed a need for better links between outcomes and interventions. It mentioned potential discrepancy in data and a need to review data collection processes for reliability and validity. With this being the second year of the PIP, it would be good to include more analyses on the impact of the

Question	Yes	No	NA	Comments
				interventions and different aspects of the improvement strategy. It would be beneficial for a more in-depth evaluation and improvement strategies focused on retaining newly enrolled and experienced providers.

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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 a good discussion at the opening on national trends and research that shows the impact on frontier areas. Magellan also incorporated their experience working in WY and provider feedback.
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 did provide a discussion of interventions, primary, and secondary drivers, but the interventions were not designed based on data analyses but were focused on addressing provider feedback and improving the provision of care to the youth.
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		While Magellan included a list of the confounding variables they planned to assess in their plan, they did not include analysis or findings for the confounding variables to account for impact.
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 included an assessment of statistical significance and stated there was no way to determine the correlation of the performance measures with the interventions. Although Magellan did provide a detailed discussion on the interventions but their impact was missing.
8.7 Overall assessment: In the comments section, note any recommendations for improving the implementation strategies.				There was improvement for both measures this year. Although the documentation included a mention of confounding variables or factors that impacted repeat measurements, there wasn't much discussion of what the factors were or how they really impacted the outcomes. With this being the second year of the PIP, it would be good to include more analyses on the impact of the interventions and different aspects of the improvement strategy. It would be beneficial for a more in-depth evaluation and improvement strategies focused on retaining newly enrolled and experienced providers.

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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			Yes, for both of the performance measures saw improvement from SFY 2025.
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 did not address whether the improvement in performance was solely a result of the interventions. Also, the measures are an evaluation of the sum of providers by type, but most of the quality improvement strategy focused on recruiting new providers only.
9.4 Is there statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention?		X		Although statistical significance tests were conducted for both performance measures, neither performance showed statistically significant improvement.
9.5 Was sustained improvement demonstrated through repeated measurements over time?		X		Although there was improvement for both measures during SFY 2025, neither were found to be statistically significant. Since SFY 21, one performance measure's (FCC) performance has seen a fluctuation in performance. The other performance measure (respite providers) has increased but is still below its baseline.
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.				There was improvement for both measures this year, although neither were found to be statistically significant. With this being the second year of the PIP, it would be good to include more analyses on the impact of the interventions and how the different aspects of the improvement strategy impacted the outcomes. It would be beneficial for a more in-depth evaluation and improvement strategies focused on retaining newly enrolled and experienced providers.

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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 conducted a range interventions to support provider outreach and sustain the current network. Despite these efforts, the PIP documentation does not quantitatively link the reported outcome measures with the interventions described in the PIP documentation. While Magellan acknowledges that training, support, and recruitment activities may have influenced changes in network size, the PIP does not include analytic evidence demonstrating the extent to which individual interventions contributed to observed performance. In addition, although potential confounding variables are identified in the PIP, the methodology does not evaluate how these factors may have affected intervention impact or performance outcomes. As a result, while the PIP reflects substantial and sustained provider engagement activity, limitations in the quantitative analysis constrain the ability to assess the relative effectiveness of specific interventions or to attribute observed changes in provider counts to particular strategies.
Rating 2: EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	The PIP performance measures showed improvement during SFY 2025. Yet, the changes were not statistically significant. Both measures increased in count from the prior measurement year, with the number of Respite providers increasing from three in SFY 2024 to nine in SFY 2025. The number of active Family Care Coordinators rose from 52 in SFY 2024 to 64 in SFY 2025; however, when examined over a longer time horizon (SFY 2021–SFY 2025), provider enrollment reflects a pattern of year-to-year fluctuation rather than consistent growth, limiting evidence of sustained improvement. In addition, while the PIP documents extensive provider engagement and outreach activities, the quantitative measures do not distinguish between new, retained, and terminated providers, and do not include percentage-based change measures or clearly defined performance targets. These limitations reduce the ability to attribute observed changes in provider counts to specific interventions or to assess the magnitude and consistency of improvement achieved through the Network PIP.

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

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

1. General PIP Information

Managed Care Plan (MCP) Name: Magellan
PIP Title: Increase the Number of Providers in the Wyoming Care Management Entity Network PIP
PIP Aim Statement: 1. 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 2025? 2. 2.) Will targeted recruitment, training and support by the CME concerning HFWA program with stakeholders throughout the state of Wyoming increase the number of respite providers in the Network for the SFY 2025?
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: youth ages 4-20 years old with Serious Emotional Disturbance (SED) Diagnosis is the population served, but the PIP focuses on the provider network of FCCs and Respite providers
Target population description, such as duals, LTSS or pregnant women (please specify): Wyoming Care Management Entity youth ages 4-20 years old with Serious Emotional Disturbance (SED) Diagnosis is the population served, but the PIP focuses on the provider network of FCCs and Respite providers
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) • Held collaborative meetings with Eastern Shoshone tribal heath throughout the year (Fremont County) concerning HFWA. • Participation in the Eastern Shoshone Tribal Health Fair • Collaboration with facility that provides both in-patient and outpatient services to become HFWA provider. • Connection of solo providers to agencies which provides a broader level of support to providers, especially new providers. • Outreach and collaboration with Indian Health Services. • Reviewed potential member demographics including Medicaid population for youth suicide rates, juvenile justice influence, DFS involvement, and overall county demographics.

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	667 (not unique) Rate: 55.87	SFY 2025 ☐ Not applicable—PIP is in planning or implementation phase, results not available	644 (not unique) Rate: 53.67	☒ Yes ☐ No Improvement from 1st Remeasurement year of 2024	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number of Respite providers	SFY 2023	6 (not unique) Rate: 0.87	SFY 2025 ☐ Not applicable—PIP is in planning or implementation phase, results not available	78 (not unique) Rate: 2.33	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First remeasurement ☒ Second remeasurement ☐ Other (specify):

Validation rating #1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results,

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

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

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

EQRO comments on validation ratings:

Rating 1: Magellan conducted a range interventions to support provider outreach and sustain the current network. Despite these efforts, the PIP documentation does not quantitatively link the reported outcome measures with the interventions described in the PIP documentation. While Magellan acknowledges that training, support, and

recruitment activities may have influenced changes in network size, the PIP does not include analytic evidence demonstrating the extent to which individual interventions contributed to observed performance. In addition, although potential confounding variables are identified in the PIP, the methodology does not evaluate how these factors may have affected intervention impact or performance outcomes. As a result, while the PIP reflects substantial and sustained provider engagement activity, limitations in the quantitative analysis constrain the ability to assess the relative effectiveness of specific interventions or to attribute observed changes in provider counts to particular strategies. Rating 2: The PIP performance measures showed improvement during SFY 2025. Yet, the changes were not statistically significant. Both measures increased from the prior measurement year, with the number of Respite providers increasing from three in SFY 2024 to nine in SFY 2025. The number of active Family Care Coordinators rose from 52 in SFY 2024 to 64 in SFY 2025; however, when examined over a longer time horizon (SFY 2021–SFY 2025), provider enrollment reflects a pattern of year-to-year fluctuation rather than consistent growth, limiting evidence of sustained improvement. In addition, while the PIP documents extensive provider engagement and outreach activities, the quantitative measures do not distinguish between new, retained, and terminated providers, and do not include percentage-based change measures or clearly defined performance targets. These limitations reduce the ability to attribute observed changes in provider counts to specific interventions or to assess the magnitude and consistency of improvement achieved through the Network PIP.
EQRO recommendations for improvement of PIP: Although there was improvement in both measures this year, neither being statistically significant, the addition of new and maintained providers would be better sub measures rather than just the raw count of providers. With this being the second year of the PIP, it is also recommended to include more analyses on the impact of the interventions and how the different aspects of the improvement strategy impacted the outcomes. It would improve the evaluation of the PIP outcomes for a more in-depth evaluation and improvement strategies focused on retaining newly enrolled and experienced providers.

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 2025 in accordance with the language from the SFY 2021 SOW. Reviewers have populated the following areas in the Contract Review tab:

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

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

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

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

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

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

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

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

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

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

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

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

Next Steps: Identification of next steps for review.

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

Appendix E: Protocol 2 - Operational Requirements Review Tool

Summary of SFY 25 Compliance with Operational Requirements

Overview

Number of OPs	23
Number of Goals	25

**These 23 are listed on tab "2. SFY 25 Contract Review". One Operational Requirement (OP) can have multiple goals. For example OPS 8-17 has 3 goals.*

Level 1 Analysis - Does the supporting data meet the goal? {Assess whether Magellan satisfied its own goals as set in the quarterly and annual reports}

Compliance Result	% of Goals
Goal Met	56.0%
Goal Not Met	20.0%
Not Applicable	20.0%
Insufficient Data	4.0%
Total	100.0%

Level 2 Analysis - Are all goals for the performance measure met? {Asses whether Magellan fully met all goals associated with a performance measure}

Compliance Result	% of Performance Measures
Yes	56.5%
No	21.7%
Not Applicable	17.4%
Insufficient Data	4.3%
Total	100.0%

Level 3 Analysis - Does the goal address the performance measure? {Assess whether the goals establisheed for the performance measure is appicable for addressing the performance measure, regardless of whether or not it was met}

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? {Assess whether the listed goals fully address the performance measure}

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? {Assess whther the performance measure addresses its operational 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

SFY25 Contract Review

#	Category	Contract Section	Contract Requirement	Performance Expectations/ Measurement	OP	Reported Measure	Goal Threshold	Findings for SFY 25					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%	295.00	286.00	275.00	332.00	1188.00	Goal Met	Yes	Yes	Yes	Yes	
					Ops 8-17A D	Number of standard requests for authorization		295.00	287.00	275.00	334.00	1191.00						
					Ops 8-17A R	Calculated N/D		100%	100%	100%	99%	100%						
					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					No extended standard auths in SFY25
					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)		31.00	38.00	34.00	58.00	161.00	Goal Met					No goal percentage specified. If goal is to report the single value, goal is met.
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%	43.00	33.00	37.00	48.00	161.00	Goal Met	Yes	Yes	Yes	Yes	
					Ops 8-19D	Data showing compliance with this requirement shall be included in the quarterly data report.		43.00	33.00	37.00	48.00	161.00						
					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 filed orally or in writing at any time. The Contractor must also ensure that individuals making decisions regarding enrollee grievances and appeals are free of conflict, were not involved in any previous level of review or decision-making, have appropriate clinical expertise for treatment, if applicable, and must consider all submitted documents and information, considered at any level of the enrollee grievance and appeal process.	An appeal must be filed by an enrollee within sixty (60) calendar days from the date on the adverse benefit determination notice. An enrollee may file a grievance with the CME at any time. The Contractor must present a proposed resolution to the issue reported within ninety (90) calendar days from the date the Contractor receives the enrollee grievance or appeal. If the Contractor's proposed resolution is not accepted by the individual or entity acting on their behalf, the Contractor has thirty (30) calendar days to review and respond to the enrollee grievance or appeal. After exhausting the enrollee grievance and appeal process with the Contractor, the enrollee must have no less than ninety (90) calendar days the date of the Contractor's final notice of resolution to request an Agency fair hearing. Contractor must resolve enrollee grievances and provide notice according to the enrollee's health condition, no more than ninety (90) calendar days from grievance receipt.	Ops 8-25N	Contractor must resolve enrollee grievances and provide notice according to the enrollee's health condition, no more than ninety (90) calendar days from grievance receipt.	100%	0.00	1.00	1.00	1.00	3.00	Goal Met	Yes	Yes	Yes	Yes	Ops 8-26, became Ops 8-25 No data in SFY25
					Ops 8-25D	# of Grievances		0.00	1.00	1.00	1.00	3.00						
					Ops 8-25R	Calculated N/D		0%	100%	100%	100%	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 SFY25
					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 SFY25
					Ops 8-29D	# of Appeals		0.00	0.00	0.00	0.00	0.00						
					Ops 8-29R	Calculated N/D		0%	0%	0%	0%	0%						
6	HFWA	Ops 8-30	**Appeals** Provide continuous enrollee benefits if the enrollee files a request for an appeal within sixty (60) calendar days from the adverse action notification. Benefits shall continue until the enrollee withdraws the appeal, fails to timely request continuation of benefits, or a State fair hearing decision adverse to the enrollee is issued. If the final resolution of appeal or State fair hearing upholds the adverse action, the Contractor may recover in accordance with State policies, the costs of the enrollee's continued benefits. The Contractor must pay for disputed services if the decision to deny, limit or delay services was overturned.	If services were not furnished during the appeal, the Contractor must authorize or provide the services as expeditiously as the enrollee's health condition requires, but no later than seventy-two hours from the date that the State fair hearing officer reverses a decision to deny, limit or delay services.	Ops 8-30N	If services were not furnished during the appeal, the Contractor must authorize or provide the services as expeditiously as the enrollee's health condition requires, but no later than seventy-two hours from the date that the State fair hearing officer	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 SFY25
					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 SFY25
					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.	95%	18.00	31.00	44.00	45.00	138.00	Goal Not Met	No	Yes	Yes	Yes	Goal updated to 95%
					EM 9-3D	# of member referrals		20.00	46.00	47.00	47.00	160.00						
					EM 9-3R	Calculated N/D		90%	67%	94%	96%	86.3%						

Appendix E: Protocol 2 - Operational Requirements Review Tool

#	Category	Contract Section	Contract Requirement	Performance Expectations/ Measurement	OP	Reported Measure	Goal Threshold	Findings for SFY 25					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						
9	Operations	EM 9-4	Assist families with the application or admission process for children and youth in accordance with the approved Policies and Procedures.	The Contractor must report on the number of children and youth referred, and turnaround time for referrals as part of the Quarterly Report	EM 9-4N	# of member referrals, The Contractor must report on the number of children and youth referred, and turnaround time for referrals as part of the Quarterly Report.		81.00	114.00	141.00	48.00	384.00	Goal Met	Yes	Yes	Yes	Yes	No goal percentage specified. If goal is to report the single value, goal is met.
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.	95%	25	38	66.00	64.00	193	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-5D	# of applications		27	38	66.00	72.00	203						
					EM 9-5R	Calculated N/D		93%	100%	100%	89%	95%						
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%	11.00	12.00	11.00	16.00	50.00	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-6D	# of referrals		11.00	12.00	11.00	16.00	50.00						
					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.	98%	53.00	52.00	79.00	74.00	258.00	Goal Not Met	No	Yes	Yes	Yes	
					EM 9-7D	# of new enrollees		64.00	66.00	83.00	78.00	291.00						
					EM 9-7R	Calculated N/D		83%	79%	95%	95%	89%						
13	Operations	EM 9-9	Process client disenrollment if the enrollee meets any of the following criteria: A. All of the goals of the family/enrollee have been met; B. No evidence of POC in place or engagement with the family for care coordination; C. Lack of cooperation by family/enrollee in POC development, implementation, refusal to sign or abide by the POC, including the refusal of critical services; D. If the enrollee is no longer Medicaid eligible; E. The enrollee moves out of state; F. The enrollee ages out of program; G. The enrollee is incarcerated; H. Enrollment with an alternate State Waiver/ Program (DD Waiver); I. The enrollee is no longer financially eligible; J. The enrollee is no longer clinically eligible; K. The enrollee is determined eligible for any excluded program/population; L. The enrollee is in an out-of-home placement longer than one hundred eighty (180) calendar days; M. Family/enrollee's choice to terminate waiver services; or N. Death of participant. The Contractor may not request disenrollment because of a change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Contractor's ability to furnish services to the enrollee or other enrollees).	Provide a thirty (30) calendar day advance notification to the enrollee and the enrollee's FCC prior to implementing a change in program eligibility and/or service amount, duration, or frequency. With exception of loss of Medicaid eligibility.	EM 9-9N	# of members that received an advanced notification within thirty (30) calendar days to the enrollee and the enrollee's FCC prior to implementing a change in program eligibility and/or service amount, duration, or frequency. With exception of loss of Medicaid eligibility.	100%	5.00	3.00	3.00	0.00	11.00	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-9D	# of members with a 30 day advance notice of termination.		5.00	3.00	3.00	0.00	11.00						
					EM 9-9R	Calculated N/D		100%	100%	100%	0%	100%						
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%	105.00	95.00	117.00	89.00	406.00	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-12D	# of members with a CASII or ECSII assessment.		105.00	95.00	117.00	89.00	406.00						
					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	65.00	82.00	78.00	287.00	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-15D	# of new enrollees.		62.00	65.00	82.00	78.00	287.00						
					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.	100%	47.00	42.00	39.00	56.00	184.00	Goal Not Met	No	Yes	Yes	Yes	
					EM 9-16D	# of new enrollees.		66.00	54.00	57.00	76.00	253.00						
					EM 9-16R	Calculated N/D		71%	78%	68%	74%	73%						
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%	294	288	278	338	1198	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-17D	# of POCs emailed.		294	290	278	341	1203						
					EM 9-17R	Calculated N/D		100%	99%	100%	99%	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%	553	533	538	603	2227	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-20D	# of youths.		569	542	546	622	2279						
					EM 9-20R	Calculated N/D		97%	98%	99%	97%	98%						
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%	202	159	197	189	747	Goal Not Met	No	Yes	Yes	Yes	
					EM 9-22D	# of enrollees with required readiness assessments due.		247	228	267	279	1021						
					EM 9-22R	Calculated N/D		82%	70%	74%	68%	73%						
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%	145	138	148	156	587						

Appendix E: Protocol 2 - Operational Requirements Review Tool

#	Category	Contract Section	Contract Requirement	Performance Expectations/ Measurement	OP	Reported Measure	Goal Threshold	Findings for SFY 25					1. Does the supporting data meet the goal?	2. Are all goals for the performance measure met?	3. Does the goal address the performance measure?	4. Is the performance measure fully addressed by the goals?	5. Does the performance measure satisfy the contract requirement?	Comments
								Q1	Q2	Q3	Q4	Annual Total						
					EM 9-23D	# of enrollees with a FCC Authorizations.		157	150	155	167	629	Goal Not Met	No	Yes	Yes	Yes	
					EM 9-23R	Calculated N/D		92%	92%	95%	93%	93%						
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	2	8	10	21	Goal Met	Yes	Yes	Yes	Yes	
					EM 9-24D	# of members with respite authorization.		1	2	8	10	21						
					EM 9-24R	Calculated N/D		100%	100%	100%	100%	100%						
22	Technical	EM 9-29	Prompt and oversee that families complete the Agency's WFI-EZ and prepare families to submit six months after enrollment.	The FCC shall prompt the enrollee and their family thirty (30) calendar days before the WFI-EZ assessment date. This shall be documented in the Contractor's deployed system.	EM 9-29N	The FCC shall prompt the enrollee and their family thirty (30) calendar days before the WFI-EZ assessment date. This shall be documented in the Contractor's deployed system.	95%	0	0	0	0	0	Insufficient Data	Insufficient Data	Yes	Yes	Yes	EM 9-29 is not displayed in the CDF.
					EM 9-29D	# new enrollees		0	0	0	0	0						
					EM 9-29R	Calculated N/D		0%	0%	0%	0%	0%						
23		PM 10-4	Conduct initial provider training and certification as an FCC, FSP, YSP, or respite provider prior to being activated to provide CME service.	All providers shall complete and successful pass the certification process prior to providing any CME service. Tier One Training shall be completed for each provider within ninety (90) calendar days of the start of the training for ninety-five percent (95%) of network providers.	PM 10-4N	All providers shall complete and successful pass the certification process prior to providing any CME service. This is reported as the average number of providers.	95%	230	235	237	268	970	Goal Met	Yes	Yes	Yes	Yes	
					PM 10-4D	Tier One Training shall be completed for each provider within ninety (90) calendar days of the start of the training for 95% of network providers. This is reported as the average number of total providers		230	235	237	268	970						
					PM 10-4R	Calculated N/D		100%	100%	100%	100%	100%						

Appendix E: Protocol 2 - Operational Requirements Review Tool

Wyoming Department of Health (WDH) - Care Management Entity (CME) Program							
Quarterly Summary of Measures							
OP	**Performance Measure Description**	**Magellan Goals**	**Q1**	**Q2**	**Q3**	**Q4**	**SFY2025 YTD**
Operations Reporting							
Ops 8-17A N	Number of standard auth decisions within timeframe (14 calendar days)		295	286	275	332	1188
Ops 8-17A D	Number of standard requests for authorization		295	287	275	334	1191
Ops 8-17A R	Calculated N/D	95%	100.00%	99.65%	100.00%	99.40%	99.75%
Ops 8-17B N	Number of extended standard auth decisions within additional timeframe (14 calendar days)		0	0	0	0	0
Ops 8-17B D	Number of standard auth extension requests		0	0	0	0	0
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)	N/A	31	38	34	58	161
Critical Incidents							
Ops 8-19N	The Contractor shall notify the Agency within two (2) business days of any critical incident event.		43	33	37	48	161
Ops 8-19D	Data showing compliance with this requirement shall be included in the quarterly data report.		43	33	37	48	161
Ops 8-19R	Calculated N/D	98%	100.00%	100.00%	100.00%	100.00%	100.00%
Grievances							
Ops 8-25N	Contractor must resolve enrollee grievances and provide notice according to the enrollee's health condition, no more than ninety (90) calendar days from grievance receipt.		0	1	1	1	3
Ops 8-25D	# of Grievances		0	1	1	1	3
Ops 8-25R	Calculated N/D	100%	0.00%	100.00%	100.00%	100.00%	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	0	0	0	0
Ops 8-28D	# of Appeals		0	0	0	0	0
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	0	0	0	0
Ops 8-29D	# of Appeals		0	0	0	0	0
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	0	0	0	0
Ops 8-30D	# of Appeals		0	0	0	0	0
Ops 8-30R	Calculated N/D	98%	0.00%	0.00%	0.00%	0.00%	0.00%
Enrollee Grievances							
Ops 8-31N	The Contractor must send enrollee grievances, received about the Contractor, to the Agency.		0	0	0	0	0
Ops 8-31D	# of Grievances		0	0	0	0	0
Ops 8-31R	Calculated N/D	100%	0.00%	0.00%	0.00%	0.00%	0.00%
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		18	31	44	45	138
EM 9-3D	# of member referrals		20	46	47	47	160
EM 9-3R	Calculated N/D	95%	90.00%	67.39%	93.62%	95.74%	86.25%

Appendix E: Protocol 2 - Operational Requirements Review Tool

OP	Performance Measure Description	Magellan Goals	Q1	Q2	Q3	Q4	SFY2025 YTD
Assist families with the application or admission process for children and youth							
EM 9-4N	# of member referrals, The Contractor must report on the number of children and youth referred,	N/A	81	114	141	48	384
Process all applications							
EM 9-5N	Process all enrollee applications within three (3) business days once application information is		25	38	66	64	193
EM 9-5D	# of applications		27	38	66	72	203
EM 9-5R	Calculated N/D	95%	92.59%	100.00%	100.00%	88.89%	95.07%
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.		11	12	11	16	50
EM 9-6D	# of referrals		11	12	11	16	50
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		53	52	79	74	258
EM 9-7D	# of new enrollees		64	66	83	78	291
EM 9-7R	Calculated N/D	98%	82.81%	78.79%	95.18%	94.87%	88.66%
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.		5	3	3	0	11
EM 9-9D	# of members with a 30 day advance notice of termination.		5	3	3	0	11
EM 9-9R	Calculated N/D	100%	100.00%	100.00%	100.00%	0.00%	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.		105	95	117	89	406
EM 9-12D	# of members with a CASII or ECSII assessment.		105	95	117	89	406
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	65	82	78	287
EM 9-15D	# of new enrollees.		62	65	82	78	287
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.		47	42	39	56	184
EM 9-16D	# of new enrollees.		66	54	57	76	253
EM 9-16R	Calculated N/D	100%	71.21%	77.78%	68.42%	73.68%	72.73%
Authorize POCs							
EM 9-17N	# of POCs reviewed, the Contractor shall review and process one hundred percent (100%) of all POCs submitted.		294	288	278	338	1198
EM 9-17D	# of POCs emailed.		294	290	278	341	1203
EM 9-17R	Calculated N/D	100%	100.00%	99.31%	100.00%	99.12%	99.58%
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.		553	533	538	603	2227
EM 9-20D	# of youths.		569	542	546	622	2279
EM 9-20R	Calculated N/D	95%	97.19%	98.34%	98.53%	96.95%	97.72%
Routine readiness assessments based on the pre-approved Transition Readiness Scale							
EM 9-22N	# of assessment within 3 months of the previous assessment.		202	159	197	189	747

Appendix E: Protocol 2 - Operational Requirements Review Tool

OP	Performance Measure Description	Magellan Goals	Q1	Q2	Q3	Q4	SFY2025 YTD
EM 9-22D	# of enrollees with required readiness assessments due.		247	228	267	279	1021
EM 9-22R	Calculated N/D	90%	81.78%	69.74%	73.78%	67.74%	73.16%
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.		145	138	148	156	587
EM 9-23D	# of enrollees with a FCC Authorizations.		157	150	155	167	629
EM 9-23R	Calculated N/D	95%	92.36%	92.00%	95.48%	93.41%	93.32%
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	2	8	10	21
EM 9-24D	# of members with respite authorization.		1	2	8	10	21
EM 9-24R	Calculated N/D	100%	100.00%	100.00%	100.00%	100.00%	100.00%
Prompt and oversee that families complete the Agency's WFI-EZ and prepare families to submit six months after enrollment.							
EM 9-29N	The FCC shall prompt the enrollee and their family thirty (30) calendar days before the WFI-EZ assessment date. This shall be documented in the Contractor's deployed system.		0	0	0	0	0
EM 9-29D	# new enrollees		0	0	0	0	0
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.		230	235	237	268	970
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.		230	235	237	268	970
PM 10-4R	Calculated N/D	95%	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)		1	1	1	1	4
OUT 13-1D	# of youth enrolled with the CME Contractor.		148	149	157	148	281
OUT 13-1R	Calculated N/D	N/A	0.68%	0.67%	0.64%	0.68%	1.42%
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)		65	69	59	27	126
OUT 13-2_2	# of youth enrolled with the CME Contractor.		148	149	157	148	281
Recidivism							
OUT 13-3N	# of youth enrolled in HLOC (PRTF)		1	1	1	1	4
OUT 13-3D	# of youth enrolled with the CME Contractor.		148	149	157	148	281
OUT 13-3R	Calculated N/D	N/A	0.68%	0.67%	0.64%	0.68%	1.42%
Recidivism (LOC) at six (6)							

Appendix E: Protocol 2 - Operational Requirements Review Tool

OP	Performance Measure Description	Magellan Goals	Q1	Q2	Q3	Q4	SFY2025 YTD
OUT 13-4N	# of graduated youth admitted to HLOC w/in 6mths. (PRTF)		0	0	1	0	1
OUT 13-4D	# of youth graduated from the CME.		24	21	22	26	93
OUT 13-4R	Calculated N/D	N/A	0.00%	0.00%	4.55%	0.00%	1.08%
Primary Care Practitioner Access (EPSDT)							
OUT 13-5N	# of CME enrolled youth with an identified Primary Care Practitioner.	N/A	61	62	79	76	278
OUT 13-5D	# of youth enrolled in the CME.	N/A	62	65	82	78	287
OUT 13-5R	Calculated N/D	N/A	98.39%	95.38%	96.34%	97.44%	96.86%
Cost Savings							
OUT 13-6N	total Medicaid cost (WYCME)	N/A	$ 709,370.01	$ 879,895.05	$ 864,594.74	$ 789,534.81	$ 5,819,999.06
OUT 13-6D	# of youth enrolled in CME	N/A	148	149	157	148	$ 281.00
OUT 13-6A	Average cost of CME youth	N/A	$ 4,793.04	$ 5,905.34	$ 5,506.97	$ 5,334.69	$ 20,711.74
OUT 13-6RON	Total Medicaid cost (other)	N/A	$ 3,724,412.93	$ 3,817,683.94	$ 3,651,289.63	$ 4,031,799.22	$ 14,245,625.40
OUT 13-6ROD	# of non-HFWA youths w PRTF	N/A	99	108	92	101	$ 163.00
OUT 13-6ROA	Average cost of PRTF youth	N/A	$ 37,620.33	$ 35,348.93	$ 39,687.93	$ 39,918.80	$ 87,396.47
Fidelity to the high fidelity wraparound (HFWA) Model							
OUT 13-7N	The Contractor shall report fidelity to the HFWA model as measured by the Wraparound Fidelity Index (WFI-EZ)	N/A	77.80%	78.10%	83.90%	76.40%	78.90%
OUT 13-7D	Compared to the National Fidelity average	N/A	75.00%	75.00%	75.00%	75.00%	75.00%
Fidelity to the high fidelity wraparound (HFWA) Model							
OUT 13-8N	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	26	33	34	45	N/A
OUT 13-8D	Number of eligible youth that have been enrolled in the HFWA program greater than or equal to 6 months for the current reporting period.	N/A	30	46	34	35	N/A
Family and Youth Participation at State-Level Advisory Meetings							
OUT 13-9N	# of Attendees Representing Families	N/A	14	12	34	19	N/A
OUT 13-9D	# of Enrollees	N/A	670	660	694	745	N/A
			2.09%	1.82%	4.90%	2.55%	2.84%
Family and Youth Participation in Communities							
OUT 13-10N	Family and Youth Participation in Communities	N/A	0	0	0	0	N/A
OUT 13-10D	# of Attendees Representing Families	N/A	670	660	694	745	N/A
OUT 13-10R	# of Enrollees	N/A	0.00%	0.00%	0.00%	0.00%	0.00%

Wyoming Department of Health - SFY 2025
External Quality Review Technical Report
Appendix F. Outcome Measures Review Tool

Outcomes Tool

No	2025 SOW Section	Outcome Name - SFY 2025	Outcome Requirement - SFY 2025	Outcome Performance Measure - SFY 2025	Outcome Performance Penalty - SFY 2025	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: 1 D: 148 %: 0.6	N: 1 D: 149 %: 0.6	N: 1 D: 157 %: 0.6	N: 1 D: 148 %: 0.6	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: 65 days CME Enrolled Youth: 148	ALOS: 69 days CME Enrolled Youth: 149	ALOS: 59 days CME Enrolled Youth: 157	ALOS: 27 days CME Enrolled Youth: 148	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: 1 D: 148 %: 0.6	N: 1 D: 149 %: 0.6	N: 1 D: 157 %: 0.6	N: 1 D: 148 %: 0.6	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: 24 %: 0	N: 0 D: 21 %: 0	N: 1 D: 22 %: 4.50	N: 0 D: 26 %: 4	Meets Requirement	Magellan reported data on recidivism at six months post graduation 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: 61 D: 62 %: 98	N: 62 D: 65 %: 95	N: 79 D: 82 %: 96	N: 76 D: 78 %: 97	Meets Requirement	Magellan reported on EPSDT Compliance / PCP identification on a quarterly basis.

Outcomes Tool

No	2025 SOW Section	Outcome Name - SFY 2025	Outcome Requirement - SFY 2025	Outcome Performance Measure - SFY 2025	Outcome Performance Penalty - SFY 2025	Q1	Q2	Q3	Q4	Status of Goal	Findings and Comments
6	OUT 13-6	Cost Savings (Healthcare Costs)	The Contractor must report healthcare costs to Medicaid for the CME enrolled youth.	Average total Medicaid healthcare costs per CME enrolled youth as compared to the total Medicaid costs for the target eligible population of non-CME enrolled youth with PRTF stays.	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%) and the decreased PMPM will continue until the next annual reporting period (following year).	Avg. cost of CME youth (6 mo.): $4,793.04 Avg. cost of PRTF youth (6 mo.): $37,620.33	Avg. cost of CME youth (6 mo.): $5,905.34 Avg. cost of PRTF youth (6 mo.): $35,348.93	Avg. cost of CME youth (6 mo.): $5,506.97 Avg. cost of PRTF youth (6 mo.): $39,687.93	Avg. cost of CME youth (6 mo.): $5,334.69 Avg. cost of PRTF youth (6 mo.): $39,918.80	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 (following quarter).	77.8%	78.1%	83.9%	76.4%	Meets Requirement	Magellan reported fidelity to the HFWA model as measured by the Wraparound Fidelity Index (WFI-EZ) on a monthly basis.
8	OUT 13-8		The Contractor must report the number of WFI-EZ surveys received to capture a valid and representative sample of the experiences of enrollees served.	Report quarterly the number of WFI-EZ surveys received during the quarterly period compared to the same quarter in the previous year.	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by one quarter of one percent (0.25%) and the decreased PMPM will continue until the next reporting period (following quarter).	# of Surveys (average): 26	# of Surveys (average): 33	# of Surveys (average): 34	# of Surveys (average): 45	Meets Requirement	Magellan reported the number of WFI-EZ surveys administered on a monthly basis.
9	OUT 13-9	Family and Youth Participation at State-level Advisory Committees	The Contractor must work with Agency to identify and invite family and youth to participate on State- level Advisory Committees.	Report quarterly for the previous quarter the Denominator - number of state-level Advisory attendees who represent family and youth enrollees and the Numerator - number of CME enrollees.	If the Contractor fails to provide this report, the PMPM for every youth enrolled with the Contractor will be decreased by half of one percent (0.5%). The decreased PMPM will continue until the next reporting period (following quarter).	N: 14 D: 223 %: 6.3	N: 12 D: 220 %: 5.4	N: 34 D: 231 %: 14.7	N: 19 D: 248 %: 7.60	Meets Requirement	Magellan reported on the Family and Youth Participation in State-level Advisory Committees on 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: 0 D: 223 %: 0	N: 0 D: 220 %: 0	N: 0 D: 231 %: 0	N: 0 D: 248 %: 0	Meets Requirement	Magellan reported on the Family and Youth Participation in Communities across on a quarterly basis.

Appendix G: Protocol 3 - Compliance Review Tool

WDH CME Program
EQR Protocol 3 Document Request

					Magellan to Complete		Guidehouse to Complete			
#	Federal regulation source(s)	Medicaid agency policy/ regulation information needed to determine MCP compliance	SFY2025 Contract Language	Potentially Applicable MCP Documents	File Names	Page Number	Documents Reviewed	Findings	Questions Asked During On-Site	Review Determination
EX1	*EXAMPLE 1*	*CMS Language*	*Language from SFY2025 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				
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 2025 Disenrollment Policy* *2) 2025 Member Handbook*	1) pg.5 2) pgs. 32, 46-47				
Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations										
1.1	**Availability of services** **Medicaid**: 42 CFR 438.206 (availability of services) and 42 CFR 10(h) provider directory) **CHIP:** 42 CFR 457.1230(a)	• The state's provider-specific network adequacy requirements and standards (and exceptions, if any).	The Contractor must develop a network of providers to ensure access to a broad array of services and supports, including peer and natural supports, and management utilization, quality and outcomes at the child and family level. Network sufficiency includes geographic sufficiency, but also an adequate array of HCBS providers, culturally and linguistically diverse providers, providers who are available on weekends and after-hours. Services Management functions include: A.Family Care Coordination, Family and Youth Peer support and advocacy, and respite providers; B.Provider network development and management; C.Ability to manage formal (e.g., clinical) and informal supports (e.g., neighbors); D.Crisis response capacity; E.Develop new services (scalability); and F.Diverse service capacity. [SOW Req ID: PM 10-1, pg.68]	• Service planning documents and provider network planning documents (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) (AM) • Service availability and accessibility expectations and standards (AM) • Other performance standards and quality indicators established by the MCP (AM) • Any measurement or analysis reports on service availability and accessibility (AM) • List of all care and service providers in the MCP's network (may be the same as the provider directory) (AM) • Organization strategic plans (AM) • Administrative policies and procedures (AM) • Medicaid and CHIP and other enrollee survey results (AM) • Utilization management policies and procedures (UM) • Service authorization policies and procedures (UM) • Provider contracts (PS) • Provider/Contractor procedure manuals (PS) • Provider/Contractor oversight and evaluation policies and procedures, audit tools (PS) • Medicaid and CHIP enrollee services policies and procedures (ES) • Statement of enrollee rights (ES) • Medicaid and CHIP enrollee handbooks (ES) • Medicaid and CHIP provider directory • Medicaid and CHIP enrollee orientation curriculum (ES) • Medicaid and CHIP enrollee grievance and appeals policies and procedures (ES)	Family Care Coordinator SOW Family Support Partner SOW Respite SOW Youth and Family Trainer Youth Support Partner SOW Network Development Plan Accessibility of Service and Care Policy Wraparound Provider Manual Final 2025 Wyoming Provider Handbook Supplement	pgs. 13-23; 27-28 pg. 2-3 Network Development Plan pgs. 36-38 Wyoming Provider Manual pgs. 20-21 Wyoming Provider Handbook	Family Care Coordinator SOW Family Support Partner SOW Respite SOW Youth and Family Trainer Youth Support Partner SOW Network Development Plan Accessibility of Service and Care Policy Wraparound Provider Manual Final 2025 Wyoming Provider Handbook Supplement	All general and appropriate parameters are included in the documents related to provider-specific network adequacy requirements and standards.		Fully Met
1.2		• The state's requirements for the MCP provider directory.	A provider directory must also be made available on the Contractor's website in a machine-readable file and format as specified by the Secretary and in 42 CFR 438.10(h). The Contractor's electronic provider directory must be updated no later than thirty (30) calendar days after the Contractor receives updated provider information. [SOW pg.12; Req ID: Ops 8-13, pg.40] If an enrollee or their guardian requests a paper copy of the provider directory, a copy of the current directory will be mailed to the enrollee within five (5) business days from the date of request. The Contractor is responsible for ensuring provider changes are accurately and timely captured in the published provider directory. Update the provider directory no later than thirty (30) calendar days after the Contractor receives updated provider information. [SOW Req ID: PM 10-19, pg.71]	• Statement of enrollee rights (ES) • Medicaid and CHIP enrollee handbooks (ES) • Medicaid and CHIP provider directory • Medicaid and CHIP enrollee orientation curriculum (ES) • Medicaid and CHIP enrollee grievance and appeals policies and procedures (ES)	Updating Provider Records-Training Tiers Network Provider Data Maintenance and Data Integrity	See all pages	Updating Provider Records-Training Tiers Network Provider Data Maintenance and Data Integrity	The "Network Provider Data Maintenance and Data Integrity" includes detailed policies and procedures for a provider directory. The provider directory is publically available online via Magellan's website with no login required. Also, Magellan explained that families are verbally informed of their provider options before they are given access to the Provider Directory.	Is the PD available online and available to mail? Please provide the PD URL for additional review.	Fully Met
1.3		• Information on the documentation that the state uses to support its certification that the MCP complied with the state's requirements for availability and accessibility of services, including the adequacy of the provider network.	The Contractor must submit documentation to the Agency demonstrating that the Contractor offers an appropriate range of services that is adequate for the anticipated number of enrollees and maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the enrollees in the service area at the time it enters in to a Contract with the Agency and any time there is a significant change (as defined by the Agency) in the Contractor's operations that impacts services. The contractor will report to the Agency the network adequacy standards for all counties, provider type, enrollees, etc. to maintain access to services (42 CFR 438.68(b)(3)). [SOW pg.12] The provider network must be sufficient to provide adequate access to all services covered under the contractual agreement for all enrollees, including those with limited English proficiency or physical or mental disabilities. The Contractor will also demonstrate that they have complied with availability and accessibility of service requirements. The Contractor provides supporting documentation demonstrating that it has the capacity to serve the expected statewide enrollment. Through geographic mapping, distribution of provider types across the State is identified. A full listing is included in the Service Report and on the Contractor's website. Geographic mapping is generated and reported on a quarterly basis and is developed by the Contractor and provided to the Agency for use in monitoring marketing, information to beneficiaries, enrollee's free choice of providers, timely access, coordination/continuity of care, coverage/authorization, quality of care, and Provider Selection. [SOW pg. 11] Provide a Quarterly Report to the Agency that includes, at minimum: J. Geographic mapping of provider networks by Contractor; L. Network adequacy assurance submitted by Contractor; M. Compliance with provider initial and recertification requirements; [SOW pgs. 49 - 50; Req ID: Ops 8-35] Provide as an Attachment to the Quarterly Report, a summary of metrics to support the Wyoming Medicaid 1915(c) Waiver. Specifically, the Contractor must provide the following measures: A.Percentage of providers that meet all initial provider credentialing and qualification requirements (total # of waiver providers that meet all provider credentialing and qualification requirements/ total # of providers enrolled); B.Percentage of providers that meet all ongoing provider credentialing and qualification requirements (total number of providers that continue to meet all ongoing provider credentialing and qualification requirements/total number of enrolled providers); [SOW pg. 51; Req ID: Ops 8-36]		All Provider Certification Tracking 8-36b Network Development Plan 2025 Geographic Maps WY CME GeoMaps SFY2025 Q1 WY CME GeoMaps SFY2025 Q2 WY CME GeoMaps SFY2025 Q3 WY CME GeoMaps SFY2025 Q4 Network Provider Data Maintenance and Data Integrity Procedure for Tracking of Onboarding for Ops 8-36A Procedure Recertification Tracking for Ops 8-36D Procedure Tier 1 and Tier 2 Tracking Process Provider Cert Recert Policy NE.03.07.WY.HFWA	pg. 23	All Provider Certification Tracking 8-36b Network Development Plan 2025 Geographic Maps WY CME GeoMaps SFY2025 Q1 WY CME GeoMaps SFY2025 Q2 WY CME GeoMaps SFY2025 Q3 WY CME GeoMaps SFY2025 Q4 Network Provider Data Maintenance and Data Integrity Procedure for Tracking of Onboarding for Ops 8-36A Procedure Recertification Tracking for Ops 8-36D Procedure Tier 1 and Tier 2 Tracking Process Provider Cert Recert Policy NE.03.07.WY.HFWA	All general and appropriate parameters are included in the documents related to network adequacy. The documents provide clear documentation to indicate that the MCP has complied with provider adequacy, availability, and accessibility. Provider certification, recertification, onboarding and training tracking procedures are detailed, indicating adequacy of the provider network. The Network Development Plan and geographic maps provide data on availability and accessibility of services in various geographic locations across the State.		Fully Met
2.1	**Furnishing of services and timely access** **Medicaid**: 42 CFR 438.206(c)(1): Furnishing of services and timely access **CHIP**: 42 CFR 457.1230(a): Availability of services	Obtain a copy of the state Medicaid and CHIP agency's standards for timely enrollee access to care and services required of Medicaid and CHIP and MCPs.	The networked providers must meet the State standards for timely access for services taking in to account the urgency of need for services. The Contractor's network of providers must offer hours of operation that are no less than the hours offered to commercial enrollees or are comparable to Medicaid fee-for-service, if the provider services only Medicaid enrollees. [SOW Req ID: PM 10-8, pg.68] Establish mechanisms in order to monitor providers regularly, ensuring the network providers comply with the timely access requirements. If providers fail to comply with the timely access requirements, the Contractor must take corrective action in accordance with the approved QAPI. [SOW Req ID: PM 10-9, pg. 68]	• Service planning documents and provider network planning documents (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) (AM) • Service availability and accessibility expectations and standards (AM) • Other performance standards and quality indicators established by the MCP (AM) • Any measurement or analysis reports on service availability and accessibility (AM) • List of all care and service providers in the MCP's network (may be the same as the provider directory) (AM) • Organization strategic plans (AM) • Service planning documents and provider network planning documents (e.g., geographic assessments, provider network assessments, • Administrative policies and procedures (AM) • Medicaid and CHIP and other enrollee survey results (AM) • Utilization management policies and procedures (UM) • Service authorization policies and procedures (UM) • Provider contracts (PS) • Provider/Contractor procedure manuals (PS) • Provider/Contractor oversight and evaluation policies and procedures, audit tools (PS) • Medicaid and CHIP enrollee services policies and procedures (ES) • Statement of enrollee rights (ES) • Medicaid and CHIP Enrollee Handbooks (ES) • Medicaid and CHIP provider directory • Medicaid and CHIP Enrollee Orientation Curriculum (ES) • Medicaid and CHIP enrollee grievance and appeals policies and procedures (ES)	Accessibility of Service and Care Policy Magellan WY CME Quality Annual Program Evaluation Network Development Plan Wyoming Provider Handbook Supplement Appendix A Timelines and Requirements FCC Family Care Coordinator SOW	pgs. 16-18; 20-23 of the Magellan WY CME Quality Annual Program Evaluation pgs. 11-14; 17-20; 23 of the Network Development Plan pgs. 20; 23-25 of the Wyoming Provider Handbook Supplement pg. 2 Appendix A of the Timelines and Requirements FCC pgs. 2-3 of the Family Care Coordinator	Accessibility of Service and Care Policy Magellan WY CME Quality Annual Program Evaluation Network Development Plan Wyoming Provider Handbook Supplement	All general and appropriate parameters are included in the documents related to furnishing of services and timeliness standards. The "Accessibility of Service and Care Policy" and "Wyoming Provider Handbook" detail the Contractor's hours of operations and access to provider services. "Magellan WY CME Quality Annual Program Evaluation" describes ways Magellan mitigates barriers to coverage gaps through leveraging telehealth. The "Network Development Plan" describes Magellan's approach to monitoring and reporting provider networks to comply with availability standards.		Fully Met
3.1	**Access and cultural considerations** **Medicaid**: 42 CFR 438.206(c)(2): Furnishing of services and cultural considerations. **CHIP**: 42 CFR 457.1230(a): Access standards	• Descriptive information on the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.	The website and any other public-facing system or tool must be fully accessible per required Section 508 Standards and contain a link to translation services if necessary. This includes the option for interpreter services for the hearing impaired and for non-English speakers. [SOW Req ID: Ops 8-15, pg.41] Provide all enrollee notices, informational and outreach materials, and communications in an easily understood format and manner. The Contractor must provide written materials for enrollees in 8th grade reading level, unless agreed to by the Agency. [SOW Req ID: Ops 8-20, pg.45] The Contractor must ensure that all written materials are provided in an easily understood language and format. Written materials must also be made available in alternative formats upon request of the potential enrollee or enrollee at no cost. Auxiliary aids and services must also be made available upon request of the potential enrollee or enrollee at no cost. Written materials must include taglines in the prevalent non-English language in Wyoming, be available in large print (a font size no smaller than 18 point) and provide an explanation of the availability of written translation, American Sign Language (ASL), or oral interpretation to understand the information provided. Written materials must include the toll-free and TTY/TDY telephone number of the Contractor's member/customer service unit. The Contractor must notify its enrollees that oral interpretation, written translation and auxiliary aids and services are available upon request at no cost for enrollees with disabilities, and provide information on how to access those services. [SOW pgs. 9-10]	• Other performance standards and quality indicators established by the MCP (AM) • Any measurement or analysis reports on service availability and accessibility (AM) • List of all care and service providers in the MCP's network (may be the same as the provider directory) (AM) • Organization strategic plans (AM) • Administrative policies and procedures (AM) • Medicaid and CHIP and other enrollee survey results (AM) • Utilization management policies and procedures (UM) • Service authorization policies and procedures (UM) • Provider contracts (PS) • Service planning documents and provider network planning documents (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) (AM) • Service availability and accessibility expectations and standards (AM) • Provider/Contractor procedure manuals (PS) • Provider/Contractor oversight and evaluation policies and procedures, audit tools (PS) • Medicaid and CHIP enrollee services policies and procedures (ES) • Statement of enrollee rights (ES) • Medicaid and CHIP Enrollee Handbooks (ES) • Medicaid and CHIP provider directory (ES) • Medicaid and CHIP Enrollee Orientation Curriculum (ES) • Medicaid and CHIP enrollee grievance and appeals policies and procedures (ES)	Member Handbook 2025 Wraparound Provider Manual Final 2025 Accessibility of Service and Care Policy Section 1557 Language Access Procedure Reasonable Modification Procedure Medicaid Enrollee Rights and Responsibilities Policy Medicaid Enrollee Communication and Information Requirements Policy WY Provider Scorecard Manual	pgs. 36-38; 35 of the Member Handbook 2025	Member Handbook 2025 Wraparound Provider Manual Final 2025 Accessibility of Service and Care Policy Section 1557 Language Access Procedure Reasonable Modification Procedure Medicaid Enrollee Rights and Responsibilities Policy Medicaid Enrollee Communication and Information Requirements Policy WY Provider Scorecard Manual	All general and appropriate parameters are included in the documents related to access and cultural considerations.		Fully Met
3.2		• The requirements the state has communicated to the MCP with respect to how the MCP is expected to participate in the state's efforts to promote the delivery of services in a culturally competent manner.	The Contractor is required to participate in the Agency's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. The contractor must report on enrolled AI/AN beneficiaries to demonstrate that their networks include sufficient Indian Health Care Providers (IHCPs) so as to ensure timely access to services for AI/AN populations (42 CFR 438.14(b)). [SOW pg. 12]		Member Handbook Medicaid Enrollee Communication and Information Requirements Policy Magellan WY CME Quality Annual Program Evaluation	pgs.7,14, 35, of the Member Handbook pgs. 11-13;18-19 of the Magellan WY CME Quality Annual Program Evaluation	Magellan WY CME Quality Annual Program Evaluation Member Handbook pgs. 7,14, 35 Medicaid Enrollee Communication and Information Requirements Policy	All general and appropriate parameters are included in the documents related to access and cultural considerations. The Magellan WY CME Quality Annual Program Evaluation mentions that there was an increase in providers during SFY'25 and increased effort to connect community to the HFWA program, particularly tribal communities. This included monthly meetings with the Indian Health Services and collaboration with the Eastern Shore Tribe. The Member Handbook and Medicaid Enrollee Communication and Information includes information about access requirements and procedures.		Fully Met
4.1	**Assurances of adequate capacity and services** **Medicaid**: 42 CFR 438.207: Assurances of adequate capacity and services **CHIP**: 42 CFR 457.1230(b): Assurances of adequate capacity and services	• Medicaid and CHIP agency documentation and submission timing standards to assure that the MCP has an appropriate range of preventive, primary care, specialty, and LTSS services that are adequate for the anticipated number of enrollees in the MCP's service area.	The Contractor must implement a regional approach to its provider network as approved by the Agency. Submit evidence as part of the Quarterly Report to the Agency demonstrating that the Contractor offers an appropriate range of services in all eight (8) regions of the state that is adequate for the anticipated number of enrollees and maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the enrollees in the service area at the time it enters in to a Contract with the Agency and any time there is a significant change (as defined by the Agency) in the Contractor's operations that impacts services. [SOW Req ID: PM 10-11, pg.70] The Contractor must submit documentation to the Agency demonstrating that the Contractor offers an appropriate range of services that is adequate for the anticipated number of enrollees and maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the enrollees in the service area at the time it enters in to a Contract with the Agency and any time there is a significant change (as defined by the Agency) in the Contractor's operations that impacts services. The contractor will report to the Agency the network adequacy standards for all counties, provider type, enrollees, etc. to maintain access to services (42 CFR 438.68(b)(3)). Documentation and geo-mapping are submitted quarterly. The data is used to monitor the above topics by obtaining information from the beneficiaries, resolving issues, and identifying and addressing trends. If deficiencies are noted the Contractor must perform corrective action until compliance is met. [SOW pg. 12-13]	• MCP 42 CFR 438.207(b) compliance documentation • MCP 42 CFR 438.207(c) compliance documentation • MCP 42 CFR 457.1230(b) compliance documentation	Network Development Plan 2025 Geographic Maps WY CME GeoMaps SFY2025 Q1 WY CME GeoMaps SFY2025 Q2 WY CME GeoMaps SFY2025 Q3 WY CME GeoMaps SFY2025 Q4	pgs. 14-23 of the Network Development Plan	Network Development Plan 2025 Geographic Maps WY CME GeoMaps SFY2025 Q1 WY CME GeoMaps SFY2025 Q2 WY CME GeoMaps SFY2025 Q3 WY CME GeoMaps SFY2025 Q4	All general and appropriate parameters are included in the documents related to network development and adequacy. For example, the Network Development Plan details regular quarterly and monthly reporting requirements on network adequacy and provider capacity, their comprehensive range of services, process for managing provider and capacity geographic distribution to meet enrollee needs, and process for implementing ongoing monitoring and corrective action processes to maintain compliance. Provider data by number, mix, and geographic distribution are reported by the Bigfoot system to track network availability.		Fully Met

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4.2		• Medicaid and CHIP agency documentation and submission timing standards to assure that the MCP maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.			Network Development Plan 2025	pgs. 17-20, 23 of the Network Development Plan	Network Development Plan 2025 Geographic Maps WY CME GeoMaps SFY2025 Q1 WY CME GeoMaps SFY2025 Q2 WY CME GeoMaps SFY2025 Q3 WY CME GeoMaps SFY2025 Q4	All general and appropriate parameters are included in the documents related to network development and adequacy. Documents provide information on the availability of practitioners and providers to ensure that all youth enrolled in services have fair and timely access to care by maintaining a robust provider network. The documents also include information on provider levels of care by year, provider linguistics, provider ethnicity. The CME has developed network adequacy standards to address challenges of providing care across the state's diverse geography. These standards ensure convenient and timely access to care in rural, urban, and frontier areas in order to balance the need for equitable access with the realities of the state's varied landscape. Regions (3, 4, and 5 for respite; 5 and 7 for YSP providers) with deficits are clearly identified. Magellan also runs reports on geomapping quarterly to gather information on provider numbers across the regions.	How does Magellan document that providers are serving multiple counties?	Fully Met
5.1	**Coordination and continuity of care for all enrollees** **Medicaid**: 42 CFR 438.208: Coordination and continuity of care **CHIP**: 42 CFR 457.1230(c): Coordination and continuity of care	The state's requirements regarding the obligation to and methods by which an MCP must: • a) Ensure enrollees have an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee. The enrollee must be provided information on how to contact their designated person or entity	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 and be provided information on how to contact their FCC. A POC must be developed for each enrollee within sixty (60) calendar days after enrollment. [SOW Req ID: EM 9-16, pg.62] The Contractor formally designates a Family Care Coordinator (FCC) of the enrollee's choosing. The FCC is responsible to coordinate the services the Contractor furnishes to the enrollee with the services the enrollee may receive in Fee For Service (FFS) Medicaid. The Contractor is required to implement procedures to coordinate the services it furnishes to the enrollee with the services the enrollee receives from community and social support providers. The Contractor will have the Electronic Health Record (EHR) to maintain enrollee information and the provider must maintain their own record as specified in the CMS 1500 Provider manual. [SOW pg. 17] The Contractor must have staff available using an 800 number, twenty-four (24) hours a day, three hundred sixty-five (365) days a year to respond to enrollee calls. The 800 number shall include telephone crisis intervention, risk assessment, and consultation to callers which may include family enrollees or other community agencies regarding behavioral health services. Interpreter services are available for the hearing impaired and for non-English speakers. Calls may range from non-urgent requests for referral to behavioral health crises. [SOW, pg. 10]	• Practice guidelines adopted by the MCP (AM) • Provider/Contractor Services policies and procedures manuals (PS) • Provider contracts (PS) • Provider/Contractor procedure manuals (PS) • Medicaid and CHIP enrollee services policies and procedures (ES) • Medicaid and CHIP enrollment and disenrollment policies and procedures (ES) • Medicaid and CHIP Enrollee Handbooks (ES) • Care coordination policies and procedures, and enrollee records (ES) • Sample of Medicaid and CHIP enrollee records (ES) • Medicaid and CHIP enrollment and disenrollment policies and procedures (ES) • A copy of the state-MCP contract provisions, which specify the methods by which the MCP assures the state Medicaid and CHIP agency that it does not request disenrollment for reasons other than those permitted under the contract.	Wyoming Provider Handbook Supplement HFWA Enrollment and Disenrollment Policy HFWA Enrollment Procedure WY CME Customer Experience Procedure	pgs. 90-92 Wyoming Provider Handbook Supplement pg. 2 HFWA Enrollment and Disenrollment Policy pgs. 5-7; 9-12 HFWA Enrollment Procedure pg. 1 WY CME Customer Experience Procedure	Wyoming Provider Handbook Supplement HFWA Enrollment and Disenrollment Policy HFWA Enrollment Procedure WY CME Customer Experience Procedure	The documents submitted include sufficient information on how the FCC works with the enrollee, their family, and the CFT. The 60-day POC timeline is documented in the Member Handbook, which states that POC development takes 15 - 45 days to complete. Compliance with this requirement is reported quarterly via the Committee Data File. Additionally, Magellan clarified that families will receive FCC contact details, including an address and phone number, in their enrollment letter. They are also educated about the FCC role and provider choice during the initial engagement and application process.	Is this documented somewhere and is this requirement upheld? How do members learn about this?	Fully Met
5.2		• b) Coordinate the services the MCP furnishes to enrollees (between settings, between MCPs, between MCP and FFS, and with services provided by community and social supports)	Coordinate the scheduling of CFT meeting and emergency meetings with the entire team. The enrollee or their family selects the meeting location unless the FCC is unwilling to attend due to safety concerns. In the event of safety concerns, the family and FCC shall work out an alternative location. [SOW Req ID: EM 9-26, pg.64]		Appendix A Timelines and Requirements FCC	pg. 10 of the Timelines and Requirements FCC	Appendix A Timelines and Requirements FCC	The coordination and continuity of care for all enrollee parameters are included in the document. While it does not detail the specifics for selecting the meeting location including alternative locations in the event of safety concerns, as mentioned in the contract, it does broadly state, "hold the first child and family team in a place that meets the family's needs."		Fully Met
5.3		• c) Make a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees	The FCC must contact every enrollee and/or family within three (3) business days after being chosen as the FCC to begin the application process. The FCC must make a best effort to conduct an initial screening of each enrollee's needs, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful per 42 CFR 438.208(b)(3). [SOW Req ID: EM 9-19, pg.62]		Wyoming Provider Handbook Supplement	Pgs. 23-26 of the Wyoming Provider Handbook Supplement	Wyoming Provider Handbook Supplement	FCCs must contact the enrollee/family within three business days and compliance with this requirement is tracked in EMS-19. If the first outreach fails, contact is repeated. Initial screening requirements are documented in the FCC SOW and are reinforced in mandatory provider trainings to ensure understanding of requirements. The needs assessment begins early and is completed within the first 60 days. The 90-day initial screening requirement is covered in provider trainings and within the Member Handbook timelines which state the Child and Adolescent Needs and Strengths assessment (CANS) and Adverse Childhood Experiences (ACEs) Surveys will occur in days 8 - 46. These requirements are reviewed with enrollees and their families during orientation.	Is this missing information documented somewhere else? How does Magellan communicate these processes to enrollees? What is Magellan's process for following up with the enrollee / family if the first attempt fails? Does Magellan complete all initial screenings within 90 days of the effective date?	Fully Met
5.4		• d) Share with the state or other MCPs serving the enrollee the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities	The Contractor is required to maintain a health information system that collects, analyzes, integrates and reports data. The Contractor's health information system shall provide information on areas including, but not limited to: denials of referrals, requests; utilization; claims; enrollee and provider grievances and appeals data; and, disenrollment for reasons other than loss of Medicaid eligibility including disenrollment requests made by an enrollee. This data must be included in a quarterly report from the Contractor to the Agency and will be used by the Agency and Contractor to monitor the following: quality of care, enrollment/disenrollment, and coordination/continuity of care, coverage/authorization and grievances. [SOW pgs. 6-7] A full listing is included in the Service Report and on the Contractor's website. Geographic mapping is generated and reported on a quarterly basis and is developed by the Contractor and provided to the Agency for use in monitoring marketing, information to beneficiaries, enrollee's free choice of providers, timely access, coordination/continuity of care, coverage/authorization, quality of care, and Provider Selection. [SOW pg. 11] Demonstrate that the FCC coordinates with and invites the DFS case worker to family meetings when appropriate. [SOW Req ID: EM 9-32, pg. 64] Demonstrate that the FCC coordinates with and invites the identified PCP to family meetings when appropriate. [SOW Req ID: EM 9-33, pg. 64]		Wraparound Provider Manual Final 2025 WY CME GeoMaps SFY2025 Q1 WY CME GeoMaps SFY2025 Q2 WY CME GeoMaps SFY2025 Q3 WY CME GeoMaps SFY2025 Q4 Team Member Report Coordination with DFS EM 9-32 EM 9-33 SFY2025.Q1. WY CME Committee.Data.File Final SFY2025.Q2. WY CME Committee.Data.File Final SFY2025.Q3. WY CME Committee.Data.File Final WY CME Committee Data File SFY 2025 Final	Pgs. 41-42, 104, 105, 109 of Wraparound Provider Manual Final	Wraparound Provider Manual Final 2025 WY CME GeoMaps SFY2025 Q1 WY CME GeoMaps SFY2025 Q2 WY CME GeoMaps SFY2025 Q3 WY CME GeoMaps SFY2025 Q4 Team Member Report Coordination with DFS EM 9-32 EM 9-33 SFY2025.Q1. WY CME Committee.Data.File Final SFY2025.Q2. WY CME Committee.Data.File Final SFY2025.Q3. WY CME Committee.Data.File Final WY CME Committee Data File SFY 2025.Final	The documents accurately describe required language arounds storing records, authorizing services, and monitoring provider performance. They include required language around tracking tasks, referrals, applications, enrollee interactions, and assessments. As described, FCCs are expected to invite team members—including DFS case workers—to meetings and document these contacts in the EHR. Magellan noted that the process for tracking denials changed on April 1, 2025, when the PA process changed. At that time, administrative non-authorizations were replaced with "pending decisions" (not denied) that may require providers to resubmit documentation. This process is documented in the Service Authorization Policy and Concurrent Review Procedure documents.	What is Magellan's process for tracking and reporting denials, if there are any?	Fully Met
5.5		• e) Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards	The Contractor will have the Electronic Health Record (EHR) to maintain enrollee information and the provider must maintain their own record as specified in the CMS 1500 Provider manual. [SOW pg. 16]		Wyoming Provider Handbook Supplement 2025	pg. 27 of the Wyoming Provider Handbook Supplement	Wyoming Provider Handbook Supplement 2025	The Wyoming Provider Handbook Supplement describes responsibilities for maintaining the provider website. Provider responsibility to maintain enrollee information in the EHR is covered in the Provider Manual, FCC SOW, onboarding training, and coaching. Providers are required to updated enrollee information to the EHR within three business days, as documented in manuals, statements of work, and onboarding training.	How are providers informed of their responsibility to maintain enrollee information in the EHR? Is this information documented anywhere?	Fully Met
5.6		• f) Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with applicable privacy requirements	Provide multiple layers of external and internal security that provides administrative, physical, and technical means to protect sensitive or confidential information used in performing the responsibilities and duties set forth in this SOW. [SOW Req ID: IT 6-37, pg.34] Facilitate the signature of consent forms from enrollees to share information between approved providers. [SOW Req ID: IT 6-40, pg.34]		General Rules for Uses and Disclosures of Protected Health Information Network Security-SC.1.421.04-Policy HFWA Enrollment Procedure	pg. 5, 7 #10	General Rules for Uses and Disclosures of Protected Health Information Network Security-SC.1.421.04-Policy HFWA Enrollment Procedure	The documents submitted comply with the regulatory and contract requirements.		Fully Met
6.1	**Additional coordination and continuity of care requirements: LTSS** **Medicaid**: 42 CFR 438.208: Coordination and continuity of care **CHIP**: 42 CFR 457.1230(c): Coordination and continuity of care	• Methods used by the Medicaid and CHIP agency to identify to the MCP enrollees who need LTSS.	The Contractor must ensure continuity of care for any youth enrolled with network providers who are unable to deliver authorized services for any reason. [SOW Req ID: PM 10-15, pg.71]	• Practice guidelines adopted by the MCP (AM) • Provider/Contractor Services policies and procedures manuals (PS) • Provider contracts (PS) • Provider/Contractor procedure manuals (PS) • Enrollee services policies and procedures (ES) • Enrollee Handbooks (ES) • Care coordination policies and procedures, and enrollee records (ES) • Sample of enrollee records (ES)	HFWA Transition of Active Enrollment to New Provider Procedure	See all pages	HFWA Transition of Active Enrollment to New Provider Procedure	The document provided includes procedures for transitioning an enrollee out of care if requested by the enrollee. When a provider cannot continue delivering services, Magellan proactively contacts families, offers choice of provider, and sends a notice of provider change. Telehealth options are available if in-person options are limited to ensure continuity of care until an in-person provider becomes available. Additionally, Magellan monitors youth age through routine POC reviews and sends automated notices to providers when a youth approaches the age- out threshold. FCCs proactively engage with older youth and their guardians to prepare for purposeful transition, ensuring connection to community-based services such as therapists, workforce resources, or educational support. The discharge plan of care documents all resource linkages, and families receive a copy outlining services to continue post-wraparound. Providers are trained to conduct follow-up check-ins after discharge, especially for age-out cases, to ensure ongoing support and success. When a member ages out, the family care coordinator participates in a "warm handoff", with signed releases coordinating directly with community stakeholders for each case. The discharge summary includes evidence of resource linkage, and families receive written documentation of ongoing services. Providers also perform post-discharge check-ins to support families after transition. The transition and discharge process is captured in the Discharging a Family from Wraparound Procedure (2024) and Transition of Care for Youth Aging out of HFWA documents, and the discharge plan of care is used to document all resource linkages and follow-up actions.	What steps does Magellan take when a provider is unable to continue serving a member and no other providers are available? How does Magellan transition a member as they age out?	Fully Met
6.2		• Whether the MCP is required to meet identification, assessment, and treatment planning requirements for dually-enrolled beneficiaries.	N/A; Duals are not included		Not applicable	Not applicable				Review Not Required
6.3		• Any Medicaid and CHIP agency LTSS assessment mechanisms requirements, including the requirement to use appropriate providers or individuals meeting the Medicaid and CHIP agency's LTSS service coordination requirements.	The Contract must ensure all evaluations for initial and ongoing program participation are completed by an appropriately qualified mental health professional (QMHP) or otherwise qualified evaluator according to Agency criteria. [SOW pg.17] The Contractor must ensure contracted providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services. The Contractor must review one hundred percent (100%) of provider certification and training qualifications and report this information to the Agency quarterly. [SOW pg.17] The Contract must ensure that all plans of care address enrollee's assessed needs (including health and safety risk factors) and personal goals, either by the provision of services or through other means and that services are sufficient in amount, duration, or scope to reasonably achieve the purposes for which services are furnished. The Contractor must review one hundred percent (100%) of all plans of care submitted and report this information to the Agency quarterly. [SOW pg.18]		Wraparound Provider Manual Final 2025 WY CME Annual Assessment Review Procedure WY CME Clinical Eligibility Policy and Procedure HFWA Enrollment Procedure	pgs. 26-27 of the Wraparound Provider Manual Final 2025	Wraparound Provider Manual Final 2025 WY CME Annual Assessment Review Procedure WY CME Clinical Eligibility Policy and Procedure HFWA Enrollment Procedure Certification and Recertification Policy	All general and appropriate parameters are included in the documents related to the use of appropriate providers. For example, the Wraparound Provider Manual states that an independent assessor (outside the High Fidelity Team) must complete the assessment. Additional documentation in the HFWA Enrollment Procedure states that the clinical eligibility assessment is completed by a QMHP. Magellan also provides a policy for provider certification and recertification policies, including training information. The plan of care has a goal of being evaluated every 90 days to ensure it is sufficient in type, amount, duration, or scope to reasonably achieve the purpose for which services are furnished. The POC should also address the strengths, needs, and goals of a youth and their family.		Fully Met
6.4		• The state's quality assurance and utilization review standards.	Comply with the external quality review (EQR), as required by federal regulations at 42 CFR § 438, subpart E. [SOW Req ID: GR 5-7, pg.22]		Magellan WY CME Quality Annual Program Evaluation WY CME Quality Improvement Program Description WY CME QI Work Plan Annual Quality Improvement Policy	See all pages	WY CME Annual Assessment Review Procedure	Magellan complied with the 2025 EQR.		Fully Met
7.1	**Additional coordination and continuity of care requirements: SHCN** **Medicaid**: 42 CFR 438.208: Coordination and continuity of care **CHIP**: 42 CFR 457.1230(c): Coordination and continuity of care	• Methods used by the Medicaid and CHIP agency to identify to the MCP individuals with special health care needs (SHCNs):	The Contractor must report demographic data …and special needs population (target population) data to the Agency annually. The measurement of any disparities by racial or ethnic groups will be used to monitor timely access and coverage and authorization of care. The disparity analysis provides information regarding the effectiveness of the program. [SOW pg.13]	• Practice guidelines adopted by the MCP (AM) • Provider/Contractor Services policies and procedures manuals (PS) • Provider contracts (PS) • Provider/Contractor procedure manuals (PS) • Enrollee services policies and procedures (ES) • Enrollee Handbooks (ES) • Care coordination policies and procedures, and enrollee records (ES) • Sample of enrollee records (ES)	Magellan WY CME Annual Program Evaluation WY HFWA Fidelity Annual Report SFY 2025	pgs. 10-20 of the Magellan WY CME Annual Program Evaluation pgs. 11-15 of the WY HFWA Fidelity Annual Report SFY 2025	Magellan WY CME Annual Program Evaluation WY HFWA Fidelity Annual Report SFY 2025	Demographic and disparities data measured by racial and ethnic groups is collected through the Fidelity system and Cognos and reported in the Magellan WY Annual Quality Program Evaluation.	Does Magellan collect race or ethnic data in any other systems, reports, or quality monitoring processes outside of this P&P?	Fully Met

Appendix G: Protocol 3 - Compliance Review Tool

7.2		• Whether the MCP is required to implement mechanisms for identifying, assessing, and producing a treatment plan for persons with SHCNs using the state's definition of SHCNs.	The Contractor must include mechanisms to assess the quality and appropriateness of care coordination furnished to enrollees with special health care needs. [SOW pg.19]		Wraparound Provider Manual Final 2025 Magellan WY CME Quality Annual Program Evaluation WY HFWA Fidelity Annual Report SFY 2025	pgs. 45-46, 47(bottom), 49 of the Wraparound Provider Manual Final 2025. pgs. 16, 28-34 of the Magellan WY CME Quality Annual Program Evaluation pgs. 11-15 of the WY HFWA Fidelity Annual Report SFY 2025	HFWA Enrollment Procedure	The Wraparound Provider Manual Final 2025 describes Core Assessments used to track and measure outcomes (community outcomes, family satisfaction, family support, school support, team process, member support) within the established process. It also describes the Wraparound Fidelity Index Survey which parents / caregivers can use to provide feedback on their experience, outcomes, and level of satisfaction. The Magellan WY CME Quality Program Evaluation mentioned additional monitoring mechanisms including intake and case review processes, provider documentation audits, network monitoring activities, advisory group, and external committee feedback. Outcomes shared in the WY HFWA Fidelity Annual Report SFY 2025 were generally better than the national mean. However, 16.8% were reported to have experienced a negative contact with police in SFY 25, which is above the national mean of 16% and up from 14.9% in SFY 24. Also, "Since starting wraparound, my child or youth has been suspended or expelled from school" went up from 11.5 in SFY 24 to 13.8% in SFY 25. Another area for improvement: "Problems that cause stress or strain to me of a family member" at 1.6 (NM 1.39), with 51.8% reporting a good deal or very much.		Fully Met
7.3		• Whether the MCP is required to meet identification, assessment, and treatment planning requirements for dually-enrolled beneficiaries.	N/A; Duals are not included		Not applicable	Not applicable				Review Not Required
7.4		• Any Medicaid and CHIP agency SHCN assessment mechanisms requirements, including the requirement to use appropriate providers or individuals meeting the Medicaid and CHIP agency's LTSS service coordination requirements.	The Contract must ensure all evaluations for initial and ongoing program participation are completed by an appropriately qualified mental health professional (QMHP) or otherwise qualified evaluator according to Agency criteria. [SOW pg.17] The Contractor must ensure contracted providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services. The Contractor must review one hundred percent (100%) of provider certification and training qualifications and report this information to the Agency quarterly. [SOW pg.17] The Contract must ensure that all plans of care address enrollee's assessed needs (including health and safety risk factors) and personal goals, either by the provision of services or through other means and that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which services are furnished. The Contractor must review one hundred percent (100%) of all plans of care submitted and report this information to the Agency quarterly. [SOW pg.18]		Provider Cert Recert Policy NE.03.07.WY HFWA WY CME HFWA Annual Assessment Review Procedure WY CME Clinical Eligibility Policy and Procedure HFWA Enrollment Procedure	pgs. 6-7 of the Provider Cert Recert Policy NE.03.07.WY HFWA	Wraparound Provider Manual Final 2025 WY CME Annual Assessment Review Procedure WY CME Clinical Eligibility Policy and Procedure HFWA Enrollment Procedure Certification and Recertification Policy	All general and appropriate parameters are included in the documents related to assessments and usage of appropriate providers. The Wraparound Provider Manual states that an independent assessor (outside the High Fidelity Team) must complete the assessment. Additional documentation in the HFWA Enrollment Procedure states that the clinical eligibility assessment is completed by a QMHP. Magellan also provides a policy for provider certification and recertification policies, including training information. The plan of care has a goal of being evaluated every 90 days to ensure it is sufficient in type, amount, duration, or scope to reasonably achieve the purpose for which services are furnished. The POC should also address the strengths, needs, and goals of a youth and their family.		Fully Met
7.5		• Whether the Medicaid and CHIP agency requires the MCP to produce a treatment or service plan for enrollees with Special Health Care Needs (SHCN) that are determined through assessment to need a course of treatment or regular care monitoring.	All enrollees must have an FCC and be provided information on how to contact their FCC. A POC must be developed for each enrollee within sixty (60) calendar days after enrollment. [SOW Req ID: EM 9-16, pg.42]		HFWA Enrollment and Disenrollment Policy HFWA Enrollment Procedure Wyoming Provider Handbook Supplement	pgs. 20-21, 23-26 of the Wyoming Provider Handbook Supplement	HFWA Enrollment and Disenrollment Policy HFWA Enrollment Procedure Wyoming Provider Handbook Supplement Family Care Coordinator SOW Member Handbook 2025	Enrollees learn how to contact their FCC directly via the enrollment letter where they are provided the FCC's address and phone number. Enrollees also receive initial education about the FCC role during the application process.	How do enrollees learn how they can contact their FCC directly?	Fully Met
7.6		• The state's quality assurance and utilization review standards.	Comply with the external quality review (EQR), as required by federal regulations at 42 CFR K 438, subpart E. [SOW Req ID: GR 5-7, pg.22]		Magellan WY CME Quality Annual Program Evaluation WY CME QI Work Plan Annual Quality Improvement Policy	See all pages	None	Magellan complied with the 2025 EQR.		Fully Met
8.1	**Disenrollment** **Medicaid**: 42 CFR 438.56: Disenrollment: Requirements and limitations **CHIP**: 42 CFR 457.1212: Disenrollment	Obtain from the Medicaid and CHIP agency information on: • Reasons for which the MCP may request the disenrollment of an enrollee.	The Contractor's health information system shall provide information on areas including, but not limited to: denials of referrals, requests; utilization; claims; enrollee and provider grievances and appeals data; and, disenrollment for reasons other than loss of Medicaid eligibility including disenrollment requests made by an enrollee. Disenrollment for enrollees requested by the Contractor will be reviewed and approved by the State. The following are some of the causes for disenrollment: A.Youth is no longer Medicaid eligible; B.Youth moves out of state; C.Youth ages out of the program; D.Youth is incarcerated; E.Youth is no longer financially eligible; F.Youth is no longer clinically eligible; G.Youth is determined eligible for any excluded program/population as detailed in the Agency's 1915(b) waiver, Section A. Part I E, (Excluded Populations); or H.Youth is in an out of home placement longer than 180 days [SOW pgs.8-9]	• Medicaid and CHIP enrollment and disenrollment policies and procedures (ES)	HFWA Enrollment and Disenrollment Policy Wraparound Provider Manual Final 2025 Disenrollment Letter Template	pgs. 30-31	HFWA Enrollment and Disenrollment Policy Wraparound Provider Manual Final 2025 Disenrollment Letter Template	All general and appropriate parameters are included in the documents related to the Contractor's health information system. Documentation complies with the contract language.		Fully Met
8.2		• Methods by which the MCP assures the Medicaid and CHIP agency that it does not request disenrollment for reasons other than those permitted under the contract.	The Contractor must track disenrollment requests by enrollee and provide a copy to the Agency of each disenrollment letter sent to enrollees so that the Agency may verify that the Contractor did not request disenrollment for reasons other than those permitted under the contract. [SOW pg.9]		HFWA Enrollment and Disenrollment Policy Wraparound Provider Manual Final 2025 Disenrollment Letter Template	pgs. 30-31 of the Wraparound Provider Manual Final 2025	HFWA Enrollment and Disenrollment Policy Wraparound Provider Manual Final 2025 Disenrollment Letter Template	All general and appropriate parameters are included in the documents related to disenrollment requests. Documents provide reasons for disenrollment as well as reasons why Magellan may not request disenrollment. Documents also provide information on the process of notifying members and the State of disenrollment.		Fully Met
8.3		• Whether the state chooses to limit disenrollment.	The Contractor may not request disenrollment because of: A.An adverse change in the enrollee's health status; B.The enrollee's utilization of medical services; C.The enrollee's diminished mental capacity; D.The enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Contractor's ability to furnish services to the enrollee or other enrollees). [SOW pg.9]		HFWA Enrollment and Disenrollment Policy Wraparound Provider Manual Final 2025	pgs. 30-31 of the Wraparound Provider Manual Final 2025	HFWA Enrollment and Disenrollment Policy Wraparound Provider Manual Final 2025	All general and appropriate parameters are included in the documents related to disenrollment. Documentation complies with the contract language providing reasons for disenrollment as well as reasons why Magellan may not request disenrollment.		Fully Met
8.4		• Medicaid and CHIP agency enrollee disenrollment request policies.	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. Causes for disenrollment may include reasons such as a move out of state, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's care needs... The effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee requests disenrollment. [SOW pg. 8]		HFWA Enrollment and Disenrollment Policy Wraparound Provider Manual Final 2025	pgs. 30-31 of the Wraparound Provider Manual Final 2025	HFWA Enrollment and Disenrollment Policy Wraparound Provider Manual Final 2025	All general and appropriate parameters are included in the documents related to disenrollments requested by the enrollee. Documentation complies with the contract language stating a disenrollment request may be made by the enrollee or family at any time for any reason including poor quality of care, lack of access to services under the contract, and lack of access to providers experienced with the enrollee's care needs.		Fully Met
8.5		• Whether the Medicaid and CHIP agency allows the MCP to process enrollee requests for disenrollment.	The Contractor may approve a request for disenrollment by or on behalf of the enrollee.... Disenrollment for enrollees requested by the Contractor will be reviewed and approved by the State. [SOW pg.8]		HFWA Enrollment and Disenrollment Policy Wraparound Provider Manual Final 2025	pgs. 30-31 of the Wraparound Provider Manual Final 2025	Wraparound Provider Manual Final 2025	All general and appropriate parameters are included in the documents related to the Contractor's request for disenrollments. Disenrollment of enrollees at Magellan's request will be reviewed and approved by the State.		Fully Met
8.6		• Whether the Medicaid and CHIP agency requires enrollees to seek redress through the MCP's grievance system before the Medicaid and CHIP agency makes a disenrollment determination on the enrollee's request.	For enrollees that have filed a grievance or appeal, the Contractor must complete the review of the grievance in time to permit the disenrollment to be effective no later than the first day of the second month, following the month in which the enrollee requests disenrollment. [SOW pg.8]		WY CME Grievance Procedure Review Medicaid Adverse Benefit Determination Appeal Policy	See all pages	WY CME Grievance Procedure Review Medicaid Adverse Benefit Determination Appeal Policy	Enrollees who want to file a grievance must file it first through Magellan. Enrollees can only submit an appeal directly to WDH if they do not agree with Magellan's decision. If WDH receives a grievance directly from an enrollee, it would be sent back to Magellan for review. Magellan ensures provision of services during the appeals process. However, services are not continued if an enrollee is disenrolled from the program.	Is this missing information documented somewhere else? How do members learn about this process? Are enrollees required to seek resolution through Magellan's grievance system first before WDH makes a disenrollment decision at their request? How is the provision of services during this process ensured?	Fully Met
9.1	**Coverage and authorization of services** **Medicaid**: 42 CFR 438.210(a-e)*: Coverage and authorization of services, including 42 CFR 440.230 Sufficiency of amount, duration, and scope; 42 CFR Part 441, Subpart B: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21;* and 42 CFR 438.114, Emergency and post-stabilization services CHIP: 42 CFR 457.1228(d): Coverage and authorization of services 42 CFR 457.1228: Emergency and post-stabilization services *Note: 42 CFR 438.210(e)(3), 438.210(b)(2)(iii), 440.230 and 441 Subpart B do not apply to CHIP	• Obtain from the state any amount, duration, and/or scope of service requirements that are greater than those set forth in 42 CFR 440.230 or, for enrollees under the age of 21, as set forth in 42 CFR Part 441, Subpart B.	The Contractor must ensure that all plans of care address enrollee's assessed needs (including health and safety risk factors) and personal goals, either by the provision of services or through other means and that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which services are furnished. [SOW pg.18]	• Provider contracts (PS) • Contracts or written agreements with organizational subcontractors (AM) • Completed evaluations of entities conducted before delegation is granted (AM) • Medicaid and CHIP and other enrollee grievance and appeals data (AM) • Utilization management policies and procedures (UM) • Coverage rules and payment policies (UM) • Data on claims denials (UM) • Service authorization policies and procedures (standard, expedited and extensions) (UM) • Policies and procedures for notifying providers and enrollees of denials of service (UM)	WYCME HFWA Concurrent Review Procedure Member Handbook Wraparound Provider Manual Final 2025	pgs. 40-41 of the Member Handbook pgs. 68-80 of the Wraparound Provider Manual Final 2025	WYCME HFWA Concurrent Review Procedure Member Handbook Wraparound Provider Manual Final 2025 However, the PA process has changed and should be reflected in the documentation.	All general and appropriate parameters are included in the documents related to amount, duration, and scope of services. Documents state that plan of care components are evaluated for adequacy, applicability, and assurance that the plan meets the youth and family needs and goals as identified by the various evaluation/assessments performed and that appropriate safeguards are identified to protect the health, welfare, and safety risk factors of the waiver youth. Service authorization requests are reviewed by the Family Care Coordinator, the Clinical Reviewer, and WY Clinical to ensure documentation reflects the individualized needs of the youth and family and supports the appropriate units requested.		Fully Met

Appendix G: Protocol 3 - Compliance Review Tool

9.2		• Obtain from the state any statutory, regulatory and policy definitions of "medical necessity", as well as any quantitative and non-quantitative treatment limitation limits set forth in those sources.	The Contractor will only conduct prior authorization (PA)/utilization management (UM) of HFWA, respite and Youth and Family Training (YFT) and Support services provided to enrolled youth. The PA/UM process will require the Contractor to implement a service authorization review process which is conducted by Contractor staff with appropriate expertise in addressing the enrollee's needs. 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. **Beginning January 1, 2026 per 438.210 subpart D 2f, following each calendar year it has a contract with a State Medicaid agency, the Contractor must report prior authorization data, excluding data on any and all drugs covered at the plan level by March 31. The Contractor must make the following data from the previous calendar year publicly accessible by posting them on its website:* *(1) A list of all items and services that require prior authorization.* *(2) The percentage of standard prior authorization requests that were approved, aggregated for all items and services.* *(3) The percentage of standard prior authorization requests that were denied, aggregated for all items and services.* *(4) The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.* *(5) The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services.* *(6) The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.* *(7) The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.* *(8) The average and median time that elapsed between the submission of a request and a determination by the Contractor for standard prior authorizations, aggregated for all items and services.* *(9) The average and median time that elapsed between the submission of a request and a decision by the Contractor for expedited prior authorizations, aggregated for all items and services. [SOW Req ID: Ops 8-17, pgs. 41-43]*		WYCME HFWA Concurrent Review Procedure Medicaid Service Authorization Determination Member Handbook 2025 Medicaid Service Authorization Addendum Attachment HFWA Enrollment and Disenrollment Policy WY CME HFWA Clinical Nonauthorization Procedure WY CME HFWA Advanced Notice of Disenrollment Procedure Wraparound Provider Manual Final 2025	pgs. 68-80 of the Wraparound Provider Manual Final 2025	WYCME HFWA Concurrent Review Procedure Medicaid Service Authorization Determination Member Handbook 2025 Medicaid Service Authorization Addendum Attachment HFWA Enrollment and Disenrollment Policy WY CME HFWA Clinical Nonauthorization Procedure WY CME HFWA Advanced Notice of Disenrollment Procedure Wraparound Provider Manual Final 2025 WY CME Clinical Eligibility Policy and Procedure	Many of the general and appropriate parameters are included in the documents related to coverage and authorization of services. The documentation explains several compliant elements of the PA/UM process as well as how Magellan conducts PA/UM for HFWA, respite, YFT, and support services provided to enrolled youth. Magellan explained that while the program uses the term "clinical eligibility" rather than medical necessity, they have updated the Medicaid Service Authorization Addendum to reference "medically necessary services". Upon further review of the Medicaid Service Authorization Addendum and the WY CME Clinical Eligibility Determinations documents, language on eligibility criteria and level of care and targeting criteria is included for this population.	Does Magellan have a new set of policies since implementing the new prior authorization process? The Medicaid Service Authorization Addendum indicates that the criteria for medical necessity are outlined in the WY HFWA Eligibility Criteria document. The addendum is also supposed to include both quantitative and non-quantitative treatment limitations. Can Magellan provide this additional documentation?	Fully Met
9.3		• Obtain from the state Medicaid and CHIP agency the state-established standards for MCP processing of standard authorization decisions.	The Contractor must have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services. The Contractor must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions. [SOW pg.16]		Medicaid Service Authorization Determination WY CME HFWA Concurrent Review Procedure Wraparound Provider Manual Final 2025	pgs. 67-80 of the Wraparound Provider Manual Final 2025	Medicaid Service Authorization Determination WY CME HFWA Concurrent Review Procedure Wraparound Provider Manual Final 2025	All general and appropriate parameters are included in the documents related to authorization of services. For example, documents contain information on policies and procedures for initial and continuing authorizations of services and include review criteria regarding decisions for initial and reauthorization of services. The WY CME HFWA Concurrent Review procedure has information on the review process while youth are receiving services. We also want to note that the PA process has changed and should be reflected in updated documentation.		Fully Met
9.4		• Any Medicaid and CHIP agency drug authorization requirements, including whether the Medicaid and CHIP agency requires approval of outpatient drugs before its dispensing under Section 1927(d)(5)(A) of the Act.	None; Pharmacy is not a covered service.		N/A	N/A				Review Not Required
10.1	**Information requirements for all enrollees** **Medicaid**: 42 CFR 438.10(b)(2)(i) Enrollee right to receive information in accordance with 42 CFR 438.10: **CHIP**: 42 C.F.R 457.1120: Enrollee rights 42 C.F.R 457.1207: Information requirements	• Whether the Medicaid and CHIP agency, enrollment broker, or MCP must provide all required information to enrollees.	The contract requires the contractor to have mechanisms in place to help enrollees and potential enrollees understand the requirements and benefits of their plan, and to provide such information in a manner and format that is easily understood and readily accessible. [SOW pg.9]	• Medicaid and CHIP and other enrollee survey results (AM) • Provider contracts (FS) • Enrollee services policies and procedures (ES) • Statement of enrollee rights (ES) • Enrollee marketing materials • Medicaid and CHIP marketing plans, policies and procedures (ES) • Medicaid and CHIP enrollment and disenrollment policies and procedures (ES) • Enrollee Handbooks (ES) • Enrollee grievance and appeals policies and procedures (ES) • Staff Handbooks (SP) • Staff Orientation and Training Curriculum (SP) • MCP provider directory (ES) • MCP formulary (ES) • MCP website (ES)	Member Referral Letter Member Handbook HFWA Enrollment Procedure Magellan in Wyoming Member Website	pg. 29-32 of the Member Handbook	Member Referral Letter Member Handbook HFWA Enrollment Procedure Magellan in Wyoming Member Website	All general and appropriate parameters are included in the documents related to helping enrollees understand the benefits of their plan. The Member Resources page on Magellan's website includes language accessibility services (e.g., interpretation and translation services) to assist members in accessing information at no cost. The website also includes a link to the Member Handbook which contains information members need to understand the requirements and benefits of the program.		Fully Met
10.2		• Medicaid and CHIP agency developed definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care.	The Contractor must abide with the following CMS standards and requirements for prepaid ambulatory health plans (PAHPs) for Medicaid Managed Care programs based on Title XIX of the Social Security Act, 42 CFR 8438 and other applicable laws as specified below. [SOW pg. 6) Department of Health, Medicaid Administrative Code: Chapter 1 - Definitions (Reference Number: 048.0037.1.1.1072011) and Chapter 47 - Children's Mental Health Waiver (CMHW) and Care Management Entity (CME) Rules (Reference Number: 048.0037.47.09232019).		Wyoming Provider Handbook Supplement WY CME HFWA Advanced Notice of Disenrollment Procedure HFWA Enrollment Procedure Enrollment Letter Template Notice of Action Letter Template Disenrollment Letter Template Clinical Nonauth at Application Letter Template Advanced Notice of Disenrollment Letter Template Administrative Extension Letter Template Member Referral Letter Template Member Notice of Provider Change Letter Template WY CME Medicaid Eligibility Verification Procedure Accessibility of Service and Care Policy WY CME Customer Experience Procedure Section 1557 Reasonable Modification Procedure Medicaid Enrollee Rights and Responsibilities Policy Disenrollment Letter Template WY CME HFWA Advanced Notice of Disenrollment Procedure Medicaid Enrollee Communication and Information Requirements Policy HFWA Enrollment Procedure HFWA Enrollment and Disenrollment Policy Member Handbook 2025	See all pages	Wyoming Provider Handbook Supplement WY CME HFWA Advanced Notice of Disenrollment Procedure HFWA Enrollment Procedure Enrollment Letter Template Notice of Action Letter Template Disenrollment Letter Template Advanced Notice of Disenrollment Letter Template Administrative Extension Letter Template Member Referral Letter Template Member Notice of Provider Change Letter Template WY CME Medicaid Eligibility Verification Procedure Accessibility of Service and Care Policy WY CME Customer Experience Procedure Section 1557 Reasonable Modification Procedure Medicaid Enrollee Rights and Responsibilities Policy Disenrollment Letter Template WY CME HFWA Advanced Notice of Disenrollment Procedure Medicaid Enrollee Communication and Information Requirements Policy HFWA Enrollment Procedure HFWA Enrollment and Disenrollment Policy Member Handbook 2025	All terms relevant to this contract were found in the documentation. The remaining definitions are not specifically applicable to this work.		Fully Met
10.3		• Medicaid and CHIP agency developed model enrollee handbooks and enrollee notices.	Develop a Member Handbook that includes, at minimum, the following information: A.Overview of the program and HFWA services; B.Information to assist in the selection of services and providers; C.Crisis planning information; D.Enrollee rights and confidentiality statements; E.Reference to the enrollee grievances, appeals, and State fair hearings process and information on how an enrollee would file a grievance directly with the State if he or she experiences issues; F.An overview of the phases of HFWA and transition approach; and G.References to additional community resources. [SOW Req ID: EM 9-13, pg.60]		Member Handbook 2025	A. Page 5 B. Pages 10 - 14 C: Page 7 D. Pages 25 - 28 E. Pages - 29 - 32 F. Pages 16 - 21 G. Page 33	Member Handbook 2025 WY CME Handbook Supplement FCC SOW	Documents contain information on what to do in the event of a crisis as well as steps for crisis planning for prevention and intervention. There is a link to the provider's website which has a list of community resources that can help with job training, food banks, and more. Magellan stated that enrollees can receive a copy of these resources by mail, if requested. Enrollees do not file grievances directly with the state. All other items in the contract language are included.	Do enrollees get a separate copy of resources if they can't find their handbook? What actions does WDH take when it receives a grievance directly?	Fully Met
10.4		• The language(s) that the Medicaid and CHIP agency determines are prevalent in the MCP's geographic service area, and all non-English languages that the Medicaid and CHIP identifies.	The website and any other public-facing system or tool must be fully accessible per required Section 508 Standards and contain a link to translation services if necessary. This includes the option for interpreter services for the hearing impaired and for non-English speakers. [SOW Req ID: OPS 9-15, pg.41] Make written information available in the prevalent non-English languages identified by the Agency in its particular service area. "Prevalent" is defined by the Agency as any language spoken by more than four percent (4%) of Wyoming's population. English and Spanish are currently Wyoming's prevalent languages. [SOW Req ID: OPS 8-23, pg.46]		External Website Content Review and Monitoring Process Medicaid: Enrollee Communication and Information Requirements	See all pages	External Website Content Review and Monitoring Process Medicaid: Enrollee Communication and Information Requirements	All general and appropriate parameters are included in the documents related to accessibility requirements. The documents provide all required information to enrollees in a manner and format that is easily understood and readily accessible at the reading level required by state law or contractual obligation. All written information is available in non-English languages and in alternative formats, as well as information regarding access to those formats at no cost to the enrollee. Interpreters are provided for enrollee office visits when non-English speakers or those who are hearing impaired receive authorized services.		Fully Met
10.5		• Policies relevant to written material language and format, for example, policies relevant to inclusion of taglines.	Provide all enrollee notices, informational and outreach materials, and communications in an easily understood format and manner. The Contractor must provide written materials for enrollees in 6th grade reading level, unless agreed to by the Agency. [SOW Req ID: Ops 8-21, pg. 44] The contractor must inform all enrollees and potential enrollees that program information is available in alternative formats and how to access those formats. [SOW Req ID: Ops 8-22, pg.44]		Member Handbook Medicaid: Enrollee Communication and Information Requirements Website	pg. 7	Member Handbook Medicaid: Enrollee Communication and Information Requirements Website	All general and appropriate parameters are included in the documents related to the Contractor's written materials. Documents instruct enrollees to call Magellan or visit the website to receive written information in their preferred language or format. Magellan notifies enrollees that written information is available in alternative formats and provides information on how to access those formats.		Fully Met
10.6		• Any interpretation services that the Medicaid and CHIP agency makes available to enrollees.	The contractor must make interpretation services available free of charge to each enrollee and potential enrollee, including American Sign Language (ASL) if needed. [SOW pg.14] The contractor must notify its enrollees that oral interpretation, written translation, and auxiliary aids and services are available upon request at no cost for enrollees with disabilities, and provide information on how to access those services. [SOW pg.11]		Member Handbook Medicaid: Enrollee Communication and Information Requirements	pg. 7	Member Handbook Medicaid: Enrollee Communication and Information Requirements Website	All general and appropriate parameters are included in the documents related to interpretation services. Interpretation services are available free of charge to each enrollee. This includes oral interpretation and the use of auxiliary aids such as TTY/TDD of 711Relay Services to connect with a relay operator for telecommunication assistance, and American Sign Languages.		Fully Met
10.7		• How the Medicaid and CHIP agency defines "reasonable time" for purposes of providing the enrollee handbook to enrollees.	Provide a copy of the Member Handbook to all new enrollees and their guardians upon enrollment activation in the Contractor's EHR. The EHR processes the enrollment, generates an enrollment letter, and sends the enrollment letter to each new enrollee within two business days of enrollment. [SOW Req ID: EM 9-15, pg.61] The contractor is required to provide each enrollee notice of any significant change in the information specified in the enrollee handbook at least thirty (30) days before the intended effective date of the change. [SOW pg.9]		HFWA Enrollment Procedure	pg. 6	HFWA Enrollment Procedure Medicaid Enrollee Communication and Information Requirements Policy	The documents partially comply with the contract language for this requirement. Documents state that the youth's guardian will fill out their preference on the Intake Consent Form to receive the Enrollee Handbook via mail with a printed copy, via email with an electronic copy, or receive via a link for website access. Once the Care Worker updates the youth's enrollment status to Enrolled, this action triggers an automated enrollment letter, sent to the youth and guardian via regular mail. Another document submitted but not included for review for this requirement includes information on the process for notifying enrollees if there are significant changes to material in the Enrollee Handbook within 30 days.		Fully Met
10.8		• Medicaid and CHIP agency developed or approved language describing grievance, appeal, and fair hearing procedures and timeframes, for inclusion in the enrollee handbook.	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 and were not a subordinate of any such individual, 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. The Contractor must also provide the enrollee or the authorized representative the opportunity to present legal and factual evidence and arguments, and review the case file, including medical records or other documentation and any new or additional evidence considered, relied upon, or generated by the Contractor in connection with the appeal of the adverse benefit determination, free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolution. [SOW Req ID: Ops 8-25, pg.45]		WY CME Grievance Procedure Review Medicaid Adverse Benefit Determination Appeal Policy Member Handbook 2025	pg. 29-32 of the Member Handbook	WY CME Grievance Procedure Review Medicaid Adverse Benefit Determination Appeal Policy Member Handbook 2025	All general and appropriate parameters are included in the documents related to the grievance, appeal, and fair hearing procedures. However, the PA process has changed and should be reflected in the documentation.		Fully Met
10.9		• Medicaid and CHIP agency policy on whether enrollees are required to pay costs for services while an appeal or state fair hear is pending – and the final decision is adverse to the enrollee – for purposes of the enrollee handbook.	The Contractor must provide specific information in the enrollee handbook including but not limited to 42 CFR 438.10(g)(2)(xi) and 42 CFR 438.100(b) that includes:…FSpecifications that, when requested by the enrollee, benefits that the Contractor seeks to reduce or terminate will continue if the enrollee files an appeal or a request for state fair hearing within the timeframes specified for filing, and that the enrollee may, consistent with state rule and policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee… [SOW pg.15]		Member Handbook 2025 Member Referral Letter Template	pgs. 31-32 of the Member Handbook 2025	Member Handbook 2025	The document includes the required information on if enrollees are approved to receive care while under appeal, issued a non-authorization, or the time period or service limits of the previously authorized service have been met. It also states that if the Hearing Officer upholds a non-authorization, the provider would not be paid for services. Magellan clarified that there would be no cost to the enrollee for services rendered during the time that they are navigating the appeals process.	Does Magellan have updated policies and procedures and Member materials since implementing with the new prior authorization process?	Fully Met
10.10		• Any content required by the state for the enrollee handbook that is not covered in 42 CFR 438.10(g).	The Contractor must provide specific information in the enrollee handbook including but not limited to 42 CFR 438.10(g)(2)(xi) and 42 CFR 438.100(b) that includes: A.Information about enrollee's rights and responsibilities (including their right to be treated with respect and in due consideration for his or her dignity and privacy); B.Enrollee's right to file grievances, appeals, State fair hearing, and receive continuation of benefits; C.Treatment options; D.Requirements and timeframes for filing a grievance or appeal; E.Information on the availability of assistance in the filing process for grievances; F.Specifications that, when requested by the enrollee, benefits that the Contactor seeks to reduce or terminate will continue if the enrollee files an appeal or a request for state fair hearing within the timeframes specified for filing, and that the enrollee may, consistent with state rule and policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee; G.Information on the availability of assistance in the filing process for appeals; and, H.Enrollee's right to request a state fair hearing after the Contactor has made a determination on an enrollee's appeal which is adverse to the enrollee. [SOW pg.10]		Member Handbook 2025	A. Pages 26 - 27 B. Pages 29 - 32 C. Pages 10 - 15 D. Pages 29 - 31 E. Page 29 F. N/A G. Page 30 H. Pages 31 - 32	Member Handbook 2025 WYCME Grievance Procedure	All of the components in the SOW language are included in the enrollee handbook. Magellan clarified that there would be no cost to the enrollee for services rendered during the time that they are navigating the appeals process.	How does Magellan share information with enrollees about cost and coverage of services furnished while an appeal or state fair hearing is pending if the final decision is adverse to the enrollee? Does Magellan have updated policies and procedures and Member materials since implementing with the new prior authorization	Fully Met

10.11		• Information on how the state has defined a "significant change" in the information MCPs are required to give enrollees pursuant to 42 CFR 438.10(g).	The Contractor is required to provide each enrollee notice of any significant change in the information specified in the enrollee handbook at least thirty (30) days before the intended effective date of the change. [SOW pg.9]		WY CME HFWA Advanced Notice of Disenrollment Procedure Medicaid Enrollee Communication and Information Requirements Policy	pg. 8, item D for Medicaid Enrollee Communication and Information Requirements Policy	WY CME HFWA Advanced Notice of Disenrollment Procedure Medicaid Enrollee Communication and Information Requirements Policy	All general and appropriate parameters are included in the documents related to notifying enrollees of significant changes to the Enrollee Handbook. Magellan gives each enrollee notice of any changes the State defines as significant at least 30 days prior to the effective date of the change.		Fully Met
10.12		• Any applicable Medicaid and CHIP laws on enrollee rights.	Develop a Member Handbook that includes, at minimum, the following information: ...D. Enrollee rights and confidentiality statements... [SOW Req ID: EM 9-13, pgs. 60-61]		Member Handbook 2025	pg.7	Member Handbook 2025	All general and appropriate parameters are included in the documents related to enrollee rights and confidentiality statements. The Member Handbook contains a section on member rights, responsibilities, and confidentiality.		Fully Met
11.1	**Enrollee right to receive information on available treatment options** **Medicaid**: 42 CFR 438.100(b)(2)(iii) Enrollee right to receive information on available treatment options and alternatives . . . including requirements of 42 CFR 38.102: Provider-enrollee communications **CHIP**: 42 CFR 457.1222: Provider-enrollee communication	Information on whether or not the MCP has documented to the state any moral or religious objection to providing, reimbursing for, or providing coverage of, a counseling or referral service for a particular Medicaid and CHIP service or services.	The Contractor must furnish information about any counseling or referral services it doesn't cover because of an objection on moral or religious grounds to the Agency with its application for this contract whenever it adopts such a policy during the term of this contract. [SOW pg.9]	• Medicaid and CHIP and other enrollee survey results (AM) • Provider contracts (PS) • Medicaid and CHIP enrollee services policies and procedures (ES) • Statement of enrollee rights (ES) • Medicaid and CHIP enrollee marketing materials (ES) • Medicaid and CHIP marketing plans, policies and procedures (ES) • Medicaid and CHIP enrollment and disenrollment policies and procedures (ES) • Medicaid and CHIP Enrollee Handbooks (ES) • Medicaid and CHIP Enrollee Orientation Curriculum (ES) • Medicaid and CHIP Enrollee grievance and appeals policies and procedures (ES) • Staff Handbooks (SP) • Staff Orientation and Training Curriculum (SP)	Member Handbook 2025	pg. 27	Member Handbook 2025 Medicaid: Enrollee Rights and Responsibilities	The Member Handbook says that enrollees will be treated fairly regardless of religion.		Fully Met
12.1	**Enrollee right to participate in decisions regarding his or her care and be free from any form of restraint** **Medicaid**: 42 CFR 438.100(b)(2)(iv) and (v): Enrollee right to: - participate in decisions regarding his or her care, including the right to refuse treatment; - Be free from any form of restraint . . . as specified in other Federal regulations And related: 42 CFR 438.3(j): Advance directives **CHIP**: 42 CFR 457.1220:	• A written description of any state law(s) concerning advance directives. The written description may include information from state statutes on advance directives, regulations that implement the statutory provisions, opinions rendered by state courts and other states administrative directives. [Note to reviewers: Each state Medicaid and CHIP agency is required under Federal regulations at 42 CFR 431.20 to develop such a description of state laws and to distribute it to all MCPs. Revisions to this description as a result of changes in State law are to be sent to MCPs no later than 60 days from the effective date of the change in state law.]	The Contractor is also required to have policies that highlight enrollee's rights consistent with 42 CFR 438.100(a) and (b), including their right to participate in decisions regarding his/her healthcare, refuse treatment... [SOW pg.9]	• Medicaid and CHIP and other enrollee survey results (AM) • Provider contracts (PS) • Medicaid and CHIP enrollee services policies and procedures (ES) • Statement of enrollee rights (ES) • Medicaid and CHIP enrollee marketing materials (ES)	Member Handbook 2025	Pages 26 - 27	Member Handbook 2025	The documentation complies with the requirement.		Fully Met
12.2		• Information on whether or not the MCP has documented to the state any moral or religious objection to fulfilling the regulatory provisions pertaining to advance directives.	The Contractor must furnish information about any counseling or referral services it doesn't cover because of an objection on moral or religious grounds to the Agency with its application for this contract whenever it adopts such a policy during the term of this contract. [SOW pg.9]		N/A	See all pages				Review Not Required
13.1	**Compliance with other Federal and state laws** **Medicaid**: 42 CFR 438.100(d): Compliance with other federal and state laws **CHIP**: 42 CFR 457.1220: Enrollee rights	Obtain from the state Medicaid and CHIP agency the identification of all State laws that pertain to enrollee rights and with which the state Medicaid and CHIP Agency requires its MCPs to comply.	Comply with all applicable federal and State laws that pertain to enrollee rights and ensure that all Network Providers take those rights in to account when furnishing services to enrollees. [Contract Req ID:Ops 8-1, pg.37]	• Medicaid and CHIP and other enrollee survey results (AM) • Provider contracts (PS) • Medicaid and CHIP enrollee services policies and procedures (ES) • Statement of enrollee rights (ES) • Medicaid and CHIP enrollee marketing materials (ES) • Medicaid and CHIP marketing plans, policies and procedures (ES) • Medicaid and CHIP enrollment and disenrollment policies and procedures (ES) • Medicaid and CHIP Enrollee Handbooks (ES) • Medicaid and CHIP Enrollee Orientation Curriculum (ES) • Medicaid and CHIP Enrollee grievance and appeals policies and procedures (ES) • Staff Handbooks (SP) • Staff Orientation and Training Curriculum (SP)	Medicaid: Enrollee Rights and Responsibilities	See all pages	Medicaid: Enrollee Rights and Responsibilities	All general and appropriate parameters are included in documents related to enrollee rights and responsibilities. Documentation states that providers share the Enrollee Rights and Responsibilities Statement with enrollees at their first appointment. It is signed by the enrollee and the provider and providers will give the enrollee the opportunity to ask any questions about their rights or responsibilities. The signed statement may be audited to ensure the provider reviewed this information with the enrollee. Magellan requires that its policies encourage open communication between practitioners and enrollees.		Fully Met
14.1	**Provider Selection** **Medicaid**: 42 CFR 438.214: Provider selection **CHIP**: 42 CFR 457.1233(a): Provider selection	Obtain from the state information on any credentialing, re-credentialing, or other provider selection and retention requirements established by the state that address acute, primary, behavioral, substance use disorder, and LTSS providers, as appropriate.	The Contractor must maintain and monitor a network of appropriate providers that is supported by written agreements and policies and procedures that document the process the Contractor requires for provider credentialing and re-credentialing. The Contractor is prohibited from restricting network providers from acting within the lawful scope of practice and/or advising or advocating on behalf of their enrollees regarding health status, treatment options, medical care, risks and benefits of non-treatment, and enrollee's right to participate in present and future healthcare decisions including the right to refuse treatment. The Agency does not require the Contractor to contract with more providers than necessary to meet the needs of its enrollees and in consideration of the number of enrollees and expected utilization of services, and the number of providers that have met ratio requirements. The Contractor must provide notification to the Agency when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the HFWA program, including the termination of the provider agreement with the Contractor. [SOW pg.11]	• Service planning documents and provider network planning documents (e.g., geographic assessments, enrollee demographic studies, population needs assessments) (AM) • Contracts or written agreements with organizational subcontractors (AM) • Procedures and methodology for oversight, monitoring, and review of delegated activities (AM) • Contracts or written agreements with organizational subcontractors (AM) • Completed evaluations of entities conducted before delegation is granted (AM) • Provider/Contractor files, 15-20 individual health care professional files, and 15-20 institutional provider files (PS) • Credentialing committee or other provider review mechanism meeting minutes (PS) • Sample of files of practitioners who have not been appointed or reappointed (PS)	Provider Cert Recert Policy NE.03.07.WY.HFWA	See all pages	Provider Cert Recert Policy NE.03.07.WY.HFWA Provider Network Monitoring and Capacity	The policy describes the certification and recertification process for the program which includes specific qualifications and training requirements. Providers have non-billable activities that ensure they are not restricted when acting within their lawful scope of practice or advocating for enrollees. Magellan emails WDH on a weekly basis with details on any changes in provider circumstances that may impact eligibility. The data includes changes in provider certification statuses as well. This information is also gathered quarterly. The Provider Network Monitoring and Capacity document states the frequency and process in which this information is gathered.		Fully Met
15.1	**Sub-contractual relationships and delegation** **Medicaid**: 42 CFR 438.230: Subcontractual relationships and delegation **CHIP**: 42 CFR 457.1233(b): Subcontractual relationships and delegation	Obtain from the state the "periodic schedule" established by the State according to which the MCP is to monitor and formally review on an ongoing basis all subcontractors' performance of any delegated activities.	The Contractor will be responsible for coordinating and delivering HFWA services through a network of providers, including targeted case management, respite care, youth and family training and support services. The Contractor will also provide administrative services for the management of the program, including managing the provider network, conducting outreach, determining eligibility and enrolling youth and providers into the program, managing provider corrective action plans, PMPM claims submission, conducting provider training, and facilitating provider and enrollee communications. [SOW, pg. 5] Any and all subcontractor(s) providing services for the operations and support of the CME services shall invoice the Contractor, who will in turn submit all invoices for payment to the Agency's primary point of contact for payment. [SOW, pg. 6]	• Procedures and methodology for oversight, monitoring, and review of delegated activities (AM) • Contracts or written agreements with organizational subcontractors (AM) • Completed evaluations of entities conducted before delegation is granted (AM) • Ongoing evaluations of entities performing delegated activities	N/A	N/A		Magellan confirmed they do not delegate services, as there are no subcontractors within the program.	Explain / confirm the process for providing services without delegating.	Fully Met
16.1	**Practice Guidelines** **Medicaid:** 42 CFR 438.236: Practice guidelines **CHIP**: 42 CFR 457.1233(c): Practice guidelines	Information on any state statutory, regulatory, or policy requirements concerning MCP practice guidelines.	The Contractor is required to use practice guidelines developed using the core values and principles of the HFWA practice. Practice guidelines should be adopted in consultation with contracting health care professionals and must be reviewed and updated periodically, as appropriate. The Contractor must disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply will be consistent with the guidelines. [SOW pg. 11]	• Provider contracts (PS) • Contracts or written agreements with organizational subcontractors (AM) • Practice guidelines (AM) • Provider/Contractor Services policies and procedures manuals (PS) • Medicaid and CHIP enrollee services policies and procedures (ES)	Final Approved Coaches Training Certification and Recertification Policy Wraparound Provider Manual Final 2025 Wyoming Provider Handbook Supplement WY CME Clinical Eligibility Policy and Procedure Coaching Plan FCC	Pgs 34-35, 50, 68-80 of the Wraparound Provider Manual Final 2025 pgs. 6-9,23-26 of the Coaching Plan FCC	Final Approved Coaches Training Certification and Recertification Policy Wraparound Provider Manual Final 2025 Wyoming Provider Handbook Supplement WY CME Clinical Eligibility Policy and Procedure Coaching Plan FCC Member Handbook	Practice guidelines are developed with input from contracting healthcare professionals. Over the past year, Magellan brought in external experts (e.g., a national motivational interviewing trainer) and local professionals to reinforce and align guidelines with best practices. They also maintained collaboration with organizations like the National Wraparound Initiative, Uplift, Wyoming Department of Education, and other community partners. The guidelines are reviewed annually, with input gathered throughout the year from professional collaborations and community partners. While the core coaching criteria remain stable (aligned with National Wraparound Initiative standards), updates are made as needed based on feedback and evolving best practices.	Can Magellan provide the full Coaching Plan FCC document (including pages 23-26) for review? Does Magellan develop the practice guidelines in consultation with contracting healthcare professionals? Can you describe that process? Does Magellan review and update the guidelines periodically as required?	Fully Met
17.1	**Health information systems** **Medicaid**: 42 CFR 438.242 **CHIP**: 42 CFR 457.1233(d):	• Information on whether or not the state has required the MCP to undergo, or has otherwise received, a recent assessment of the MCP's health information system. If the state has required or received such an assessment, obtain a copy of the information system assessment from the state or the MCP. Also obtain contact information about the person or entity that conducted the assessment and to whom follow-up questions may be addressed.	The Contractor's selected data center shall perform SSAE-16/18 Type 2 audits annually (by an independent auditor). Responses to findings, action plans, and remediation plans shall be submitted to the Agency for approval. The Contractor must coordinate responses to initial findings with the Agency that may impact operations. [SOW Req ID: IT 6-30, pg.33] Routinely review an appropriate subset of audit logs of any Contractor systems activity looking for suspicious activity. Conduct audit reviews for suspicious activity no less than quarterly. [SOW Req ID: IT 6-34, pg.33]	• QAPI project descriptions, including data sources and data audit results (AM) • Medicaid and CHIP and other enrollee grievance and appeals data (AM) • Analytic reports of service utilization (UM) • Information systems capability assessment reports (IS) • Policies and procedures for auditing data or descriptions of other mechanisms used to check the accuracy and completeness of data (internally generated and externally generated data) information system • Completed audits of data or other evidence of data monitoring for accuracy and completeness both for MCP data and information system • Provider/Contractor Services policies and procedures manuals (PS) • Provider contracts (PS)	Audit Logging and Monitoring - SC.1437.05 - Policy Access Control - SC.1424.05 - Policy Cloud Security - SC.1431.04 - Policy Cyber Security Risk Management - SC.1441.05 - Policy. Data Protection - SC.1428.04 - Policy Disaster Recovery Strategy_2025 Email Security - SC.1427.04 - Policy Encryption Management - SC.1432.04 - Policy Enterprise Cyber Security Program - SC.1444.04 - Policy External Website Content Review and Monitoring Process - OP.369.07 - Policy Identity and Password Management - SC.1423.07 - Policy Information Technology Backup, Disaster.SFY2025 Recovery and Business Continuity - SC.1429.04 - Policy Network Security - SC.1421.04 - Policy. Physical Security - SC.1419.07 - Policy. Security Assessment and Authorization - SC.1442.05 -Policy. WY CME Magellan Encounter Process Policy and Procedure	See all pages	Audit Logging and Monitoring - SC.1437.05 - Policy Access Control - SC.1424.05 - Policy Cloud Security - SC.1431.04 - Policy Cyber Security Risk Management - SC.1441.05 - Policy. Data Protection - SC.1428.04 - Policy Disaster Recovery Strategy_2025 Email Security - SC.1427.04 - Policy Encryption Management - SC.1432.04 - Policy Enterprise Cyber Security Program - SC.1444.04 - Policy External Website Content Review and Monitoring Process - OP.369.07 - Policy Identity and Password Management - SC.1423.07 - Policy Information Technology Backup, Disaster.SFY2025 Recovery and Business Continuity - SC.1429.04 - Policy Network Security - SC.1421.04 - Policy. Physical Security - SC.1419.07 - Policy. Security Assessment and Authorization - SC.1442.05 -Policy. WY CME Magellan Encounter Process Policy and Procedure	All general and appropriate parameters are included in documents related to independent audits. For example, documents include guidelines on the development and implementation of event logging and continuous monitoring strategy and supports processes to identify and respond to indicators of attack, anomalies, and suspicious or inappropriate activities. Magellan also has a clear policy establishing accountability of users for their actions involving information assets and provide necessary evidence in the event of a security incident or breach.		Fully Met
17.2		• State specifications for data on enrollee and provider characteristics that must be collected by the MCP.	The Contractor's IT solution shall support the services and business needs as outlined in this SOW. The Contractor's IT solution shall maximize operational and provider efficiencies, maintain compliance with State and federal rules and regulations, and support Contract reporting and requirements. Minimum functions include, but are not limited to: A.Correspondence module to support enrollee and provider letters, notifications, and communications; B.Provider documentation and notes application to support Contract documentation needs; C.Reporting function to manage, track, and generate reports on required data sets and waiver performance metrics; D.Support and track outcomes and metrics as detailed in the executed Contract; E.Tracking and managing referrals; F.Manage and report Provider Scorecards; G.Manage and store POCs; H.Manage and store Prior Authorizations (PAs) of POCs; I.Provide for automated program integrity reviews, such as monitoring level of service against the POC and units authorized and cross-checking units against claims, converts to 835, 278, 270, and 271; J.Track and manage compliance with provider contact requirements; K.Track provider compliance and status of training and certification requirements; L.Allow upload of provider training requirements into the system for trainer to review; M.Utilization of services; N.Enrollee grievances and appeals; O.Support the generation of surveys, as detailed in Appendix A, Section 5.1 (A-5.1); P.Allow providers to capture informal and formal supports; Q.Monitor the use and transition from formal to informal supports; R.Provide for critical incident reporting monitoring; and S.Capture of crisis support. [SOW Req ID: IT 6-1, pg.27]		Wyoming Provider Handbook Supplement 2025 Training Letter Tier 1 Trainings WY CME HFWA Advanced Notice of Disenrollment Procedure Enrollment Letter Template HFWA Enrollment Procedure Notice of Action Letter Template Disenrollment Letter Template Clinical Nonauth at Application Letter Template Advanced Notice of Disenrollment Letter Template Administrative Extension Letter Template Member Referral Letter Template Member Notice of Provider Change Letter Template WY CME Medicaid Eligibility Verification Procedure Accessibility of Service and Care Policy WY CME Customer Experience Procedure Section 1557 Reasonable Modification Procedure Medicaid Enrollee Rights and Responsibilities Policy Medicaid Enrollee Communication and Information Requirements Policy WY Provider Scorecard Manual Wraparound Provider Manual Final 2025 Certification and Recertification Policy Information Technology Backup, Disaster Recovery and Business Continuity Policy WY CME Minimum Contact Note Documentation Quality Check WY CME Grievance Procedure Review WY CME HFWA Critical Incident Review Process Member Experience Survey Policy	pgs. 23-26; 34-37,44,46 of the Wyoming Provider Handbook Supplement 2025 Wraparound Provider Manual Final 2025 (pages 68-121)	Wyoming Provider Handbook Supplement 2025 Training Letter Tier 1 Trainings WY CME HFWA Advanced Notice of Disenrollment Procedure Enrollment Letter Template HFWA Enrollment Procedure Notice of Action Letter Template Disenrollment Letter Template Clinical Nonauth at Application Letter Template Advanced Notice of Disenrollment Letter Template Administrative Extension Letter Template Member Referral Letter Template Member Notice of Provider Change Letter Template WY CME Medicaid Eligibility Verification Procedure Accessibility of Service and Care Policy WY CME Customer Experience Procedure Section 1557 Reasonable Modification Procedure Medicaid Enrollee Rights and Responsibilities Policy Medicaid Enrollee Communication and Information Requirements Policy WY Provider Scorecard Manual Wraparound Provider Manual Final 2025 Certification and Recertification Policy Information Technology Backup, Disaster Recovery and Business Continuity Policy WY CME Minimum Contact Note Documentation Quality Check WY CME Grievance Procedure Review WY CME HFWA Critical Incident Review Process Member Experience Survey Policy	All team members involved in the wraparound process and their roles (formal/informal) are tracked via the EHR teams page and the Team Member Demographics Report. The EHR allows labeling of supports as formal or informal, and this can be updated as the wraparound process progresses. Historical transitions are captured in the plan of care submitted for review, while the EHR shows the current status. Program directors and coaches can pull reports (e.g., team member demographics report) to view the makeup of teams and monitor these transitions. Magellan noted the Annual Quality Program Evaluation includes the questions and responses for both provider and member surveys. Upon further review of this document, questions required by the SOW Appendix A including 1) if respondents would recommend the HFWA to others or 2) usability of Contractor-provided systems and recommendations for improvements were included to fully meet this requirement.	Does Magellan have documentation that explains how it monitors and transitions from information to formal supports? Explain the process. Can you please provide copies of the Provider and Member survey questions for review?	Fully Met

Appendix G: Protocol 3 - Compliance Review Tool

17.3		• Information on whether or not the state has conducted a recent review and validation of the MCP's encounter data, or required the MCP to undergo, or has otherwise received, a recent validation of the MCP's encounter data. If the state has required or received such a validation review, obtain a copy of the review from the state or the MCP. Also obtain contact information about the person or entity that conducted the validation and to whom follow-up questions may be addressed.	The Contractor must conduct routine penetration and vulnerability testing of the pertinent Contractor systems containing enrollee ePHI. An executive summary of the annual findings will be submitted to the Agency in the following quarterly report. The report must contain an overview of the test performed by the third-party group and a summary of the findings identified during the test. [SOW Req ID: IT 6-41, pg.33]		Patch and Vulnerability Management Policy Executive Summary SFY2025 Q1 Executive Summary SFY2025 Q2 Executive Summary SFY2025 Q3 Executive Summary SFY2025 Q4 WY CME Magellan Encounter Process Policy and Procedure	See all pages	Patch and Vulnerability Management Policy Executive Summary SFY2025 Q1 Executive Summary SFY2025 Q2 Executive Summary SFY2025 Q3 Executive Summary SFY2025 Q4 WY CME Magellan Encounter Process Policy and Procedure	The documentation complies with the contract language. Technical vulnerability management processes are evaluated on a weekly and quarterly basis to ensure efficacy and efficiency. Last year, Magellan had at least 3 external entities (i.e., AT&T, LevelBlue, and Novacoast) conduct quarterly evaluations. Each entity submitted summaries of findings identified during the test. Internal penetration tasks are conducted annually. Magellan submits a quarterly report with these updates provided to WDH.	Can Magellan please provide the missing quarterly Executive Summary Report? Do the full AT&T, LevelBlue, and Novacoast reports list a contact person that you could reach out to for questions or clarification about the findings?	Fully Met
17.4		• State specifications for how MCPs are to (1) collect data elements necessary to enable the mechanized claims processing retrieval systems to provide for electronic transmission of claims data in the format consistent with the Transformed Medicaid Statistical Information System (T-MSIS); (2) collect and transmit data on enrollee and provider characteristics specified by the state, on all services furnished to enrollees through an encounter data system; and (3) Ensure that data received from providers is accurate and complete.	The Contractor must provide the necessary tools, systems, and infrastructure to support the CME operations and its providers. The Contractor's deployed IT solution(s) shall reflect user experience (UX) design principles to maximize operational and provider efficiencies, maintain compliance with State and federal rules and regulations, and support Contract reporting and requirements, as outlined in the SOW. The Contractor must integrate its IT solution(s) with Agency systems as necessary to streamline the administrative processes for the Agency, the Contractor, and its providers. [SOW pg. 26] The Contractor is required to maintain a health information system that collects, analyzes, integrates and reports data. The Contractor's health information system shall provide information on areas including, but not limited to: denials of referrals, requests; utilization; claims; enrollee and provider grievances and appeals data; and, disenrollment for reasons other than loss of Medicaid eligibility including disenrollment requests made by an enrollee. This data must be included in a quarterly report from the Contractor to the Agency and will be used by the Agency and Contractor to monitor the following: quality of care, enrollment/disenrollment, and coordination/continuity of care, coverage/authorization and grievances. [SOW pgs. 6-7] Provide a Quarterly Report to the Agency that includes, at minimum: A.Clinical and functional outcomes as measured by the clinical eligibility assessment tool, as specified by the Agency and the agreed upon assessment timeframes; B.Statistics on enrolled youth and families served; C.Prior Authorizations; D.Youth and family satisfaction survey results; E.Disenrollment requests from the plan made by enrollees; F.Denials and referral requests, including the number of children and youth referred, and turnaround time for referrals; G.Enrollee grievance and appeals data; H.Trends in coordination and continuity of care to include any enrollee disruption in care, barriers to enrollee care coordination and accessing care, or continued enrollment in the CME program; I.Summary of enrollee grievances received from enrollees and providers; J.Geographic mapping of provider networks by Contractor; K.Demographics of children and youth served, including age, race, ethnicity, gender, school, parental status, and involvement in public child-serving systems; L.Network adequacy assurance submitted by Contractor; M.Compliance with provider initial and recertification requirements; N.Compliance with the sixty (60) calendar day POC development timeframe requirement; O.Trends and resolutions from enrollee and provider calls and emails; P.Number of all QIC and Advisory council meetings; Q.Compliance with waiver metrics, performance indicators and outcomes, as part of the SOW; R.Implementation status of PIPs; S.Utilization and outcomes management, including:		WY CME Magellan Encounter Process Policy and Procedure WY CME Medicaid Eligibility Verification Procedure	See all pages	WY CME Magellan Encounter Process Policy and Procedure WY CME Medicaid Eligibility Verification Procedure	Magellan demonstrated compliance by deploying IT solutions grounded in user experience (UX) design principles to enhance operational and provider efficiencies, ensure adherence to State and federal rules and regulations, and support Contract reporting and requirements, as outlined in the SOW. For example, after gathering provider feedback through a survey, Magellan identified concerns related to claims processing timelines and plans to address those issues. In addition, Magellan utilizes a ticketed case review process to manage and resolve user challenges within the Fidelity system.	Does Magellan have documentation on the UX design principles and how Fidelity HER records are maintained?	Fully Met
17.5		• Specifications for submitting encounter data to the Medicaid and CHIP agency in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format.	Provide a claim and prior authorization solution and submit electronically to the State. The solution shall: A.Validate Magellan PMPM claims prior to submission; B.Magellan PMPM claims will be submitted to the Agency in standardized Accredited Standards Committee (ASC) X12N 837 format, the ASC X12N 835 format, and EDI 270/271 Eligibility Benefit Inquiry and Response formats, as appropriate. The Contractor must provide sufficient Magellan PMPM claims and prior authorization data to identify the provider who delivers any services to individuals. [SOW Req ID: IT 6-9, pgs.29-30]		WY CME Magellan Encounter Process Policy and Procedure WY CME Medicaid Eligibility Verification Procedure	See all pages	WY CME Magellan Encounter Process Policy and Procedure WY CME Medicaid Eligibility Verification Procedure	Magellan is required to submit a compliant HIPAA 837 X12 ostract to the client at contracted intervals for billing the PMPM fee for administrative services. Magellan also has processes set up to receive any of the standard HIPAA compliant response files (999, TA1, 277, and 835). Magellan clarified that eligibility benefits are checked manually through the State's BMS system. The 837 and 835 transactions are used for claim submission and claim payment notification, respectively. This has been the process since the program began. Magellan has read-only access to BMS for eligibility checks, which provides more	Does Magellan submit PMPM claims data in the EDI 270/271 Eligibility Benefit Inquiry and Response formats? If so, where is this	Fully Met
17.6		• Make all collected data available to the state and upon request to CMS.	The Contractor is required to maintain a health information system that collects, analyzes, integrates and reports data. The Contractor's health information system shall provide information on areas including, but not limited to: denials of referrals, requests; utilization; claims; enrollee and provider grievances and appeals data; and, disenrollment for reasons other than loss of Medicaid eligibility including disenrollment requests made by an enrollee. This data must be included in a quarterly report from the Contractor to the Agency and will be used by the Agency and Contractor to monitor the following: quality of care, enrollment/disenrollment, and coordination/continuity of care, coverage/authorization and grievances. [SOW pgs. 6-7]		Wyoming Provider Handbook Supplement 2025 Training Letter Tier 1 Trainings WY CME HFWA Advanced Notice of Disenrollment Procedure Enrollment Letter Template HFWA Enrollment Procedure Notice of Action Letter Template Disenrollment Letter Template Clinical Nonauth at Application Letter Template Advanced Notice of Disenrollment Letter Template Administrative Extension Letter Template Member Referral Letter Template Member Notice of Provider Change Letter Template WY CME Medicaid Eligibility Verification Procedure Accessibility of Service and Care Policy WY CME Customer Experience Procedure Section 1557 Reasonable Modification Procedure Medicaid Enrollee Rights and Responsibilities Policy Medicaid Enrollee Communication and Information Requirements Policy WY Provider Scorecard Manual Wraparound Provider Manual Final 2025 Certification and Recertification Policy Information Technology Backup, Disaster Recovery and Business Continuity Policy WY CME Minimum Contact Note Documentation Quality Check WY CME Grievance Procedure Review WY CME HFWA Critical Incident Review Process	pgs. 23-26, 34-37,44,46 of the Wyoming Provider Handbook Supplement 2025 Wraparound Provider Manual Final 2025 (pages 68-121)	Wyoming Provider Handbook Supplement 2025 Wraparound Provider Manual Final 2025 Training Letter Tier 1 Trainings WY CME HFWA Advanced Notice of Disenrollment Procedure Disenrollment Letter Template Enrollment Letter Template HFWA Enrollment Procedure Notice of Action Letter Template WY Provider Scorecard Manual WY CME Customer Experience Procedure Section 1557 Reasonable Modification Procedure Medicaid Enrollee Rights and Responsibilities Policy Medicaid Enrollee Communication and Information Requirements Policy WY CME Minimum Contact Note Documentation Quality Check Member Experience Survey Policy Provider Experience Survey Policy	The Fidelity EHR system is used to store enrollee records, authorize services, and monitor provider performance. It tracks key operational components, including tasks, referrals, applications, interactions, and assessments. Enrollee behavioral health records are accessible for review and audit, and access is appropriately terminated when individuals are disenrolled. Magellan produces quarterly data reports that include information on disenrollments, service requests, utilization, claims, grievances, and appeals. The Provider Scorecard—posted quarterly on the Magellan of Wyoming website—provides performance data on key provider indicators. In addition, Magellan conducts routine record reviews to monitor quality of care and coordination/continuity of care. Denial notices are provided to enrollees as required. Magellan stated the Fidelity EHR system has the capability to track denials. However, Magellan issues pended and partial approvals. If a youth or family requests copies of their records while enrolled, Magellan requires completion of the Release of Records Form, which is routed through compliance and clinical teams to fulfill the request. The FCC manages the transition process when a youth ages out, coordinating with community stakeholders as authorized by signed releases from the family. A discharge plan of care is completed, summarizing resource linkages and ongoing services, and is provided to the family. Magellan itself does not directly transfer records; the FCC facilitates this at the case level.	Does Magellan have documentation that explains its denial process within the EHR? How are denials recorded in the EHR, and what steps do you take when a youth or family request copies of their records? When youth age out, what process do you follow to transition them to a new provider? How are records transferred as part of that process?	Fully Met
17.7		• The state's procedures and quality assurance protocols to ensure that enrollee encounter data submitted by the MCP is a complete and accurate representation of the services provided to its enrollees.	The Contractor is required to maintain a health information system that collects, analyzes, integrates and reports data. The Contractor's health information system shall provide information on areas including, but not limited to: denials of referrals, requests; utilization; claims; enrollee and provider grievances and appeals data; and, disenrollment for reasons other than loss of Medicaid eligibility including disenrollment requests made by an enrollee. This data must be included in a quarterly report from the Contractor to the Agency and will be used by the Agency and Contractor to monitor the following: quality of care, enrollment/disenrollment, and coordination/continuity of care, coverage/authorization and grievances. 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. 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. The Contract also establishes expectation around continuous quality improvement that includes participating in the development of measures of performance and collecting and reporting baseline data on identified performance indicators, and development and implementation of improvement plans. Measures must be designed with the goal of maintaining quality of services, controlling costs and are consistent with its responsibilities to enrollees. The results are reported to the Agency and the Agency discusses the findings and identifies opportunities for improvements. In addition, this information aids in the assessment of the effectiveness of the quality improvement process. The data from all sources is analyzed for compliance. The identified aspects are integrated into the implementation of continuous quality improvement processes. The findings will be included in the Contractor's performance evaluation. The Agency will require the Contractor to undergo annual, external independent reviews of the quality, timeliness, and access to the services covered under this contractual agreement. [SOW pgs. 6-7]		Patch and Vulnerability Management Policy Executive Summary SFY2025 Q1 Executive Summary SFY2025 Q2 Executive Summary SFY2025 Q3 Executive Summary SFY2025 Q4 WY CME Magellan Encounter Process Policy and Procedure WY CME Provider Record Documentation Review Procedure WY CME Standardized Data Validation Plan for Performance Improvement Projects	See all pages	Patch and Vulnerability Management Policy Executive Summary SFY2025 Q1 Executive Summary SFY2025 Q2 Executive Summary SFY2025 Q3 Executive Summary SFY2025 Q4 WY CME Magellan Encounter Process Policy and Procedure WY CME Provider Record Documentation Review Procedure WY CME Standardized Data Validation Plan for Performance Improvement Projects WY CME Committee Data File	All general and appropriate parameters are included in the documents related to the Contractor's health information system. Documents outline requirements for detecting, analyzing, and remediating vulnerabilities in Magellan's information assets, including quarterly security audits and provider documentation reviews to ensure SOW compliance. Documents detail processes for data validation, quality control, and encounter data submission. Magellan submits quarterly reports providing data on monitoring quality of care, enrollment/disenrollment, coordination of care, or comprehensive performance measures as required by the agency. Magellan explained that the provider documentation review evaluates several data points, including: • Meeting frequency; • Involvement and invitation of applicable team members and natural supports; • Evidence of care coordination with various team members and resources; • Completion and use of required assessments; • Inclusion of primary care provider and regular contact with the family; and • Frequency of family meetings. These items are checked during the documentation audit.	Request missing Executive Summary quarterly report for Magellan. What data is reviewed in the evaluation of quality of services during provider record documentation review?	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) calendar days of the start of the training for ninety-	Family Care Coordinators, Family and Youth Peer Support and Advocacy, and Respite providers.	Medicaid	Statewide	Committee Data File - Quarterly

five percent (95%) of network 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 as adequate based on their caseloads.	According to the Network Development Report, "This network is closely monitored to meet the needs of the enrolled population through strategic oversight, regular reporting, and collaborative efforts." Magellan conducts monthly monitoring of provider levels, which is included in a quarterly reports to the State. They also compile weekly provider lists to the Reporting Team that "compare provider capacity with the number of enrolled youth".
(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.	7 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 (including the Reservation) Region 6 – Carbon, Sweetwater, and Uinta Counties Region 7 – Lincoln, Sublette, and Teton Counties
(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 no 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 no 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 no 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.	N/A	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	WY CME Committee Data File SFY 2025.Final	Excel file	Numerator: "All providers shall complete and successful pass the certification process prior to providing any CME service." Denominator: "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."	State requires Magellan to deliver the Committee Data file quarterly and annually.	Magellan also provides WDH weekly updates on providers enrolled, training status, and disenrollments.

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.	N/A	N/A	N/A	N/A	There is no reportable information to validate this indicator.
7 regions with associated counties	Network Development Plan SFY 2025	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 and there is no way to evaluate partial caseloads between counties.
List of members and their assigned provider(s) (FCC completed Tier 1 trainings)	List	PDF	List of members and the names of their Family Care Coordinator Name	Reported weekly to WDH from Magellan	There is no indicator on the weekly case reports that indicate completed training levels per provider.
List of members and their assigned provider(s) (FCC completed Tier 2 trainings)	List	PDF	List of members and the names of their Family Care Coordinator Name	Reported weekly to WDH from Magellan	There is no indicator on the weekly case reports that indicate completed training levels per provider.
List of members and their assigned provider(s) (YSP, FSP)	List	PDF	List of members and the names of Youth and Family Support Partner’s provider names	Reported weekly to WDH from Magellan	There is no indicator on the weekly case reports that indicate completed training levels per provider.

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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								The EQRO evaluated the ISCA but the providers are enrolled through the WDH provider system. Because of the system for the CME program, the EQRO could not evaluate provider data system.

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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	WY CME Committee Data File SFY 2025
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 - Bachelor of Science in Business Management, 16 years' experience in data and analytics • Clinical Analyst - Bachelor of Science in Information Management, 15 years' experience as a data analyst • Quality Director - Master of Arts in Clinical Psychology, Licensed Clinical Social Worker, Lean Six Sigma Green Belt certification: 20 years' experience in Quality processes
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?	None
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 and the data or regular reports that demonstrate adequacy that could be validated.
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	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 - Bachelor of Science in Business Management, 16 years' experience in data and analytics • Clinical Analyst - Bachelor of Science in Information Management, 15 years' experience as a data analyst • Quality Director - Master of Arts in Clinical Psychology, Licensed Clinical Social Worker, Lean Six Sigma Green Belt certification: 20 years' experience in Quality processes
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. There is also no indicator for acuity of youth served or what percentage are served through telehealth impacting caseloads.
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. There is also no indicator for acuity of youth served or what percentage are served through telehealth impacting caseloads.
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. Provide average acuity of caseloads and percentage of caseload served through telehealth or alternative modes of care.

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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		The reports are manually created and the EQRO was not provided access to the source system so the reports could not be validated. 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		No quantitative data was provided or collected consistently or regularly to allow for validation 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	There were no changes in systems, but since there were 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	Neither encounter nor utilization data were 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 was 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 completed.
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 completed.
Assessment of MCP Network Adequacy Methods				
Are the methods selected by the MCP to calculate this indicator appropriate for the state		X		The MCP reported indicators based on the SOW and Contract developed by the State. The State and the program are small enough that manual reviews are possible and more efficient for report, even if they do not provide a method for validation.
Are the methods selected by the MCP to calculate this indicator appropriate to the state Medicaid and CHIP population(s)?		X		The MCP reported indicators based on the SOW and Contract developed by the State. The State and the program are small enough that manual reviews are possible and more efficient for report, even if they do not provide a method for validation.

Question	Yes	No	Not Applicable	Comments
Are the methods selected by the MCP adequate to generate the data needed to calculate this indicator?		X		Magellan did not provide a quantitative measure for the data to demonstrate compliance, it 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			Although the MCP reports by provider types, there is not an indicator to evaluate the compliance to caseload standards required by training levels completed.
If applicable, does the MCP's approach for addressing telehealth match the state's expectations?	X			Although the approach is acceptable for the State's expectations, there is no way to validate or track the use of telehealth use in each provider's caseloads.
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	Sampling was not used in the reporting methodology.
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	Sampling was not used in the reporting methodology.
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	Sampling was not used in the reporting methodology.
In calculating this indicator, were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field.			X	Sampling was not used in the reporting methodology.
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 does not take into consideration 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 does not take into consideration distance or time.

Question	Yes	No	Not Applicable	Comments
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. There is no way to evaluate the compliance to caseload standards required by training levels completed.
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 take into consideration time.
Are the methods used to calculate this indicator rigorous and objective?		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.
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 and thus could not be validated or replicated.
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 quantitative measurements provided to WDH to demonstrate compliance that could be validated.
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 quantitative measurements provided to WDH to demonstrate compliance that could be validated.
In calculating this indicator, did the MCP produce reliable results—that is, were the MCP's results reproducible and consistent?		X		There are no quantitative measurements provided to WDH to demonstrate compliance that could be validated.
In calculating this indicator, did the MCP accurately interpret its results?		X		There are no quantitative measurements provided to WDH to demonstrate compliance that could be validated.
Comments				
Please note any recommendations for improving the data collection procedures to calculate this indicator.				The indicator should be updated so that it would require quantitative data that could be replicated and validated to demonstrate compliance.
Please note any recommendations for improving the sampling methods to calculate this indicator.				Sampling was not used.
Please note any recommendations for improving the analysis to calculate this indicator.				The indicator should be updated so that it would require quantitative data that could be replicated and validated to demonstrate compliance.

Question	Yes	No	Not Applicable	Comments
Please note any recommendations for improving the results to calculate this indicator.				The indicator should be updated so that it would require quantitative data that could be replicated and validated to demonstrate compliance.

Calculate validation score:

A. Total number of "Yes" responses	**2**
B. Total number of "No" responses	**15**
Score = A / (A + B) x 100	**11.76%**

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: Although the indicator was acceptable to the State's requirements in the SOW and Contract, it was collected via manual reviews and reported to WDH, but it could not be replicated or validated by the EQRO. The indicator should be updated so that it would require quantitative data that could be replicated and validated to demonstrate compliance.

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: 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				

Question	Yes	No	Not Applicable	Comments
Were all data sources (and year[s] of data) needed to calculate this indicator submitted by the MCP to the EQRO?		X		Magellan provided the Committee Data File with the reported information submitted to WDH, but the source data was not provided, thus data validation could not be completed by the EQRO.
For each data source, were all variables needed to calculate this indicator included?		X		Magellan provided the Committee Data File with the reported information submitted to WDH, but the source data was not provided, thus data validation could not be completed by the EQRO.
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			As this is reported quarterly to WDH and reviewed by WDH, it must be assumed the process is consistent over time, but as no source data was provided, compliance could not be validated.
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.

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 MCP reported indicators based on the SOW and Contract developed by the State. With the size of the program and the indicator, the method of reporting regularly to WDH was efficient, even if it did not provide a method for validation.
Are the methods selected by the MCP to calculate this indicator appropriate to the state Medicaid and CHIP population(s)?		X		Magellan did not provide a quantitative measure for the data to demonstrate compliance that could be validated. The measure was reported quarterly to WDH through the Committee Data File.
Are the methods selected by the MCP adequate to generate the data needed to calculate this indicator?		X		Magellan did not provide a quantitative measure for the data to demonstrate compliance that could be validated. The measure was reported quarterly to WDH through the Committee Data File. 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.

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		Magellan did not provide a quantitative measure for the data to demonstrate compliance that could be validated. The measure was reported quarterly to WDH through the Committee Data File.
Are the methods used to calculate this indicator unlikely to be subject to manipulation? If “no,” please describe in the “comments” field.		X		Magellan did not provide a quantitative measure for the data to demonstrate compliance that could be validated. The measure was reported quarterly to WDH through the Committee Data File.
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 quarterly totals appear to be reasonable, but the annual total seems incorrect as the network doesn’t have that many providers. Since the source data was not provided, the results can’t be validated.

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		The quarterly totals appear to be reasonable, but the annual total seems incorrect as the network doesn't have that many providers. Since the source data was not provided, the results can't be validated.
In calculating this indicator, did the MCP produce reliable results—that is, were the MCP's results reproducible and consistent?		X		The quarterly totals appear to be reasonable, but the annual total seems incorrect as the network doesn't have that many providers. Since the source data was not provided, the results can't be validated.
In calculating this indicator, did the MCP accurately interpret its results?		X		The quarterly totals appear to bereasonable, but the annual total seems incorrect as the network doesn't have that many providers. Since the source data was not provided, the results can't be validated.
Comments				
Please note any recommendations for improving the data collection procedures to calculate this indicator.				The indicator should be updated so that it would require quantitative data that could be replicated and validated to demonstrate compliance.
Please note any recommendations for improving the sampling methods to calculate this indicator.				Sampling was not used.
Please note any recommendations for improving the analysis to calculate this indicator.				The indicator should be updated so that it would require quantitative data that could be replicated and validated to demonstrate compliance. Source data and how exactly the numerator and denominator are calculated should be provided.
Please note any recommendations for improving the results to calculate this indicator.				The quarterly totals appear to be reasonable, but the annual total seems incorrect as the network doesn't have that many providers. Since the source data was not provided, the results can't be validated. The indicator should be updated so that it would require quantitative data that could be replicated and validated to demonstrate compliance.

Calculate validation score:

A. Total number of "Yes" responses	**3**
B. Total number of "No" responses	**11**
Score = A / (A + B) x 100	**27.3%**

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. There was no documentation to validate the calculations and no source data provided to validate the indicator.
For each data source, were all variables needed to calculate this indicator included?		X		There was no documentation to validate the calculations and no source data provided to validate the 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.

Question	Yes	No	Not Applicable	Comments
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 regularly to inform proof of compliance. There was no documentation to validate the calculations and no source data provided to validate the indicator.
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 were 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				

Question	Yes	No	Not Applicable	Comments
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 MCP reported indicators based on the SOW and Contract developed by the State. The state is also small enough that manual reviews are possible and appropriate, even if not sufficiently rigorous and could not be validated. It would be recommended that results be independently validated.
Are the methods selected by the MCP to calculate this indicator appropriate to the state Medicaid and CHIP population(s)?	X			WDH does not have concerns with the indicator as presented. The MCP reported indicators based on the SOW and Contract developed by the State. The state is also small enough that manual reviews are possible and appropriate, even if not sufficiently rigorous and could not be validated.
Are the methods selected by the MCP adequate to generate the data needed to calculate this indicator?		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.
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 provider directory does distinguish by provider type.
If applicable, does the MCP's approach for addressing telehealth match the state's expectations?		X		Provider use of telehealth was not included in the reporting of the indicator nor is it reported in the directory.
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.

Question	Yes	No	Not Applicable	Comments
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		Magellan reported that their method of confirming compliance relied on periodic manual reviews. There was no documentation to validate the calculations and no source data provided to validate the indicator.
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.

Question	Yes	No	Not Applicable	Comments
Comments				
Please note any recommendations for improving the data collection procedures to calculate this indicator.				The indicator should be updated so that it requires quantitative data that could be replicated and validated to demonstrate compliance.
Please note any recommendations for improving the sampling methods to calculate this indicator.				Sampling was not used.
Please note any recommendations for improving the analysis to calculate this indicator.				The MCP reported indicators based on the SOW and Contract developed by the State. The state is also small enough that manual reviews are possible and appropriate, even if not sufficiently rigorous and could not be validated. It would be recommended that results be independently validated.
Please note any recommendations for improving the results to calculate this indicator.				The indicator should be updated so that it would require quantitative data that could be replicated and validated to demonstrate compliance. The results should also be independently validated.

Calculate validation score:

A. Total number of "Yes" responses	**3**
B. Total number of "No" responses	**14**
Score = A / (A + B) x 100	**21.4%**

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: The quarterly totals appear to reasonable but the annual total seems incorrect as the network doesn't have that many providers. Since the source data was not provided, the results can't be validated. The indicator should be updated so that it would require quantitative data that could be replicated and validated to demonstrate compliance.	

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: 7 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			Magellan provided the Regions and the respective counties in each region. Although the indicator meets the State requirement in the SOW, it is not a quantitative indicator that evaluates the strength of the provider network.
For each data source, were all variables needed to calculate this indicator included?		X		Magellan provided the Regions and the respective counties in each region. Although the indicator meets the State requirement in the SOW, it is not a quantitative indicator that evaluates the strength of the provider network. The full list of all providers: in-process, enrolled, or disenrolled was not provided so counts could not be validated.
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 2025 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 2025 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 region.

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 2025 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 region.
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 were 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			The MCP reported indicators based on the SOW and Contract developed by the State. With the size of the program and the indicator, the method of reporting regularly to WDH was efficient, even if it did not provide a method for validation.

Question	Yes	No	Not Applicable	Comments
Are the methods selected by the MCP to calculate this indicator appropriate to the state Medicaid and CHIP population(s)?	X			Magellan provided the Regions and the respective counties in each region. Although the indicator meets the State requirement in the SOW, it is not a quantitative indicator that evaluates the strength of the provider network.
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 geomaps values do not consider if a 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.
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		Magellan provided the Regions and the respective counties in each region. They also provided geomaps that identified providers in counties registered. Although the indicator meets the State requirement in the SOW, it is not a quantitative indicator that evaluates the strength of the provider network.
Are the methods used to calculate this indicator unlikely to be subject to manipulation? If "no," please describe in the "comments" field.		X		The geomaps values do not consider if a provider delivers telehealth services in several regions when considering regional access to services. As such, providers are counted multiple times in several regions.
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 did not align across the data sources provided (i.e., Geomaps, SFY 2025 Network Development Plan). The Geomaps also did not account for providers that deliver services in several regions when denoting the number of providers active in each region.
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 did not align across the data sources provided (i.e., Geomaps, SFY 2025 Network Development Plan). The Geomaps also did not account for providers that deliver services in several regions when denoting the number of providers active in each region.

Question	Yes	No	Not Applicable	Comments
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 did not align across the data sources provided (i.e., Geomaps, SFY 2025 Network Development Plan). The Geomaps also did not account for providers that deliver services in several regions when denoting the number of providers active in each region.
In calculating this indicator, did the MCP accurately interpret its results?		X		Magellan's number of providers did not align across the data sources provided (i.e., Geomaps, SFY 2025 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 region.
Comments				
Please note any recommendations for improving the data collection procedures to calculate this indicator.				The indicator should be updated so that it requires quantitative data that could be replicated and validated to demonstrate compliance.
Please note any recommendations for improving the sampling methods to calculate this indicator.				Sampling was not used.
Please note any recommendations for improving the analysis to calculate this indicator.				The indicator should be updated so that it requires quantitative data that could be replicated and validated to demonstrate compliance.
Please note any recommendations for improving the results to calculate this indicator.				Magellan provided the Regions and the respective counties in each region. They also provided geomaps that identified providers in counties registered. Although the indicator meets the State requirement in the SOW, it is not a quantitative indicator that evaluates the strength of the provider network.

Calculate validation score:

A. Total number of "Yes" responses	**4**
B. Total number of "No" responses	**13**
Score = A / (A + B) x 100	**30.8%**

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: 7 regions with associated counties
Validation rating: ☐ High confidence ☐ Moderate confidence ✓ Low confidence ☐ No confidence
Comments: Magellan provided the Regions and the respective counties in each region. They also provided geomaps that identified providers in counties registered. Magellan's number of providers does not align across the data sources provided (i.e., Geomaps, SFY 2025 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. Although the indicator meets the State requirement in the SOW, it is not a quantitative indicator that evaluates the strength of the provider network.

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 aligned with several agencies while provided the same provider is listed with multiple agencies. There is also no way to validate case load requirements or ability to evaluate average acuity of provider levels. There is also no identification as to provider type.
For each data source, were all variables needed to calculate this indicator included?		X		Numbers for provider caseloads were not provided and aligned with several agencies while provided the same provider is listed with multiple agencies. There is also no way to validate case load requirements or ability to evaluate average acuity of provider levels. There is also no identification as to provider type.

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		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		Numbers for provider caseloads were not provided and aligned with several agencies while provided the same provider is listed with multiple agencies. There is also no way to validate case load requirements or ability to evaluate average acuity of provider levels. There is also no identification as to provider type.
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		There was no discussion or documents submitted that discussed the methodology to create the caseload reports.
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.
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.

Question	Yes	No	Not Applicable	Comments
Assessment of MCP Network Adequacy Methods				
Are the methods selected by the MCP to calculate this indicator appropriate for the state		X		Although the indicator is accepted by WDH and identified in the SOW and Contract, it is not quantitative data that can be validated.
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		Numbers for provider caseloads were not provided and aligned with several agencies while provided the same provider is listed with multiple agencies. There is also no way to validate case load requirements or ability to evaluate average acuity of provider levels. There is also no identification as to provider type.
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			The caseload report does not provide any indicator that provider provides services via telehealth or other alternative model. As there was no documentation on methodology or source data that allowed the EQRO to validate the indicator.
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.

Question	Yes	No	Not Applicable	Comments
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		Numbers for provider caseloads were not provided and aligned with several agencies while provided the same provider is listed with multiple agencies. There is also no way to validate case load requirements or ability to evaluate average acuity of provider levels. There is also no identification as to provider type.
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		As there was no documentation on methodology or source data that allowed the EQRO to validate the indicator.
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				

Question	Yes	No	Not Applicable	Comments
In calculating this indicator, did the MCP produce valid results—that is, did the MCP measure what they intended to measure?		X		Numbers for provider caseloads were not provided and aligned with several agencies while provided the same provider is listed with multiple agencies. There is also no way to validate case load requirements or ability to evaluate average acuity of provider levels. There is also no identification as to provider type.
In calculating this indicator, did the MCP produce accurate results—that is, did the MCP's calculated values reflect the true values?		X		Numbers for provider caseloads were not provided and aligned with several agencies while provided the same provider is listed with multiple agencies. There is also no way to validate case load requirements or ability to evaluate average acuity of provider levels. There is also no identification as to provider type.
In calculating this indicator, did the MCP produce reliable results—that is, were the MCP's results reproducible and consistent?		X		Numbers for provider caseloads were not provided and aligned with several agencies while provided the same provider is listed with multiple agencies. There is also no way to validate case load requirements or ability to evaluate average acuity of provider levels. There is also no identification as to provider type.
In calculating this indicator, did the MCP accurately interpret its results?		X		Numbers for provider caseloads were not provided and aligned with several agencies while provided the same provider is listed with multiple agencies. There is also no way to validate case load requirements or ability to evaluate average acuity of provider levels. There is also no identification as to provider type.
Comments				
Please note any recommendations for improving the data collection procedures to calculate this indicator.				Numbers for provider caseloads were not provided and aligned with several agencies while provided the same provider is listed with multiple agencies. There is also no way to validate case load requirements or ability to evaluate average acuity of provider levels. There is also no identification as to provider type.
Please note any recommendations for improving the sampling methods to calculate this indicator.				Sampling was not used.
Please note any recommendations for improving the analysis to calculate this indicator.				As there was no documentation on methodology or source data that allowed the EQRO to validate the indicator.

Question	Yes	No	Not Applicable	Comments
Please note any recommendations for improving the results to calculate this indicator.				The indicator should be updated so that it would require quantitative data that could be replicated and validated to demonstrate compliance.

Calculate validation score:

A. Total number of "Yes" responses	**1**
B. Total number of "No" responses	**17**
Score = A / (A + B) x 100	**5.9%**

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: The indicator should be updated so that it would require quantitative data that could be replicated and validated to demonstrate compliance. Numbers for provider caseloads were not provided and aligned with several agencies while provided the same provider is listed with multiple agencies. There is also no way to validate case load requirements or ability to evaluate average acuity of provider levels. There is also no identification as to provider type.

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	The indicator should be updated so that it would require quantitative data that could be replicated and validated to demonstrate compliance.
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	The quarterly totals appear to reasonable, but the annual total seems incorrect as the network doesn't have that many providers. Since the source data was not provided, the results can't be validated. The indicator should be updated so that it would require quantitative data that could be replicated and validated to demonstrate compliance.
Manual review of "assigned hours" as they align with the working hours indicated in providers'	✓ Addressed ☐ Missing	☐ High confidence ☐ Moderate confidence ✓ Low confidence ☐ No confidence ☐ Could not be validated	The indicator should be updated so that it would require quantitative data that could be replicated and validated to demonstrate compliance.

Network adequacy indicator	Did the MCP address this indicator in its network adequacy monitoring activities?	Validation rating	Comments
Medicaid applications			The results should also be independently validated.
7 regions with associated counties and providers per region	✓ Addressed ☐ Missing	☐ High confidence ☐ Moderate confidence ✓ Low confidence ☐ No confidence ☐ Could not be validated	Magellan provided the Regions and the respective counties in each region. They also provided geomaps that identified providers in counties registered. Magellan's number of providers does not align across the data sources provided (i.e., Geomaps, SFY 2025 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 region. Although the indicator meets the State requirement in the SOW, it is not a quantitative indicator that evaluates the strength of the provider network.
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	The indicator should be updated so that it would require quantitative data that could be replicated and validated to demonstrate compliance. Numbers for provider caseloads were not provided and aligned with several agencies while provided the same provider is listed with multiple agencies. There is also no way to validate case load requirements or ability to evaluate average acuity of provider levels. There is also no identification as to provider type.

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 4.8. 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): 2024

EQRO Prior Recommendations (if applicable):

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.

Summary of MCP Response to Prior Recommendations (if applicable): N/A; The SOW was not updated regarding Network Adequacy indicators.

EQRO Assessment of Degree to which MCP Effectively Addressed the Recommendations (if applicable):

There wasn't much progress made or at that we could identify through the documents that were provided. The EQRO is aware that during SFY2025 the MCP and the State worked on a new list of indicators and standards for the evaluation of network adequacy, but they will not be implemented until the next evaluation year, SFY2026.

Current Recommendation Year: 2025

EQRO Current Recommendations for MCP Assessment of Network Adequacy:

- There wasn't much progress made or at that we could identify through the documents that were provided. The EQRO is aware that during SFY2025 the MCP and the State worked on a new list of indicators and standards for the evaluation of network adequacy, but they will not be implemented until the next evaluation year, SFY2026.
- In the meantime, we recommend the following items be added or revised:
    - Caseload Report:
        - Clear reporting of current caseloads for providers.
        - Clear identification of what provider agency the provider is aligned to.
        - Whether a provider provides services through telehealth or other alternative delivery mode and how that impacts their caseload.
        - The average acuity of a provider's caseload so that appropriate quality of care can be maintained.
        - Listing of providers identify provider type and if appropriate training level accomplished.
    - Provider Reporting:

	▪ If a provider enrolls to serve youth in multiple counties, utilize a methodology that appropriately distributes a provider's access in the evaluation of the total provider network availability. ▪ Whether a provider provides services through telehealth or other alternative delivery mode and how that impacts their caseload.

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Appendix I: Quality Strategy Findings

Wyoming Department of Health Care Management Entity (WDH CME)

External Quality Review (EQR) Quality Strategy Data Request and Review Tool

Process:
As part of the SFY 2025 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. 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 2026.

		WDH to Complete			Guidehouse to Complete		
#	Document Description	File Names	Page Number	Notes	Documents Reviewed	Insights	Questions Asked During On-Site
1	Annual work plans (if available).	Network Development Plan		Magellan should also be submitting	Network Development Plan - Approved.docx	Network Development Plan supports the following Quality Strategy goals: Goal 1: Reduce rate of admissions to inpatient psychiatric treatment facilities/ Goal 2: Reduce frequency of admissions to inpatient psychiatric treatment facilities/ Goal 5: Improve Child and Family Integration into Home and Community Life/ Goal 6: Assist enrolled youth in cultivating family partnerships and natural supports.	
2	Information on recent significant program changes (if any). Examples: • Any procedural, policy-based, or contractual changes to the Wyoming CME program.					Refer to Protocol 1, for details on PIP termination.	
3	Stakeholder feedback on the state's current quality strategy. Examples: • Any emailed or mailed feedback from a Wyoming CME stakeholder. • Grievances related to the Quality Strategy.				EQR Report 2024	In their feedback on the SFY 2024 EQR report, CMS noted that while the state posted public and tribal notices for the 30-day comment period on the 2024 EQR Quality Strategy, they did not clarify whether feedback was sought from the Medical Care Advisory Committee (MCAC). WDH responded that no public comments were received, though the strategy was posted on the state website and could be shared with the Wyoming Medicaid Advisory Group (MAG). During the virtual onsite, WDH explained that since the MAG has not been active due to staffing and leadership transitions at the State, they have not received feedback on the Quality Strategy from the group. Once the new medical/clinical director is in place and the MAG is reactivated, they will seek feedback.	Has the state received any public comment on the Quality Strategy following CMS feedback on the 2024 EQR?
4	State demographic data and trend reports, including information on trends related to health disparities and social determinants of health.	HealthStat		SDOH aren't tracked in WY	SFY 2025 CME HealthStat Forms.pptx	WDH noted in the 10/28/25 weekly call that they do not address health disparities for these youth and will likely not report on this unless required by CMS. During the virtual onsite, Magellan explained that AI/AN demographics can also be pulled directly from their system when members self-identify. AI/AN network adequacy requirement are also maintained. Access to services is ensured through standard processes: youth and families select a provider from the available provider list, and service receipt is reflected through authorization and minimum contact requirements. Magellan confirmed that AI/AN considerations are incorporated into their standard evaluation processes rather than through a separate or specialized review.	

					WY CME PP SFY 2025 Year-end Review Final.pptx	The WY CME PP SFY 2025 Year end Review is thorough and supports the following Quality Strategy goals: Goal 5: Improve Child and Family Integration into Home and Community Life/ Goal 6: Improve Child and Family Integration into Home and Community Life. The High Fidelity Wraparound (HFWA) model emphasizes family-centered care, natural supports, and integration into home/school/community. - The presentation highlights growth in provider network and census. - Youth outcomes (slide 19) show Wyoming youth had lower rates of new placements in institutions compared to national mean. - CANS data shows improvement in behavioral/emotional needs. - Members found that the basic foundations of wraparound are present and to a high degree (92%-100%). 98% of youth of agree or strongly agree with "I am satisfied with the wraparound process in which my family and I have participated." - 98% of caregivers of agree or strongly agree with "I am satisfied with the wraparound process in which my family and I have participated." - Satisfaction surveys (slides 17–18) show high caregiver and youth satisfaction with wraparound services, including progress toward family goals. - The enrollee satisfaction rate increased from 72.72% in 2024 to 92.85% in 2025.	
5	Information system descriptions of how the state captures enrollee demographic information.				Network Development Plan 2025 2025 Collaborative Connections Conference Report	The Wyoming High Fidelity Wraparound collects member demographic data, including but not limited to ethnicity, race, and gender. This demographic data can be used to analyze disparities in access, engagement, and care authorization. Documentation states awareness of member demographics and health disparities is essential to ensuring services are delivered in culturally competent manner.	
6	State public health agency health disparities reduction plans. Examples: • A description of activities the Quality Improvement Committee is conducting to address health disparities/ SDoH-related trends among the CME enrollees.			Magellan Conference Summary (to be submitted by Magellan)	Brenda.Stout.Conference.schedule.pdf		
					Collaborative Connections Conference Schedule and Map of LCCC.pdf Tribal Advisory Presentation CME program.10.16.2025.pdf	The conference schedule includes key focus areas such as Leveraging Natural Supports, Barrier-Busting with the Wraparound Process, and Building Community for Families, Healthcare Providers, and Educators. These topics indicate a focus on providing continuous education for staff. The Tribal Advisory Presentation outlines steps for provider onboarding, training, and ongoing support, demonstrating a commitment to sustainability and quality improvement. During the virtual onsite, Magellan explained that their tribal engagement strategy centers on sustained relationship-building with tribal communities and Indian Health Services (IHS). Over the past 3-4 years, Magellan has worked with IHS to establish tribal providers within the network. Over the past eight months, the Eastern Shoshone Tribe has been actively working through the process of becoming a network provider. Their engagement efforts also included attending the IHS health fair, meeting with community members, and presenting information about wraparound services. Magellan staff have visited the Wind River Reservation multiple times, participated in the Tribal Advisory Group (TAG), and worked to develop rapport and trust with both tribes. Regarding member enrollment, Magellan described a community-based strategy rooted in personal outreach. Ties to Riverton and Wind River communities helped connect with families, educators, and other local stakeholders with providers. Magellan also engages directly with tribal providers, teachers, and community members to share information about the program and encourage enrollment. They emphasized that progress is closely tied to building trust within the community, which continues to develop as they	What is the tribal population engagement strategy and how is Magellan working to improve previous challenges with low tribal provider enrollment? What is the enrollment strategy for members?
7	Other relevant state-specific reports by advisory committees, areas of legislature concern, or audit findings.	Family Services Dept. of Interagency Children's Collaborative; Chapter 1: Interagency Children's Collaborative			ICC - DFS Rules.pdf	WDH organizes the Interagency Children's Collaborative (ICC) within the Wyoming Department of Family Services to improve coordination among agencies to reduce the time children spend on temporary placements and out-of-home care. The ICC's collaborative approach not only streamlines service delivery and reduces systemic barriers, but also ensures that family voice, community integration, and cost-effectiveness are prioritized. By reviewing cases, engaging multiple agencies, and including family representation, the ICC directly supports the reduction of unnecessary admissions, readmissions, and lengths of stay, while promoting positive outcomes for children and families across Wyoming.	What challenges has the ICC encountered in coordinating across multiple agencies, and how have these been addressed? How are families informed about the ICC's role and their opportunities for involvement? How are best practices identified by the ICC disseminated and implemented across agencies and local teams? What mechanisms exist for public or stakeholder feedback on the ICC's performance and recommendations?

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 proactively saw that performance in the PA PIP was still not being achieved as expected and proposed additional improvements to the State.	Strength	Quality
4	The quantitative structure and statistical framing of the Network PIP limit the ability to clearly interpret the magnitude and significance of improvement attributable to the PIP interventions.	Needed Improvement	Quality
5	Magellan's PIP design identifies secondary drivers but do not include evaluation of their impact on performance measures.	Needed Improvement	Access to Care
Protocol 2. Validation of Performance Measures			
7	Clinical and technical teams are knowledgeable, engaged, and invested.	Strength	Quality
8	Documentation describing measure result creation is detailed and robust.	Strength	Quality
9	Measure creation staff are cross-trained.	Strength	Quality
10	Reporting Metric documentation is inaccurate.	Needed Improvement	Quality
11	Manual process calculation is needed for LOS and reporting days.	Needed Improvement	Quality; Timeliness

#	Finding	Strength or Needed Improvement	Domain
12	Contract and business requirements documents (BRD) require more clarity to accurately perform calculations.	Needed Improvement	Quality
Protocol 3. Compliance with Medicaid Managed Care Regulations			
13	Magellan exhibited strong adherence to enrollee rights and protections.	Strength	Quality; Access to Care
14	Magellan demonstrated effective service provision and care coordination.	Strength	Quality; Access to Care
15	Magellan fostered strong processes for provider network management.	Strength	Quality; Access to Care
16	Magellan utilized a mature health information system infrastructure.	Strength	Quality; Timeliness
17	Policies, manuals, and enrollee-facing materials do not consistently align with operations supporting enrollee protections.	Needed Improvement	Quality; Access to Care
18	Documentation lacks consistency in providing clear definitions for Medicaid Managed Care terms.	Needed Improvement	Quality
Protocol 4. Validation of Network Adequacy			
19	Magellan has already made significant progress to report on and meet the new network adequacy standards and indicators for SFY 2026.	Strength	Access to Care
20	Magellan has made significant improvements in developing and documenting their targeted provider outreach and recruitment efforts.	Strength	Access to Care
21	Magellan has continued to grow and develop the WY CME provider network to meet the needs of program enrollees.	Strength	Access to Care
22	Magellan's weekly caseload reports do not clearly demonstrate compliance with provider caseload requirements.	Needed Improvement	Access to Care

#	Finding	Strength or Needed Improvement	Domain
23	Magellan and WDH do not have a definition or formal measures to determine what constitutes adequate access to services.	Needed Improvement	Access to Care
24	Magellan does not have a process to define demand for services that inform network needs and goals.	Needed Improvement	Access to Care; Quality