Wyoming Department of Health
Care Management Entity Program
SFY 2019 External Quality Review
Technical Report

April 20, 2020

guidehouse.com/healthcare

NAVIGANT
A Guidehouse Company

Contents

Figures and Tables

Executive Summary

Wyoming implemented the statewide Care Management Entity (CME) program in 2015 to provide targeted case management services via a high fidelity wraparound (HFWA) delivery model for Medicaid eligible youth 4 – 20 years old with serious emotional disturbance (SED) or serious and persistent mental illness (SPMI) who are high utilizers of behavioral health services. This followed a seven-county pilot program in 2013 and subsequent approval of the State's 1915(b) waiver by the Centers for Medicare & Medicaid Services (CMS). The Wyoming Department of Health (WDH) contracted with Magellan Healthcare, Inc. (Magellan) to serve as the single statewide prepaid ambulatory health plan (PAHP) for the CME program.

Federal regulation mandates states to conduct an annual external quality review (EQR) of Medicaid services delivered through managed care entities including PAHPs. WDH contracted Navigant – A Guidehouse Company (Navigant) to perform the EQR of Magellan for services delivered in State Fiscal Year (SFY) 2019 and produce this technical report.

Scope of EQR Activities Conducted

At the request of WDH, Navigant performed four mandatory activities for EQR as set forth in 42 CFR § 438.358:

1. Assessment of Compliance with Medicaid Managed Care Regulations
2. Validation of Measures Reported by the PAHP
3. Validation of a Performance Improvement Project (PIP)
4. Validation of Network Adequacy

The purpose of these activities is to provide review of the quality, timeliness of and access to the services included in the contract (statement of work (SOW)) between WDH and Magellan.

Unlike traditional managed care programs, the CME program does not provide acute care services and many aspects of the EQR are not fully applicable to Magellan. Performance measures stipulated in the SOW focus on operational requirements and validation of these measures consisted of a five-tiered approach. Similarly, traditional provider network adequacy requirements such as time and distance standards do not apply to the CME program. WDH identified two PIPs for Navigant's review, consisting of a Provider Scorecard initiative (which was continued from SFY 2018 to SFY 2019) and Minimum Contacts tracking (which is a new initiative starting SFY 2019).

Overall Review Findings

Navigant's review of Wyoming's CME program resulted in identification of:

- 6 areas of strength
- 16 areas of needed improvement
- 17 recommendations in relation to quality, timeliness, and access to services

As a relatively new program, there are many opportunities for both WDH and Magellan to focus efforts and scale performance related to quality, timeliness, and access to services. WDH should explicitly describe its expectations for Magellan in the SOW between WDH and Magellan, which will help target performance initiatives. Many recommendations address issues with clarity in internal and enrollee-facing materials, which may have adverse impacts on quality and access, as well as ways to ensure network adequacy. While this assessment presents a number of areas with necessary improvements, Navigant has also identified several strengths, demonstrated largely by the collaborative efforts between Magellan and WDH and Magellan's robust policies governing enrollees' access to care. Youth enrolled in the CME program are well-served by Wyoming's CME program and will be better-served with a coherent and active quality assurance and improvement process.

Section I. Introduction

Wyoming's Care Management Entity Program

In 2013, the Wyoming Department of Health (WDH) implemented a seven-county pilot program called the Care Management Entity (CME) to provide services via a nationally-recognized high fidelity wraparound (HFWA) delivery model for youth with complex behavioral conditions and their families. Beginning July 1, 2015, the WDH Division of Healthcare Financing (DHCF) contracted with Magellan Healthcare, Inc. (Magellan) as the single statewide prepaid ambulatory health plan (PAHP) to expand the CME program throughout Wyoming and improve the coordination, quality, and cost of care for youth ages 4 through 20 with serious emotional disturbance (SED) or serious and persistent mental illness (SPMI) who are high-utilizers of behavioral health services. The program serves Medicaid-enrolled children and youth who have a SED or SPMI and who meet criteria for Psychiatric Residential Treatment Facility (PRTF) or acute psychiatric stabilization hospital levels of care as well as those who are enrolled in Wyoming's Children's Mental Health (CMHW) 1915(c) Medicaid waiver. The CME program served 328 youth in 2016, 431 youth in 2017, and 494 youth in 2018, and 402 youth in 2019.

HFWA is a community-based delivery service model for providing Medicaid State Plan targeted case management services via four provider types, Family Care Coordinator (FCC), Family Support Partner (FSP), Youth Support Partner (YSP), and Respite providers. These providers are selected by and work with the enrolled youth and family team to accomplish clearly defined objectives and treatment goals. HFWA is effective for coordinating care and service delivery so that enrolled youth receive a better-integrated system of care which allows them to reside in their community with minimal disruptions to family and living situations, while receiving maximum support.

Wyoming's 1915(b) Waiver Program

In August 2015, the Centers for Medicare & Medicaid Services (CMS) approved WDH's application for a 1915(b) waiver to operate the CME program as a PAHP (effective September 1, 2015), a risk-based managed care arrangement in which WDH paid Magellan a capitated per member per month (PMPM) amount to provide covered services to eligible youth. The capitated payment methodology aimed to incentivize Magellan to meet specific outcome measures.

At the direction and approval of CMS, effective July 1, 2018 for State Fiscal Year (SFY) 2019, WDH amended the State's 1915(b) Medicaid waiver to shift from a capitated risk-based payment model to a non-risk fee-for-service (FFS) based payment model. This change was intended to alleviate challenges arising with a capitated risk-based payment to Magellan for a small population of enrollees (approximately two hundred enrollees in a given month) with varying periodic changes in direct service uptake, utilization, and provider network development.

Figure 1, on the following page, outlines WDH's steps for developing the CME program, including the original pilot program through the transition to FFS.

Figure 1. CME Implementation Timeline

February 2010	Wyoming is awarded a grant under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to support creation of a CME program for Medicaid and CHIP-enrolled children with serious behavioral health challenges.
June 2013	WDH implements a seven-county CME pilot program.
July 2015	Magellan begins statewide expansion of CME program.
August 2015	CMS approves WDH's 1915(b) waiver application for the CME program.
June 2018	CMS approves WDH's 1915(b) waiver amendment to shift from capitated payment to FFS payment, effective July 2018.

Overview of the External Quality Review

In accordance with federal regulations at 42 CFR § 438, subpart E, states must conduct an external quality review (EQR) of contracted managed care entities, including managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), PAHPs, and primary care case management (PCCM) entities. The EQR focuses on analyzing and evaluating the quality, timeliness, and access to healthcare services provided to Medicaid recipients. An EQR Technical Report must be completed and made available to the CMS and the public by April 30 of each year.

The EQR consists of four mandatory and seven optional activities, as listed in Table 1 on the following page.

Table 1. EQR Activities and Protocols

Activity	
Mandatory	1. Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations
	2. Protocol 2: Validation of Measures Reported by the MCO
	3. Protocol 3: Validation of Performance Improvement Projects (PIPs)
	4. Validation of Network Adequacy
Optional	5. Protocol 4: Validation of Encounter Data
	6. Protocol 5: Administration or Validation of Consumer or Provider Surveys of Quality of Care
	7. Protocol 6: Calculation of Performance Measures
	8. Protocol 7: Implementation of PIPs
	9. Protocol 8: Focused Studies
	10. Assisting with Quality Rating
	11. EQRO Technical Assistance Related to EQR

The four mandatory activities described below align with Sections III through VI of this EQR Technical Report.

- **EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations:** States are required to perform a compliance review of each PAHP once in a 3-year period to determine the extent to which PAHPs comply with federal regulatory provisions, State standards, and the PAHP's contract requirements.[1]
- **EQR Protocol 2: Validation of Measures Reported by the PAHP:** States must provide to the EQRO and the PAHP the performance measures they must calculate, the specifications for the measures, and State-specific reporting requirements.[2] EQR Protocol 2 evaluates:
    - The accuracy of the Medicaid PAHP's reported performance measures based on the measure specifications and State reporting requirements

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html.
[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html.

  - If the PAHP followed the rules outlined by the State Agency for calculating the measures
  - The integrity of the PAHP's information system and completeness and accuracy of the data produced, in accordance with the Information System Capabilities Assessment (ISCA)[3]

- **EQR Protocol 3: Validation of Performance Improvement Projects:** PAHPs are required to implement a performance improvement project (PIP). In Protocol 3, the EQRO assesses the validity and reliability of a PIP.[4]
- **Validation of Network Adequacy:** The EQR must validate the PAHP's network adequacy during the preceding 12 months to comply with requirements set forth in 42 CFR § 438.68 which requires the State to develop and enforce network adequacy standards.

WDH contracted with Navigant – A Guidehouse Company (Navigant) as the External Quality Review Organization (EQRO) to conduct the four mandatory EQR activities in a manner consistent with the protocols established by CMS to evaluate Magellan's provision of healthcare services during SFY 2019 (July 1, 2018 to June 30, 2019). WDH had previously contracted Navigant to conduct the EQR to evaluate Magellan's activities during SFY 2018 (July 1, 2017 to June 30, 2018). This EQR relies on discussions with WDH and CME staff, documentation provided by WDH and Magellan, and Navigant's industry experience working with Health and Human Services agencies in 49 states and Washington, D.C. This report summarizes the findings of the EQR and provides recommendations for Magellan and WDH to improve operational and program performance.

Results of SFY 2018 External Quality Review

Navigant's SFY 2018 review of Wyoming's CME program resulted in identification of five areas of strength, 13 areas of needed improvement, and 15 recommendations in relation to quality, timeliness, and access to services.

There were two areas where WDH and/or Magellan fully addressed recommendations from the SFY 2018 review:

- **Develop disenrollment policies that reflect disenrollment requirements outlined in the SOW:** Magellan submitted a formal disenrollment policy (although, the policy effective date fell outside of the SFY 2019 review period).
- **Develop standards for Magellan's communication of PIP status and results to WDH:** The SFY 2019 SOW requires annual submission of PIP status and results.

All other SFY 2018 recommendations either have not been addressed and are re-iterated in this year's report, or WDH and/or Magellan indicated that they are currently working on

[3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Appendix V: Information System Capabilities Assessment – Activity Required for Multiple Protocols*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/app5-isassessment.pdf.
[4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html.

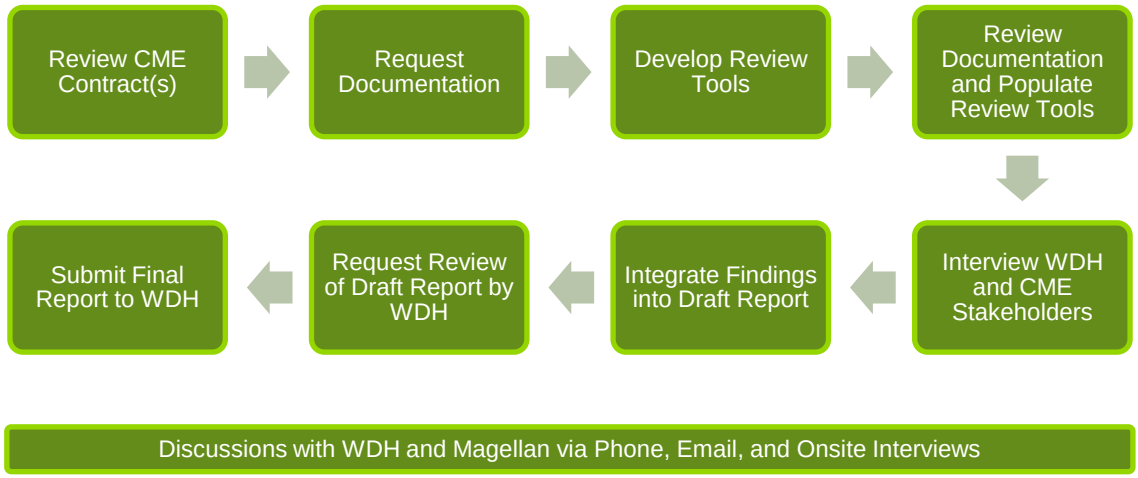
implementing the recommendation. For example, WDH and/or Magellan are currently making updates to address the following recommendations from SFY 2018:

- **Implement an Annual Quality Work Plan and Quality Improvement Program Annual Evaluation:** During the SFY 2018 review, Magellan did not have clearly documented quality assurance policies and procedures, which was an outstanding issue during the SFY 2019 review. Magellan indicated that the quality work plan, program description, and program evaluation documents were being drafted, but not in use during the SFY 2019 review period and are currently undergoing internal Magellan approval.
- **Update materials to clarify State fair hearings and grievance processes and the relationship between complaints and grievances:** During the SFY 2018 review, there were discrepancies between complaints and grievances definitions in enrollee materials. Although significant updates were not made prior to the SFY 2019 review, Magellan indicated they are currently making updates to materials to clarify terminology.
- **Establish a margin within which Magellan can report findings and remain fully compliant:** During the SFY 2018 review and continued into the SFY 2019 review, WDH and Magellan used goal thresholds of 100 percent for goals submitted in the quarterly reports. WDH is currently considering modified thresholds for inclusion in the SFY 2021 SOW.

Section II. Methodology

Navigant's methodology and associated review tools for all mandatory activities were adapted from the CMS established protocols, approved by WDH, and encompassed the following key steps, visualized in Figure 2.

Figure 2. Key Assessment Steps



The methodology varied slightly for each mandatory activity:

- **EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations:** Relied heavily upon review of documentation and onsite discussions with Magellan and WDH.
- **EQR Protocol 2: Validation of Measures Reported by the PAHP:** Relied heavily upon review of documentation, validation of data and measures, and onsite demonstrations.
- **EQR Protocol 3: Validation of Performance Improvement Projects:** Relied heavily upon review of documentation and onsite discussions with Magellan and WDH.
- **Validation of Network Adequacy:** Relied heavily upon review of documentation and onsite discussions with Magellan and WDH.

Review of Documentation

Assessment and validation for this EQR required mapping relevant language from the effective contract between WDH and Magellan, herein referenced as the statement of work (SOW), to the Medicaid managed care regulations set forth in 42 CFR § 438:

- **Subpart B** – State Responsibilities
- **Subpart C** – Enrollee Rights and Protections
- **Subpart D** – MCO, PIHP, and PAHP Standards
- **Subpart E** – Quality Measurement and Improvement; External Quality Review

- **Subpart F** – Grievance and Appeal System

After identifying the elements of the SFY 2019 SOW which operationalized the relevant federal code requirements, Navigant requested and reviewed relevant documentation from Magellan and WDH including, but not limited to, the following:

- Magellan corporate policies and procedures (and, where different, Magellan of Wyoming policies and procedures) related to quality, timeliness, and access to service and care
- Enrollee and provider handbooks
- Outreach and marketing templates and materials
- Quarterly reports to WDH (including SFY 2019 Quarters 1 – 4, with the Quarter 4 report also serving as the annual report)
- Geographic information on enrollee residences and provider service areas
- Provider agreements, provider certification requirements, and training requirements
- Wyoming Administrative Rules

Discussions with WDH and Magellan

This EQR relied on frequent communication with both WDH and Magellan. Key points of contact included:

- Weekly telephone meetings between Navigant and WDH from December 2019 to February 2020
- Onsite visit to the Wyoming CME on January 28-29, 2020
- Ad-hoc emails and meetings

Validation of Data and Measures

Section IV, Validation of Performance Measures, details the methodology used to review and validate performance measures in accordance with the operational requirements under the SFY 2019 SOW. Section IV also reviews designated “outcome” measures and other aspects of EQR Protocol 2 for evaluation.

Section III. Compliance with Medicaid Managed Care Regulations

EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations evaluates Magellan's compliance with federal regulatory provisions, State standards, and the PAHP's SOW requirements. States must perform a compliance review of each PAHP once in a 3-year period to determine the extent of the PAHP's compliance.

Navigant followed CMS's *EQR Protocol 1 Compliance Review Worksheet* to collect information from WDH, establish compliance thresholds, and perform review of Magellan's compliance across 41 elements applicable to the CME program.[5] The compliance review encompassed the following topics:

- **Enrollee Rights and Protections**: Includes standards for content and distribution of enrollee materials and State laws on enrollee rights.
- **Quality Assessment and Performance Improvement:** Includes standards for network adequacy, timely access to services, delivery of services in a culturally competent manner, coordination and continuity of care, service authorization, provider selection, enrollment and disenrollment, performance measurement and improvement, and health information systems.
- **Grievance System:** Includes standards for resolution and notification of grievances and appeals and communication to providers and enrollees regarding the grievance system.

For the compliance evaluation, Navigant used a three-point rating scale consisting of:

- **Fully Met** – All documentation listed under the regulatory provision, or component thereof, is present; and Magellan staff provide responses to Navigant reviewers that are consistent with each other and with the documentation.
- **Partially Met** – Magellan staff can describe and verify existence of compliance practices during interview(s) and/or discussion(s) with Navigant reviewers, but required documentation is unavailable, incomplete, or inconsistent with practice.
- **Not Met** – Submitted documentation does not meet federal or State standards, or, no documentation is present and Magellan staff have little to no knowledge of processes or issues that comply with regulatory provisions.

Appendix B includes Navigant's review tool for EQR Protocol 1. Table 2, on the following page, provides an overview of Magellan's compliance by topic.

[5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1 – Assessing MCO Compliance with Medicaid and CHIP Managed Care Regulations Attachment A: Compliance Review Worksheet*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1-attachment-a.pdf

Table 2. Extent of Compliance with EQR Protocol 1 Elements

Compliance Level	Enrollee Rights and Protections		Quality Assessment and Performance Improvement		Grievance System		TOTAL	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Fully Met	6	67%	20	91%	9	75%	**35**	81%
Partially Met	2	22%	2	9%	3	25%	**7**	16%
Not Met	1	11%	0	0%	0	0%	**1**	2%
Total Applicable	**9**	100%	**22**	**100%**	**12**	**100%**	**43**	**100%**
Not Applicable	4	--	7	--	0	--	**12**	--

Magellan fully met 81 percent of applicable elements, partially met 16 percent, and did not meet 2 percent in SFY 2019. When Navigant conducted the EQR for SFY 2018, Magellan fully met 76 percent of the applicable elements, partially met 20 percent, and did not meet 5 percent.

There were several elements of the compliance review worksheet that were not applicable to the CME program and were excluded from review, including elements regarding the following:

- Participation in State managed care initiatives that employ mandatory enrollment: Wyoming does not have this initiative.
- Regulations and descriptions regarding advanced directives: Advanced directives do not apply to the CME program population; CME program does not deliver medical services.
- Time and distance standards for beneficiary travel to access covered services: Time and distance standards do not apply due to the community-based nature of the program in which providers travel to enrollees.
- Identification of individuals with special health care needs: All CME program enrollees fall under this category.
- Standards regarding subcontractor monitoring: The CME program does not utilize subcontractors.
- Regulations regarding Medicare Advantage: Medicare Advantage does not apply to the enrollee population.

The areas of strength and needed improvement listed below highlight areas where WDH and Magellan performed well, areas where WDH and Magellan could improve, and specific recommendations for improvement.

Areas of Strength and Needed Improvement

Enrollee Rights and Protections

Magellan fully met 67 percent, partially met 22 percent, and did not meet 11 percent of the applicable requirements relating to Enrollee Rights and Protections.

Strength: Magellan has robust systems in place that largely align with federal and State standards regarding enrollee rights, protections, and information.

Magellan distributes appropriate and timely information to enrollees, primarily through the Magellan Wyoming Care Management Entity Family and Youth Guide to High Fidelity Wraparound (herein referred to as the member handbook), which includes the following regarding enrollee rights and protections:

- Information on enrollee rights and responsibilities, including, but not limited to:
    - The right to receive information in a language the enrollee and their family can understand and receive free translation
    - The right to be treated fairly, regardless of race, religion, gender, sexual orientation, ethnic background, disability, source of payment, etc.
- Information on accessible communication, including:
    - The provision of free aids and services to enrollees with disabilities, such as sign language and written language in other accessible formats
    - The availability of free interpreters and information written in other languages for enrollees whose primary language is not English

Magellan updates the member handbook on an annual basis. Once updated, Magellan sends out a notification so enrollees can request a copy of the handbook or view it online.

Magellan's internal policies also dictate standards for enrollee materials. These policies require the materials to align with information requirements outlined in 42 CFR § 438.10, including easily understandable language and format, certain font sizes, and instruction for requesting auxiliary aids and services. Magellan has established policies and procedures to send enrollee materials within appropriate timeframes. Magellan sends enrollment letters and member handbook information within the first 30 calendar days of his or her referral to the CME program. Other forms of communication with enrollees include a monthly e-newsletter, quarterly printed newsletter, and postcards with relevant updates.

(This is a continued strength from SFY 2018.)

Needed Improvement: The SOW uses terminology which requires further clarification.

Although Magellan and WDH have robust systems for enrollee rights, protections, and information, there is opportunity to further strengthen their respective systems. WDH does not currently define "easily understandable" and "significant change" in relation to enrollee materials.

- *Easily understandable:* The SOW indicates that Magellan "must provide all enrollment notices, informational materials, and instructional materials … in an *easily understandable* language and format. 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..." However, WDH does not define what it considers "easily understandable" in indicating a standard for reading level.
- *Significant change:* Per 42 CFR § 438.10, "The MCO, PIHP, PAHP, or PCCM entity must give each enrollee notice of any change that the State defines as *significant* in the information specified in this paragraph (g), at least 30 days before the intended effective date of the change." However, WDH does not currently define what it considers a significant change that would require informing enrollees. Magellan agreed that there is no formal understanding of "significant change" but Magellan would consider updates regarding program changes or eligibility to be "significant."

Recommendation for WDH: Clarify certain terminology used in the SOW.

WDH can clarify its intentions and assure that it receives the expected outcomes by defining the following terms:

- *Easily understandable:* While WDH clearly indicates expectations around language availability, font sizes, and formats, WDH may strengthen requirements around this terminology by requiring materials to meet certain reading level thresholds (e.g., Flesch-Kincaid Grade Level).
- *Significant change:* WDH may define this term in the SOW rather than operate under a mutual / informal assumption with Magellan on when changes are "significant," as is current practice.

(This is a continued needed improvement from SFY 2018 as this item was still outstanding during the review period.)

Needed Improvement: The SOW does not include language to address aspects of certain State / federal regulations.

Neither Magellan nor WDH document the following elements described in federal regulations:

- *Provider's right to appeal*: Per 42 CFR § 438.100, WDH must provide information on whether Magellan "has documented to the State any moral or religious objection to providing, reimbursing for, or providing coverage of, a counseling or referral service…" WDH noted during discussion that it does not allow providers the right to challenge failure to cover contracted services themselves and can only submit appeals on behalf of enrollees; however, there is no formal documentation to support this.
  Magellan's policies and procedures also do not note whether there is an appeal process for providers, only for enrollees. For example, the Benefit Certification Appeal General Guidelines policy outlines the appeal process of adverse benefit determination or claim for benefit payment, which also applies when providers act as an authorized

representative of the individual. The policy does not discuss if providers also have this right.

- *Moral and religious objections*: Per 42 CFR § 438.100, WDH must define whether or not Magellan "has documented to the State any moral or religious objection to providing, reimbursing for, or providing coverage of, a counseling or referral service…" Currently, there is no applicable language in the SOW. Magellan noted that no moral or religious objections apply to this program; however, there is no formal documentation to support this. The Medicaid Enrollee Rights and Responsibilities policy indicates that for a counseling or referral service that Magellan does not cover because of moral or religious objections, Magellan must inform enrollees that the service is not covered and how to obtain information from WDH about how to access the service. This discrepancy regarding moral or religious objections may lead to confusion in determining the approach for any counseling or referral services.

Recommendation for WDH: Add language to the SOW to reflect a provider's right to an appeal and clarify moral and religious objections.

There is an opportunity to add and clarify language in the SOW regarding the following:

- *Provider's right to appeal*: WDH may formally define in its SOW whether the provider has the right to challenge a failure to cover contracted services or if providers can only submit grievances/appeals on behalf of employees.
- *Moral and religious objections*: WDH may formally define in its SOW whether moral and religious objections apply to this program.

Quality Assessment and Performance Improvement

Magellan fully met 91 percent and partially met 9 percent of the applicable requirements relating to Quality Assessment and Performance Improvement.

Strength: Magellan and WDH demonstrate considerable efforts to promote delivery of services in a culturally competent manner.

The HFWA model is considered a culturally-competent model in and of itself. The model incorporates enrollee and family input during each phase of the HFWA process. Particularly, the model includes assessments like the Strength, Needs, and Cultural Discovery (SNCD) in which families discuss their culture, parenting styles, family operations, and more.

Additionally, the member handbook recognizes cultural competency as a core principle of the CME program and indicates that "the plan respects and builds on the values, preferences, beliefs and culture of the child/youth and family."

When enrolled into the provider network, all Magellan staff and providers must complete HFWA training and cultural competency training. Magellan's provider handbook indicates that "Magellan is committed to embracing the rich diversity of the people we serve. We believe in providing high-quality care to culturally, linguistically and ethnically diverse populations, as well as to those who live with disabilities such as visual and hearing impairment."

(This is a continued strength from SFY 2018.)

Needed Improvement: Enrollee-facing documents do not consistently provide information on the right to a State fair hearing.

The SOW indicates that Magellan must inform enrollees of their right to a State fair hearing. However, many of the enrollee outreach materials, such as the member handbook and letters sent to the enrollee (e.g., grievance resolution letter) do not include information regarding the enrollee's right to State fair hearing. The Notice of Adverse Action letter template was the only document that referenced enrollees' right to a hearing with the Wyoming Department of Health and explained the method for requesting a hearing.

Magellan's revised member handbook for SFY 2020 now includes information on the right to a State fair hearing; however, this version was not in use within the current review period (SFY 2019).

Recommendation for Magellan: Update enrollee-facing materials to clarify information on the enrollee's right to a State fair hearing.

Magellan can clarify the State fair hearings and grievances processes to enrollees by updating enrollee materials, such as the grievance resolution letter template, to explain State fair hearings and how an enrollee can request one.

Grievance System

Magellan fully met 75 percent and partially met 25 percent of the applicable requirements relating to the Grievance System.

Needed Improvement: There are discrepancies between terminology regarding complaints and grievances.

Magellan's internal policies describe the timeframes, requirements, and process for grievances and appeals. Enrollee-facing materials, such as the member handbook, also include details on grievances and appeals. The member handbook used for SFY 2019 informs enrollees of their right to file a complaint or grievance with Magellan and implies that "complaint" and "grievance" can be interchangeable. Similarly, in Magellan internal policy, the Medicaid Enrollee Grievances policy explains the purpose of the enrollee grievance process is "to provide an opportunity for a Medicaid enrollee to express a Grievance or complaint related to the manner in which care or services were provided." However, during onsite discussion, Magellan indicated grievances and complaints have different definitions and separate processes.

The identified discrepancies may lead to confusion in filing a complaint or grievance, and may lead to improper resolution if quality issues are not documented, triaged, and resolved properly and in accordance with the SOW.

Recommendation for Magellan: Update materials to clarify grievance processes and the relationship between complaints and grievances.

Magellan can address the discrepancy between complaints and grievances by clarifying the differences in the member handbook and updating Magellan policies to address complaints and grievances and their associated resolution systems. This includes differentiating language and timelines for action between complaints and grievances, as

well as any other similar terminology. Magellan should also update its internal policies and enrollee materials to describe what constitutes a complaint, and if there is a resolution process available.

(This is a continued needed improvement from SFY 2018 as this item was still outstanding during the review period.)

Needed Improvement: Magellan's enrollee-facing materials do not inform enrollees whether they have the authority to file a grievance with WDH.

As noted throughout Magellan policy, enrollees have the right to file a grievance and request an appeal with Magellan. For instances, the Medicaid Adverse Benefit Determination Appeal policy indicates that the "enrollee may file a grievance and request an appeal with the MCO" and the Medicaid Enrollee Rights and Responsibilities policy indicates that each enrollee "has the right to file a complaint/grievance about Magellan, a provider or the care received." Per discussions with WDH, enrollees must exhaust the grievance process with Magellan first. If they have an issue with Magellan, the grievance can arise to State level review. However, the enrollee right to file a grievance with WDH is not communicated in enrollee-facing materials.

Recommendation for Magellan: Update enrollee-facing materials to clarify information on the enrollee's right to file a grievance with WDH.

Magellan can clarify the grievance processes to enrollees by updating enrollee materials, such as the member handbook, to explain whether an enrollee can file a grievance directly with WDH and how/when the enrollee would do so.

Needed Improvement: There are inconsistencies regarding timeframes for grievances, appeals, and adverse benefit determinations.

Several documents describe the timelines in place for grievances, appeals, and adverse benefit determinations. Table 3, on the following page, includes the timeframes for selected processes and how the timeframes compare across reviewed documents. Most processes below indicate some inconsistency, with some documentation showing more lenient or more stringent timeframes, some documentation not specifying business or calendar days, and some documentation not even mentioning the timeframes. In particular:

- Several internal Magellan policies do not align with external materials. For example, regulations, SOW, and Magellan's internal policies indicate that an enrollee has 60 calendar days to file an appeal for an adverse benefit determination, but member handbooks (used in SFY 2019 and SFY 2020) either say within 30 calendar days or do not mention the timeframe at all. Similarly, regulations and internal Magellan policies indicate enrollees have 120 calendar days to request a State fair hearing, whereas member handbooks either say 30 days (does not specify calendar or business) or do not mention the timeframe at all.

- In some instances, Magellan's timeframes are more stringent than those within regulations or SOW, which does not pose an issue but is worth mentioning. For example, regulations and SOW require Magellan to complete disposition of a grievance within 90 calendar days, but the member handbook used during SFY 2019 indicates within 30 days.

Table 3. Timeframes for Grievances, Appeals, and Adverse Benefit Determinations

Timeframe Description	Source of Information			
	Federal Regulations	SOW	Magellan Internal Policy	Magellan External Materials
Magellan's disposition of grievances	Within 90 calendar days *Source: 42 CFR 438.408*	Within 90 calendar days	Within 90 calendar days *Source: Medicaid Enrollee Grievances policy*	*Member Handbook (used during SFY 2019):* Within 30 days (does not specify business or calendar days) *Member Handbook (used during SFY 2020):* Within 45 calendar days
Enrollee's right to file an appeal for a grievance (not related to service benefits)	Not applicable	Not applicable	Not mentioned	*Member Handbook (used during SFY 2019)*: Within 30 business days *Member Handbook (used during SFY 2020):* Not mentioned
Magellan's disposition of a grievance appeal (not related to service benefits)	Not applicable	Not applicable	Within 30 calendar days *Source: Medicaid Enrollee Grievances policy*	*Member Handbook (used during SFY 2019)*: Within 90 calendar days *Member Handbook (used during SFY 2020):* Not mentioned
Enrollee's right to file an appeal for adverse benefit determination	Within 60 calendar days *Source: 42 CFR 438.402*	Within 60 calendar days	Within 60 calendar days *Source: Adverse Benefit Determination Appeal policy*	*Member Handbook (used during SFY 2019)*: Not mentioned *Member Handbook (used during SFY 2020):* Within 30 calendar days

Timeframe Description	Source of Information			
	Federal Regulations	SOW	Magellan Internal Policy	Magellan External Materials
Magellan's disposition of an appeal for adverse benefit determination	Within 30 calendar days *Source: 42 CFR 438.408*	Within 30 calendar days	Within 30 calendar days *Source: Adverse Benefit Determination Appeal policy*	*Member Handbook (used during SFY 2019)*: Not mentioned *Member Handbook (used during SFY 2020):* Within 30 calendar days
Enrollee's right to a State Fair Hearing	Within 120 calendar days *Source: 42 CFR 438.408*	Not mentioned	Within 120 calendar days *Source: Adverse Benefit Determination Appeal policy*	*Member Handbook (used during SFY 2019)*: Not mentioned *Member Handbook (used during SFY 2020):* Within 30 days (does not specify business or calendar days)

Recommendation for Magellan: Magellan should clarify the existing language and timelines in all applicable documents regarding grievances, appeals, adverse benefit determinations.

For consistency and to avoid confusion, Magellan can update its existing documents regarding any discrepancies in timeframes noted above.

Recommendation for WDH: Update the SOW to clarify timeframes for State fair hearings.

The SOW references State fair hearings several times but does not indicate relevant timeframes. WDH should update the SOW to clearly indicate the timeframe in which an enrollee must request a State fair hearing, in accordance with federal regulations.

(This is a continued needed improvement from SFY 2018 as this item was still outstanding during the review period.)

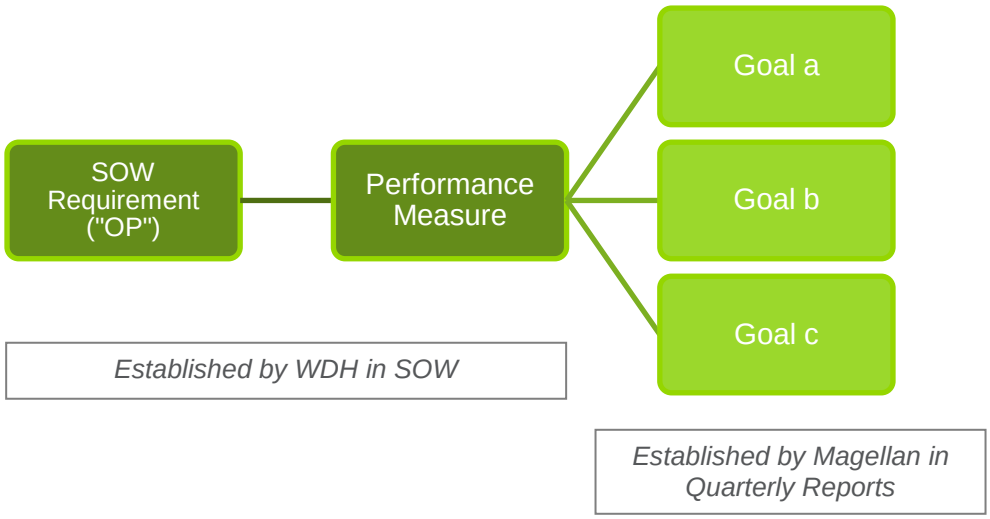
Section IV. Validation of Performance Measures

EQR Protocol 2: Validation of Measures Reported by the PAHP evaluates the accuracy and appropriateness of performance measures reported by Magellan and the extent to which the performance measures follow WDH's specifications and reporting requirements. Additionally, this section assesses the integrity of the PAHP's information system and the completeness and accuracy of the data in accordance with the ISCA.

Methodology

Each SOW requirement is given an OP number ("OP" abbreviates "operational requirement") and is assigned to one of seven categories (HFWA, Operations, Project Management, Provider Network, System of Care, Technical, or Financial). Magellan subsequently developed "goals" approved by WDH for how it would measure and report its performance for each OP; goals are not established explicitly in the SOW but are reported in the quarterly reports with associated data. Data included in quarterly reports to WDH provided the largest source of information for validation of performance measures (PMs). Figure 3 displays the relationship between SOW or operational requirements, performance measures, and goals.

Figure 3. SOW Requirements, Performance Measures and Goals



For SFY 2019, review and validation of reported data included 71 goals established by Magellan for 31 operational requirements in the SOW.

Appendix C includes a listing of the operational requirements based on the SOW**.**

Levels of Analysis

Navigant conducted five levels of analysis for the goals and operational requirements, displayed in Figure 4, on the following page, and organized by specificity to a particular goal. Table 4 provides an example of an operational requirement from the SOW, the corresponding

performance measure, and the corresponding set of goals. Table 5, on the following page, further describes each level of analysis and the applicable range of outcomes for each level.

Figure 4. Levels of Analysis

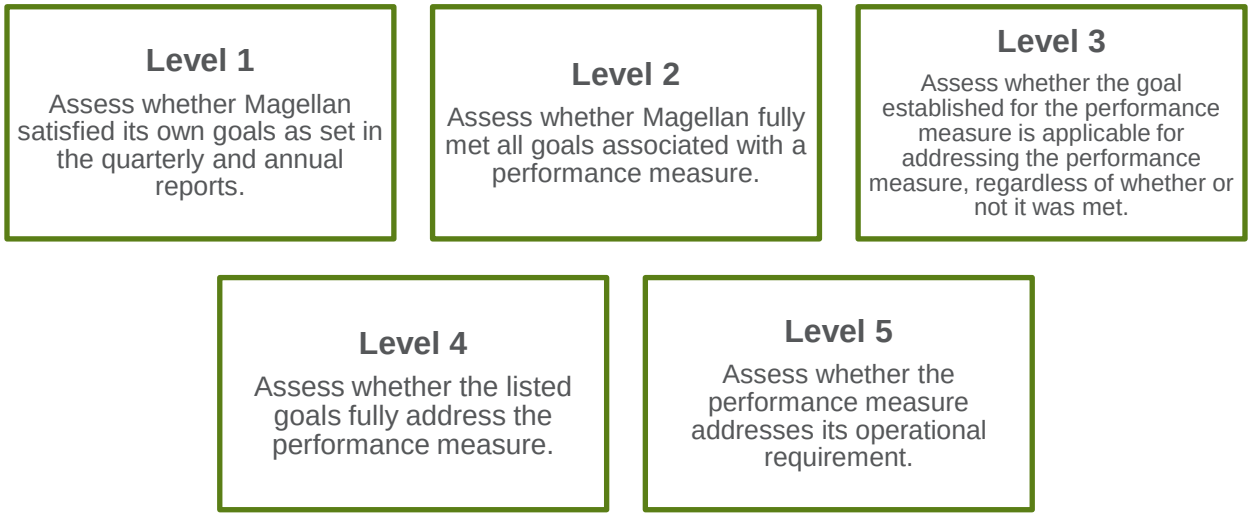


Table 4. Example SOW Operational Requirement, Performance Measure, and Goals based on SFY 2019 SOW OP-01

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.
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.
Goals and Related Goal Thresholds
• **Goal OP-01a:** Rate of providers in network meeting all requirements: 100% • **Goal OP-01b:** 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% • **Goal OP-01c:** Rate of providers completing annual recertification: 100% • **Goal OP-01d:** Rate of new providers completing initial provider training: 100%

Table 5. Description of Five Tiers of Analysis

Level	Description of Analysis	Possible Outcomes of Analysis	Example
Level 1	**Assess whether Magellan satisfied its own goals as set in the quarterly and annual reports.** 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 Navigant reviewed these and the annual report which captures all data from the quarterly reports.	• **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. • **Insufficient Data**: Performance measure did not have an established goal set or Magellan did not present adequate data to determine achievement of the goal. • **Not Applicable:** There was no applicable data in SFY 2019 for this measure.	For Goal OP-01a, "Rate of providers in network meeting all requirements," the target was 100 percent but the reported data from the quarterly reports indicates 100 percent, 92 percent, 91 percent, 87 percent for the four quarters, so the outcome is "Goal Not Met."
Level 2	**Assess whether Magellan fully met all goals associated with a performance measure.** Many operational requirements and performance measures include multiple associated goals.	• **Yes**: Reported data meets all established goals associated with the performance measure. • **No**: Reported data did not meet any goals or did not provide sufficient data for evaluation of any goals under this performance measure. • **Not Applicable:** There was no applicable data in SFY 2019 for this measure.	For OP-01, Goal OP-01a, Goal OP-01b, Goal OP-01c, and Goal OP-01d were not met. Therefore, the outcome is "No," as Magellan did not meet any of the associated goals.
Level 3	**Assess whether the goal established for the performance measure is applicable for addressing the performance measure, regardless of whether or not it was met**. This tier determines whether a listed goal is appropriate	• **Yes**: The goal is relevant in addressing the performance measure. • **No**: The goal is not relevant or sufficient in addressing the performance measure.	For Goal OP-01b, the goal 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 performance measure language "The

Level	Description of Analysis	Possible Outcomes of Analysis	Example
	and relevant in addressing the performance measure.		Contractor must provide percent of HFWA providers in the network who complete training including ethics." Therefore, the outcome for this goal is "Yes," as the goal addresses the performance measure.
Level 4	**Assess whether the listed goals fully address the performance measure.** Similar to Level 3, this tier analyzes the goals' efficacy in addressing the performance measure. The focus is not on whether an individual goal is relevant to meeting the performance measure but whether the listed goal(s) together fully assess the performance measure.	• **Yes**: The performance measure is fully addressed by its listed goals. • **No**: All listed goals, considered together, do not sufficiently address the performance measure. One or more goals must be added or amended for the performance measure to be fully addressed by its listed goals.	For OP-01, all four goals associated with the performance measure align with statements from the performance measure. Therefore, the outcome is "Yes," the performance measure is fully addressed by the goals.
Level 5	**Assess whether the performance measure addresses its operational requirement.** A performance measure accompanies every operational requirement.	• **Yes**: The performance measure adequately addresses the SOW requirement. • **Partially**: The performance measure addresses part, but not all, of the SOW requirement. • **No**: No portion or aspect of the performance measure addresses the SOW requirement.	For OP-01, the contract requirement indicates that "All successful and attempted contacts should be documented by the Contractor" but the performance measure does not address this. Therefore, the outcome is "Partially," because the performance measure addresses some, but not all, parts of the contract requirements.

Overview of Reporting Requirements

The SOW requires Magellan to submit two sets of performance data:

- **Operational Requirements:** The SOW outlines several operational requirements and associated performance measures. Magellan is required to submit data for these measures in a quarterly report to WDH.

- **Outcome Measures:** The SOW includes 10 outcome measures with specific measurement instructions for each measure. Annually, Magellan reports on outcomes to WDH and may be subject to payment penalties for failing to meet outcome measure goals.

Operational Requirements

To evaluate the accuracy and appropriateness of performance measures, Navigant evaluated 71 goals and 31 operational requirements. Table 6 below provides the number of goals and operational requirements by category. Appendix D includes Navigant's review tool for validating operational requirements.

Table 6. Goals and Operational Requirements by Category

Contract Category	SFY 2019 SOW	
	# of Goals	# of OPs
High Fidelity Wraparound	34	15
Operations	15	8
Project Management	4	1
Provider Network	1	1
System of Care	10	3
Technical	6	2
Financial	1	1
Total	**71**	**31**

Outcome Measures

Navigant evaluated Magellan's performance on 10 outcome measures, as specified in the SOW. Appendix E includes Navigant's review tool for validating these outcome measures, which include but are not limited to the following topic areas:

- Cost savings
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) compliance
- Family and youth participation
- Fidelity to the high fidelity wraparound model
- Length of stay and recidivism
- Out-of-home placements
- Psychotropic medication use

Performance on Operational Requirements

Magellan's Performance on Goals

Navigant assessed data from Magellan's quarterly reports to evaluate Magellan's performance on 71 goals. Table 7 below provides findings from Navigant's Level 1 analysis described previously, which assesses Magellan's performance satisfying the goals. Table 7 indicates Magellan met 59 percent of its total goals and did not meet 38 percent.

Table 7. Assess whether Magellan satisfied its own goals as set in the annual report[6]

Level 1 Evaluation	Percent of Goals
Goal Met	**59%**
Goal Not Met	**38%**
Not Applicable	**3%**
Total	**100%**

Table 8 below provides findings from Navigant's Level 2 analysis described previously, which assesses Magellan's performance satisfying *all goals associated with a performance measure* (i.e., Magellan's performance meeting the performance measures themselves). Table 8 indicates Magellan met nearly half (48 percent) and did not meet nearly half (45 percent) of all associated goals for the performance measures.

Table 8. Assess whether Magellan fully met all goals associated with a performance measure[7]

Level 2 Evaluation	Percent of PMs
Yes	**48%**
No	**45%**
Not Applicable	**7%**
Total	**100%**

Per Table 7 above, Magellan did not meet 38 percent of its goals. In particular, more than 90 percent of unmet goals fell under the HFWA category, requirements which primarily measure the quality, access, and timeliness of care provided to enrollees. The following goals report

[6] Percentages may not sum to 100 percent due to rounding.
[7] Percentages may not sum to 100 percent due to rounding.

findings below 50 percent of the target metric in one or more quarters and demonstrate consistent issues:

- OP-04: Rate of new referrals contacted by chosen FCC within three working days
- OP-07a: Rate of enrollees enrolled with FSP
- OP-07b: Rate of enrollees enrolled with YSP
- OP-10a: Rate of enrollees contacted by phone at least once a week

Additionally, several unmet goals declined in performance throughout the measurement period. The following goals saw the most drastic declines in performance over the review period, with Q4 data being at least 10 percentage points lower than Q1 data:

- OP-01d: Rate of new providers completing initial provider training
- OP-01b: 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
- OP-01a: Rate of providers in network meeting all requirements

See Appendix F for a full list of goals with declining performance.

Relationship Between Goals and Performance Measures

Navigant evaluated how well Magellan's goals align with their associated performance measures. Table 9 below provides findings from Navigant's Level 3 analysis described previously, which assesses whether a particular goal is applicable for addressing the associated performance measure. Table 9 indicates most goals (99 percent) address the performance measure and 1 percent does not address the performance measure.

Table 9. Assess whether a particular goal addresses its performance measure, regardless of whether or not it was met[8]

Level 3 Evaluation	Percent of Goals
Yes	**99%**
No	**1%**
Total	**100%**

Table 10, on the following page, provides findings from Navigant's Level 4 analysis described previously, which assesses whether the listed goals fully address their associated performance measure. Table 10 indicates most (87 percent) of performance measures were fully addressed by their goals, whereas 13 percent were not.

[8] Percentages may not sum to 100 percent due to rounding to the nearest full percentage.

Table 10. Assess whether the listed goals fully address their performance measure[9]

Level 4 Evaluation	Percent of PMs
Yes	**87%**
No	**13%**
Total	**100%**

Per Tables 9 and 10 above, most goals address their performance measure, and most performance measures are satisfactorily addressed by their listed goals. This indicates that the listed goals are sufficient in measuring or operationalizing the intent of the performance measure.

However, one goal did not address its performance measure: OP-28: Rate of referral to C Waiver within timeframe.

- As noted in the Quarterly Reports, the numerator for goal OP-28 uses a timeline of two business days: "Number of children and enrollees who qualify for the CME program but do not have/ are not eligible for Medicaid who are referred to the C Waiver within timeframe (2 business days)." The reported goal itself does not specify the timeframe.
- The SOW's performance measure requires referrals within two *calendar* days, whereas Magellan's goal is more lenient with two business days.

There were four areas where the performance measures were not fully addressed by the listed goals: OP-19, OP-20, OP-27, and OP-30.

- **OP-19**: The performance measure describes requirements for standard authorization timeframes, which are addressed by the goals. However, the goals OP-19a, OP-19b, OP-19c, and OP-19d all do not address the following points from the performance measure:
    - If the Contractor's review results in an adverse action, the Contractor shall provide a thirty (30) calendar day advance notification to the enrollee and the enrollee's family care coordinator prior to implementing a change in program eligibility and/or service amount, duration or frequency.
    - The Contractor must report quarterly on the status of the Contractor's relationship with the PA / UM vendor. The Agency reserves the right to request that additional information be included. Requested data must be included on the next quarterly report.
- **OP-20**: The performance measure requires Magellan to provide a quarterly report of how flex funds were spent, including "recipient, the amount, reason for the flex fund distribution, the date of distribution, and a brief description of the flex funds

[9] Percentages may not sum to 100 percent due to rounding to the nearest full percentage.

use/purpose." However, the goals OP-20a, OP-20b, and OP-20c do not describe the details of each flex fund request - such as the recipient, the amount of the funds, or the dates of distribution.

- **OP-27**: The performance measure requires Magellan to provide quarterly reports which include "number of meetings with stakeholders, agencies, organizations, and resources across the State. This includes all QIC and Advisory council meetings." However, none of the associated goals (OP-27a, OP-27b, OP-27c, OP-27d, OP-27e, OP-27f, OP-27g, and OP-27h) mention "QIC meetings."
- **OP-30**: The performance measure requires submission of both provider and enrollee satisfaction results. However, the associated goal includes provider results but does not include enrollee results.

Relationship Between Performance Measures and Operational Requirements

Navigant assessed the appropriateness of the performance measures in relation to the operational requirements. WDH developed both the operational requirements and the associated performance measures. Table 11 provides findings from Navigant's Level 5 analysis, which assesses the adequacy of performance measures in addressing and operationalizing the intention of the contract requirement. Table 11 indicates that 61 percent of performance measures address the operational requirement and 39 percent partially address the operational requirement.

Table 11. Assess whether a particular performance measure addresses its operational requirement[10]

Level 5 Evaluation	Percent of PMs
Yes	**61%**
Partially	**39%**
No	**0%**
Total	**100%**

There were 12 performance measures that did not fully address the operational requirements, which includes, but is not limited to, the following:

- **OP-01**: The associated contract requirement indicates that "all successful and attempted contacts should be documented by the Contractor," but the performance measure does not address documentation of attempted contacts.
- **OP-13**: The performance measure does not address how Magellan will "communicate an out-of-home placement" or "work with children and youth who are in out-of-home placements…" as indicated in the contract requirement.

[10] Percentages may not sum to 100 percent due to rounding.

- **OP-23**: The contract requirement indicates quarterly reporting should be submitted "accurate and timely." However, the performance measure does not mention accuracy and timeliness of reports.

Validation of Selected Measures

Navigant conducted a detailed review of the data analysis and collection methods for six performance measures, as selected by WDH for validation. Three of the six performance measures were divided into multiple sub-parts and were necessary to validate as well. Selected performance measures include the following:

- **OP-01:** Provider Network Certification
- **OP-03:** SNCD Compliance
- **OP-04:** Family Engagement Timelines
- **OP-10:** FCC Ongoing Contact
- **OP-12:** Child and Family Team (CFT) Meetings
- **OP-14:** Evaluations and Re-assessments

Table 12, on the following page, describes results of the performance measure validation and indicates that Magellan:

- Fully met three of the six performance measures (OP-03, OP-04, OP-10).
- Did not meet three of the six performance measures (OP-01, OP-12, OP-14).

A performance measure was considered “fully met” if Magellan was able to demonstrate valid creation methods and accurate source data, according to the following three areas:

- **Accurate Creation of Numerator** – All measurement specifications are defined for the creation of the denominator; Magellan staff must also properly demonstrate the steps to generate the numerator for the performance measure during onsite validation.
- **Accurate Creation of Denominator** – All measurement specifications are defined for the creation of the denominator; Magellan staff must also properly demonstrate the steps to generate the denominator for the performance measure during onsite validation.
- **Accurate Source Data** – Magellan has properly defined and identified the data source used to generate the performance measure.

For performance measures that were not met, Navigant consistently found similar issues, including, but not limited to:

- Magellan did not develop appropriate nor complete measurement plans / programming specifications.
- There is no defined process to check the reasonableness of data to report the performance measures.

- Performance measurement reporting programs are not reviewed or validated by supervisory staff.
- Magellan did not establish internal backup staff for the performance measure creator (the staff member who creates / analyzes the performance measure data).

Table 12. Measure Accuracy

Measures and Findings[11]	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
OP-01: Provider Network Certification			
Overall Findings: • Magellan did not develop appropriate nor complete measurement plans / programming specifications. • There is no defined process to check the reasonableness of data to report the performance measures. • Performance measurement reporting programs are not reviewed or validated by supervisory staff. • A single staff member is responsible for manually completing, assessing, and reporting this measure. At this time, there is no process documentation or peer review process prior to or following submission; this may allow any potential errors to go unnoticed. • Magellan did not establish internal backup staff for the performance measure creator (the staff member who creates / analyzes the performance measure data).	NA	NA	NA
OP-01a1: Rate of providers in network meeting all requirements • **Numerator**: Number of providers in network meeting all requirements • **Denominator**: Number of providers in network			
Magellan believes the denominator has historically been overstated. There is also an opportunity to clarify the measurement requirements. • For example, during onsite validation the Navigant team found an instance of a provider that was miscategorized due to a lack of measure specifications. • The provider in question was enrolled in the network but could not render services anymore since the provider left the agency. Magellan noted that, technically, the provider could render services if they work for another agency. • Magellan staff also confirmed that this provider should not be included in the denominator.	✓	✕	✕

[11] Each measure's naming convention (e.g., OP-01a1), numerator, and denominator are from the quarterly reports.

Measures and Findings[11]	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
OP-01a2: Rate of providers in network not meeting all requirements • **Numerator**: Number of providers in network not meeting all requirements • **Denominator**: Number of providers in network			
There may be inaccuracies in the rate calculation. For example, the total of OP-01a1 and OP-01a2 (for February 2018, November 2018, March 2019, and June 2019) did not equal 100 percent. The performance measure creator noted that this result may be due to a mathematical error. Two main factors may contribute to mathematical errors in this rate: • This measure process is entirely manual (no Structured Query Language (SQL)) code or other extract programming). • Providers frequently move in-and-out of the program and between different agencies. Note, this measure shares the denominator with OP-01a1, which also is an inaccurate calculation.	✗	✗	✓
OP-01a3: Rate of providers in network who received training on abuse, neglect, and exploitation identification and reporting procedures annually as part of the recertification process • **Numerator**: Number of providers in network who received training on ANE identification and reporting procedures annually as part of the recertification process • **Denominator**: Number of providers in network			
Note, this measure shares the denominator with OP-01a1, which also is an inaccurate calculation.	✓	✗	✓
OP-01b: Rate of providers completing annual recertification • **Numerator**: Number of providers completing annual recertification • **Denominator**: Number of providers with annual recertification expirations			
The total number of annual expirations should be closely aligned to the total number of in-network providers, as each provider must re-certify annually. However, the total expirations reported is less than 10 percent of the total providers. Magellan noted validity of the premise but could not explain the discrepancy. Additionally, the process for determining the measure results is manual through review of a PDF file of results. Magellan should consider moving this information to the provider records. This will allow Magellan to automatically generate the measure results and allow additional staff to have insight into the underlying data.	✗	✗	✓

Measures and Findings[11]	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
OP-01c: Rate of new providers completing initial provider training • **Numerator**: Number of new providers completing initial provider training • **Denominator**: Number of new providers initially certified			
The rate is generated correctly; however, the numerator value may be under-reported due to Magellan not capturing providers who have not officially enrolled into the network yet. For a provider to be actively working with families, and therefore be considered in-network, three elements must be met. 1. Basic qualifications must be met, as defined in the provider handbook. 2. Must be enrolled in WY Medicaid under the CME program. 3. Must go through certification process and complete the Tier 1 (initial training) and Tier 2 training. However, some providers complete the Tier 1 certification prior to completing the Medicaid application and therefore are not included in the numerator value. Results of the rate may report a higher denominator than numerator or vice-versa in any given month.	✓	✓	✕
OP-03: Rate of SNCDs completed prior to initial CFT Meeting[12] • **Numerator**: Number of SNCDs completed prior to initial CFT • **Denominator**: Number of initial CFT meetings during the measurement month			
OP-03 measures the rate at which the SNCD is completed for each person prior to his/her initial CFT meeting. The calculation method and numerator/denominator values reported are accurate based upon the available data. • This measure is generated using SQL and there are no manual calculations in the process. • After this measure is produced each month, the data and analytics staff discuss and confirm accuracy of numerator and denominator with a subject matter expert from the clinical team. • Magellan staff complete a manual review to verify counts and dates against progress note data. Overall Findings: • Magellan did not develop appropriate nor complete measurement plans / programming specifications. • Magellan did not establish an internal backup for performance measure creator.	✓	✓	✓

[12] The SNCD is one of several assessments and includes member information, reason for referral, disability information, details regarding family, life domain, and child and family team information.

Measures and Findings[11]	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
OP-04: Rate of new referrals contacted by chosen FCC within 3 working days • **Numerator**: Number of new referrals contacted by chosen FCC within 3 working days • **Denominator**: Number of new referrals who have chosen FCCs			
Magellan clearly demonstrated how data is entered for this measure. • All new referrals are entered in the provider portal within one business day, and the FCC is notified of the referral via an authorization note. • It is the responsibility of the FCC to contact the child/family within 3 business days of the selection. The calculation method and numerator/denominator values reported are accurate based upon the available data. Magellan created a quality assurance process to ensure the accuracy of this measure. • The analytics staff confirms the accuracy of the numerator and denominator with a subject matter expert from the clinical team. • When noticing downward trends for this rate, the clinical team discusses ideas for intervention during the monthly quality discussion. • The clinical team may then contact providers through conference calls, newsletters, training, and general reminders regarding making contact with the new referrals and submitting the appropriate documentation.	✓	✓	✓
OP-10: FCC Ongoing Contact			
For both OP-10a and OP-10b, contact may be initiated by either the enrollee or the FCC. In either case, when the contact is properly documented, the count will be included in the measure report. The calculation method and numerator/denominator values reported are accurate based upon the available data. • This measure is generated using SQL, and there are no manual calculations in the process. • The clinical team reviews the results of OP-10 on a weekly basis. • There are additional systems in place to verify that the progress note entries are representative of the service(s) provided. Overall Findings: • Magellan did not develop appropriate nor complete measurement plans / programming specifications.	NA	NA	NA

Measures and Findings[11]	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
• Magellan did not establish an internal backup for performance measure creator.			
OP-10a: Rate of enrollees contacted by phone at least once a week • **Numerator**: Number of enrollees contacted by phone at least once a week • **Denominator**: Number of enrollees with a full week within measurement period			
None	✓	✓	✓
OP-10b: Rate of enrollees contacted in-person at least twice a month • **Numerator**: Number of enrollees contacted in person at least twice a month • **Denominator**: Number of enrollees with a full month within measurement period			
None	✓	✓	✓
OP-12: Rate of CFT Meetings with invited formal supports • **Numerator**: Number of CFT meetings with invited formal supports[13] • **Denominator**: Number of CFT meetings			
This measure includes the attended/invited/refused data reported by the providers using the progress notes user interface. The calculation method and numerator/denominator values reported are accurate based upon the available data. Magellan demonstrated that the measure is generated using SQL, and there are no manual calculations in the process. However, the reported data, particularly the numerator, may be inaccurate due to the way providers submit this information. • The data for this measure comes from providers' progress note entries. • Providers must select checkboxes to indicate who was invited, attended, or refused to attend the CFT meeting. • The measure creation team expressed concern over providers often selecting the "Attended" option on the progress note, but not always selecting the "Invited" option. • Providers under-reporting the number of invites may result in OP-12 numerator being under-reported. Overall Findings: • Magellan did not develop appropriate nor complete measurement plans / programming specifications.	✓	✓	✗

[13] Formal supports include people such as the child's Primary Care Provider (PCP), a representative of the Wyoming Department of Family Services (DFS), or those holding degrees or other education preparing them to act as part of the support team for the child.

Measures and Findings[11]	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
• There is no defined process to check the reasonableness of data to report the performance measures. • Performance measurement reporting programs are not reviewed or validated by supervisory staff. Magellan did not establish an internal backup for the performance measure creator.			
OP-14: Evaluations and Re-assessments			
Overall Findings: • Magellan did not develop appropriate nor complete measurement plans / programming specifications. • There is no defined process to check the reasonableness of data to report the performance measures. • Performance measurement reporting programs are not reviewed or validated by supervisory staff. • Magellan did not establish an internal backup for the performance measure creator.	NA	NA	NA
OP-14a: Rate of enrollees meeting all evaluation requirements (LOC[14], CASII[15], CANS[16]) for enrollment • **Numerator**: Number of enrollees meeting all evaluation requirements (LOC, CASII, CANS) for enrollment • **Denominator**: Number of enrollees			
None	✓	✓	✓
OP-14b: Rate of annual re-evaluations conducted prior to or on expiration date • **Numerator**: Number of annual re-evaluations conducted prior to or on expiration date • **Denominator:** Number of annual re-evaluations conducted			
The creation method appears to be valid based on review of Magellan's SQL queries; the SQL queries also appear to be appropriate given the measure description. However, the reported data may be inaccurate. The reported denominator was under-reported due to: • The majority of date values in MemberQueue appear to be correct; however, there are occurrences with no sample value.	✓	✓	✗

[14] LOC – Level of Care: Assessment tool used to help make decisions and determine the level of care needed to provide treatment
[15] CASII – Child and Adolescent Service Intensity Instrument: standardized assessment tool that provides a determination of the appropriate level of service intensity needed by a child or adolescent and his or her family. It is unique in its capacity to determine a service intensity need, guide treatment planning, and monitor treatment outcome in all clinical and community-based settings. Source:https://www.aacap.org/AACAP/AACAP/Member_Resources/Practice_Information/CASII.aspx.
[16] CANS – Child and Adolescent Needs and Strengths: multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. Source: https://praedfoundation.org/tools/the-child-and-adolescent-needs-and-strengths-cans/.

Measures and Findings[11]	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
• Some records have the same beginning and end year value. As a result, the assessment period was viewed as one day, and not one year. • Some new assessments replace existing assessments instead of becoming a new record entry in the database.			
OP-14c: Rate of OOH placements returned to community with new LOC evaluations • **Numerator**: Number of OOH placements returned to community with new LOC evaluations • **Denominator**: Number of OOH placements returned to community			
Magellan believes that the "return to community" self-report from the provider may not always be submitted.	✓	✓	✕
OP-14d: Rate of enrollees with a valid CASII/ESCII • **Numerator**: Number of enrollees with a valid CASII or ESCII[17] on file • **Denominator**: Number of enrollees			
The numerator may be over-reported. • The SOW specifies that OP-14 measures "*CASII and ESCII and level of care (LOC).*" • Currently, the measure only incorporates values for LOC and excludes the case if no CASII is found. • Correcting this measure will likely result in a decreased rate as the criteria would be more stringent.	✕	✓	✓
OP-14e: Rate of enrollees with a valid CANS • **Numerator**: Number of enrollees with a valid CANS on file • **Denominator**: Number of enrollees			
Similar issues reported in OP-14b exist in OP-14e.	✓	✓	✕
OP-14f: Rate of enrollees with a valid LOC attestation • **Numerator**: Number of enrollees with a valid LOC attestation • **Denominator:** Number of enrollees			
None	✓	✓	✓
OP-14g: Rate of assessments completed by qualified evaluator • **Numerator**: Number of assessments completed by qualified evaluator • **Denominator:** Number of assessments completed (CASII, ESCII, CANS, LOC)			
None	✓	✓	✓

[17] ESCII – Early Childhood Service Intensity Instrument: standardized tool used to determine the intensity of services needed for infants, toddlers, and children from ages 0-5 years; similar to the CASII but used for children under five years of age. Source: https://www.aacap.org/AACAP/Member_Resources/Practice_Information/ECSII.aspx.

Performance on Outcome Measures

Navigant assessed data provided by Magellan to evaluate compliance with ten outcome measures, only nine of which were applicable during SFY 2019. Note that the outcome measures changed with the SFY 2019 contract and no longer align with the measures used for SFY 2016-2018. Table 13 below provides a summary of the outcome measure results based on performance throughout SFY 2019. Table 13 indicates Magellan:

- Met eight of nine applicable outcome measures (89 percent).
- Partially met one of nine applicable measures (11 percent).

Table 13. Status of Outcome Measures

Outcome Measure	Status
OUT-1: Out-of-Home (OOH) Placements The Contractor shall, report the number of OOH placements of Contractor youth. OOH=Out-of-Home (anything other than a family or adoptive placement)	Meets Requirement
OUT-2: Decreased Length of Stay (LOS) for Inpatient and Residential Treatment admissions The Contractor shall report the overall length of stays for inpatient and residential treatment for youth enrolled in the CME.	Meets Requirement
OUT-3: Recidivism The Contractor shall decrease the recidivism of youth served by the Contractor moving from a lower level of care to a higher level of care.	Partially Meets Requirement
OUT-4: Recidivism (LOC) at six (6) months post CME graduation The Contractor shall report recidivism of youth served by the Contractor and who graduated from the CME program who are moving from a lower LOC to a higher LOC within six (6) months of graduation from the CME.	Not Applicable
OUT-5: Compliance with EPSDT The Contractor shall report the CME enrolled youth's compliance with EPSDT standards.	Meets Requirement
OUT-6: Appropriate Use of Psychiatric Medication The Contractor shall report on the number of CME enrolled youth not meeting the state standards for psychotropic medications (too much, too many, too young, polypharmacy) as reported by the Pharmacy Unit.	Meets Requirement
OUT-7: Cost Savings (Healthcare Costs) The Contractor shall report healthcare costs to Medicaid for the CME enrolled youth.	Meets Requirement
OUT-8: Fidelity to the high fidelity wraparound (HFWA) Model	Meets Requirement

Outcome Measure	Status
-The Contractor shall report fidelity to the HFWA model as measured by the Wraparound Fidelity Index (WFI-EZ) **-** The Contractor shall report the number of WFI-EZ surveys administered to capture a valid and representative sample of the experiences of enrollees served.	
OUT-9: Family and Youth Participation at state-level Steering Committees The Contractor shall report family and youth participation on state-level Steering Committees.	Meets Requirement
OUT-10: Family and Youth Participation in Communities The Contractor shall report family and youth participation on the CME's community advisory boards, Support groups and other stakeholder meetings facilitated by the Contractor.	Meets Requirement

Magellan successfully met reporting requirements for eight of the nine applicable measures, so Magellan will not be subject to payment penalties for those measures.

Magellan partially met the requirement "OUT-3: The Contractor shall decrease the recidivism of youth served by the Contractor moving from a lower level of care to a higher level of care."

- Magellan reported the number of youth who moved to a higher level of care on a quarterly basis, which addresses the *outcome performance measure*.
- However, the *outcome requirement* requires Magellan to decrease the recidivism of youth; recidivism did not decrease throughout SFY 2019. Instead, recidivism increased from 0 percent in Q1 to 2 percent in Q4.
- Per WDH, Acute Psychiatric Stabilization and PRTF admissions were the only level of care available for analysis. This measurement's language changed in subsequent iterations of the SOW post SFY 2019.

Areas of Strength and Needed Improvement for All Measures

Magellan's performance and outcome measures and associated processes demonstrate several strengths and areas for improvement, described below.

Strength: Data and analytics staff is knowledgeable, engaged, and invested.

In reviewing the measures, documentation, and demonstrations provided by Magellan staff, it is evident that Magellan has a team of people who are knowledgeable about both the technical creation of the measure details and the clinical and personal information that supports each data point. As each measure result is generated, the technical team provides the results, along with any suspected errors, to the subject matter experts for review. The weekly and monthly quality meetings also serve as opportunities for further review and discussion of trends, as well as areas for improvement and education. Magellan clinical staff is engaged in the process from a provider's or enrollee's enrollment through the various updates to include certification, assessments, provider selections, etc.

Needed Improvement: Magellan does not clearly document measure creation processes.

Although Magellan staff were able to explain the processes for measure creation, most of the processes are not documented. Additionally, there are instances where only one staff member knows how to generate a data point and no other staff validate the process.

Recommendation for Magellan: Ensure cross-training and development / maintenance of measure-level execution documents.

Magellan should consider:

1. Developing technical specifications for creating each measure, and
2. Cross-training at least one additional staff member for each step of the process.

While the current team has the institutional knowledge and technical skills to create the various reports each week, month, quarter, and year, it is critical that Magellan can continue this level of service in the event of employee emergency or departure. The technical specification should include systems accessed, data sources, location and names of each program / file (e.g., SQL source, Excel workbook), timing for both run and delivery, test scenarios, manual adjustments to data, approval requirements, common errors and other technical details. The documents may also include any notes that would help a substitute staff member execute the measure, as well as any common errors or anomalies along with research or other steps required to resolve.

Needed Improvement: There are misunderstandings and conflicting perspectives regarding details of the measures.

While the SOW requirements are appropriate as a contractual Statement of Work, the developers and testers associated with the measure creation could benefit from more detail regarding the intent of each operational requirement. Currently, Magellan staff and WDH staff indicated approaching the same measures from different perspectives.

Recommendation for WDH and Magellan: Clarify intentions for reporting requirements by developing documentation to capture non-technical business requirements.

A national measure steward does not exist for many of the quality measures for the CME program. Consequently, WDH and Magellan need to document measure details comparable to national measure documentation. Magellan and WDH would benefit from creating business requirements which should include enough detail for the staff coding and testing the measures. WDH may work with Magellan to create a “business requirements” document, or “statement of understanding” to specify Magellan’s understanding and approach to each measure (e.g., clarifying numerators and denominators). This would allow both parties to avoid making assumptions on the intent of each measure, query, definition, or report. Several times during Navigant’s assessment, Magellan or WDH staff discussed “what the measure meant to them.” These lower level details have not been previously documented. Documenting these low-level details will remove the ambiguity of each measure. Furthermore, it would allow

both parties to specify the desired data sources, code values, date spans, etc. This document would not require detailed technical specifications.

Information Systems Capabilities Assessment

Navigant assessed the integrity of Magellan's information system and the completeness and accuracy of the data in accordance with the ISCA. Navigant's assessment of the information system relied on review of Magellan's completed ISCA worksheet, review of submitted policy and procedure documents, interviews with Magellan's information system leadership, and interviews with WDH staff.

Overview of Magellan's Information System

Magellan uses in-house information technology (IT) resources to support the CME program. Magellan processes case management claims which providers submit as professional claims. Providers primarily submit claims electronically through Magellan's online provider portal (www.MagellanProvider.com), and Magellan uses Claims Adjudication Payment System (CAPS) to process claims on an AS400 mainframe (this is its transactional system). Magellan also pulls data from Wyoming's fiscal agent, Conduent, as part of its processes. The data exports to an Enterprise Data Warehouse (EDW), which Magellan uses for reporting functions.

In previous years, the information system was not specific to the CME program and Magellan did not have sufficient IT staff to support the system; however, at the time of this review, Magellan has resolved these and other previously-identified issues and its system demonstrates no areas for concern.

Staffing

Magellan's staffing level for those who support adjudication and reporting is appropriate for processing claims and generating measures. Claims processors and measure generation staff receive suitable training:

- Claims processors receive extensive classroom training during the first few weeks of employment which includes technical instruction, benefit information, and hands-on experience. Once claims processors begin processing claims, more senior staff audit all of a newer processor's claims until the staff member has demonstrated 100 percent ongoing accuracy.
- Analytics and reporting staff are trained and experienced in SQL Server, Oracle SQL, Cognos, and Microsoft Office.

Processes and Technology

Magellan appropriately documented processes to support adjudication and reporting, including documentation which supported the following processes:

- **Technology:** Magellan processes claims on an AS400 mainframe then loads those claims into an EDW for reporting. Magellan also pulls data from Wyoming's Conduent system.

- **Claims adjudication, editing, and processing:** Providers submit all claims through Magellan's online provider web portal. All original claims are electronic; however, providers must submit any adjustments as paper claims. The electronic portal requires claims to contain all necessary elements prior to successful submission. Once Magellan staff process the claim, they send the claim to WDH for review and payment. WDH reviews the claim then sends Magellan a response indicating whether Magellan can pay the claim; if WDH approves the claim, it also sends payment. Generally, all claims are processed within 30 calendar days unless there are issues with the enrollee's eligibility, which may cause a claim to be in suspended status at WDH until resolution.
- **Claims auditing process:** Magellan performs quality and adjudication accuracy audits on two percent of all completed claims (including both paid and denied claims). Magellan also conducts pre-disbursement audits on high dollar claims. During the audit process, Magellan confirms the claim paid or denied correctly, and, if the claim paid, that the claim priced correctly.
- **Data flows through system:** Magellan uses several systems and programs to store and process data. Magellan loads all data into a data warehouse.
- **Data reporting:** Magellan populates quarterly and annual report data based on claims data, authorizations data, and Wyoming Medicaid's Cognos system.
- **Verification and approval of data:** Magellan validates performance measure data using their internal subject matter experts, whom Magellan calls "data owners." Data owners review the data for accuracy and completeness, including comparing data to previous quarters and identifying trends and / or anomalies.
- **Disaster recovery plan:** Magellan maintains a disaster recovery plan with strategies for confirming business continuity in case of catastrophic events. Magellan replicates data to a secure remote site and recovery teams can access the site remotely to restore business critical operations. Magellan performs "rehearsals" or tests to confirm the disaster recovery plan.

Section V. Validation of Performance Improvement Projects

EQR Protocol 3: Validation of Performance Improvement Projects assesses the validity and reliability of Magellan's PIP(s) during SFY 2019. Per WDH's direction, Navigant reviewed two PIPs:

- Minimum Contacts PIP that began during SFY 2019
- Provider Scorecard PIP that began during SFY 2018 and continued into SFY 2019

Minimum Contacts PIP

Overview

The Minimum Contacts PIP tracks the performance of providers on two main measures, OP-10a and OP-10b, which assess FCCs' compliance with the requirement to maintain regular in-person and telephone contact with the enrollee and caregivers. The minimum contacts requirement is an integral part of the HFWA process, as it ensures enrollees and caregivers are consistently engaged and able to obtain full benefit from the program. WDH and Magellan prioritized this PIP as an opportunity to improve provider and enrollee engagement in Wyoming's CME program.

Study Topic

In designing this project, WDH and Magellan considered ongoing concerns that providers were not meeting minimum contact requirements since contract inception in 2015. As of July 2018, 33 percent of enrollees were contacted at least once by phone weekly and 81 percent of enrollees were contacted in person at least twice monthly. For SFY 2019, Magellan prioritized these concerns and began formal efforts at targeting these metrics for improvement. Magellan initiated a formal Minimum contacts workgroup in November 2018 that includes a multidisciplinary team to improve the frequency of contacts with enrollees / caregivers.

Although Magellan did not specifically solicit enrollee feedback to inform this study topic, Magellan considered previous informal feedback from WFI-EZ enrollee survey results and gathering feedback from staff who were former HFWA enrollees. Magellan directly incorporated provider feedback by administering a provider survey to understand why providers were struggling with OP-10 compliance.

Study Questions

The intended outcome for the Minimum Contacts PIP is to "improve the frequency in which providers are in compliance with minimum contact requirements for both phone and face-to-face contacts with enrollees and caregivers." Magellan's study question / objective was measurable and stated clearly in writing. The question/objective directly corresponds to the two study indicators described below.

Study Indicators

The goal of this activity is to improve the frequency in which FCCs contact enrollees / caregivers. Table 14 below includes the PIP's indicators. The goal for both measures was a rate of 100 percent.

Table 14. Minimum Contacts Study Indicators

Measures	Numerator / Denominator
Measure 1: Rate of enrollees / caregivers contacted by telephone at least once a week.	• **Numerator**: Number of enrollees contacted by phone at least once a week. • **Denominator**: Number of enrollees enrolled with a full week within measurement period
Measure 2: Rate of enrollees / caregivers contacted in person at least twice a month.	• **Numerator**: Number of enrollees / caregivers contacted in person at least twice a month • **Denominator**: Number of enrollees / caregivers enrolled with a full month within measurement period.

Study Population and Sampling Methods

The PIP incorporates data from all FCCs in Magellan's network who had at least one year of data available. Additionally, the data reflects all enrollees active in the program during the review period. Magellan did not use a sampling method.

Data Collection Procedures

Magellan collects the measure data using progress note entries in the provider portal. Providers use check boxes and free text fields to indicate if there was a face-to-face visit or phone call with the enrollee. A qualified data and reporting analytics staff member collects this information from the provider portal on a weekly basis and uses SQL to extract the numbers and counts for each measure. Magellan staff analyze the data through Excel to populate the quarterly report and minimum contacts dashboard. Magellan shares a weekly report both internally and with WDH. Magellan distributes this information to the providers / agencies on a monthly basis.

Magellan has technology controls in place to ensure the data collection process facilitates consistent and accurate data collection over the time period studied. Magellan's data mart receives data from other systems daily for areas such as claims, enrollees, providers, and assessments. A staff member compares control totals to the SQL Server to ensure the daily refresh matches, and the IT team helps resolve any errors.

Improvement Strategies

Magellan established a Minimum Contacts Workgroup to understand why providers were experiencing challenges to achieving minimum contact requirements. The workgroup developed a provider survey for both the FCC role and for HFWA coaches to conduct a barrier analysis. Survey participants included 23 FCCs (which accounts for a 37 percent response rate) and 6 coaches.

Magellan identified seven barriers, which relate to both Measure 1 and Measure 2, and implemented nine interventions in response. Table 15 below describes the identified barriers.

Table 15. Barriers for Performance Improvement

ID	Barrier
1	Providers are unaware of a process to utilize if they are sick or have a planned absence and how to meet minimum contacts.
2	Providers report they are not familiar with the minimum contact requirements for each phase of HFWA.
3	Providers do not know how to resolve any engagement issues they may encounter within the HFWA process.
4	Provider agencies do not have standard operating procedures outlining how to achieve minimum contacts with enrollees / caregivers.
5	Individual / solo providers do not have backup FCCs to provide services in his/her absence.
6	Providers report confusion regarding how to properly fill out the progress note template on the portal to ensure obtain credit for meeting minimum contact requirements.
7	Providers are unaware of their overall rate of achievement of minimum contacts.

In response to provider survey responses, Magellan implemented focused interventions across several categories, including external communication via email and provider / CME meetings, training and education, monitoring, and internal process changes. Table 16, on the following page, describes the nine interventions Magellan implemented to address five out of the seven barriers above. For example, Magellan updated provider communications to clarify the importance of selecting checkboxes on progress notes and to explain the process changes and importance of meeting minimum contact requirements. Magellan implemented this activity to address providers' "confusion regarding how to properly fill out the progress note template on the portal" (Barrier 6 above).

Table 16. Interventions for Performance Improvement

ID	Intervention	Barrier(s) Addressed
A	Development of Minimum Contact Drilldown Report (OP-10 Report) at the provider level for analysis and review with providers.	7
B	Implementation of weekly Clinical Dept review of OP-10 Report to determine how to assist specific providers with meeting minimum contact requirements.	2, 3, 7
C	Provider communications regarding: • The importance of selecting checkboxes on progress notes within the Provider Portal to ensure they are obtaining credit for their contacts with enrollees / caregivers • Process changes and the importance of meeting minimum contact requirements	6
D	Development and utilize of the Provider Scorecard and review of the OP-10 drilldown report with Network and provider 1:1s (claims-based report was utilized for provider education prior to the development of the OP-10 drilldown report in 12/2018).	2, 7
E	Development and roll-out of a training to provide education re minimum contact requirements and how to properly complete a progress note (sent out to Program Directors and Coaches and reviewed during the External QIC held 6/20/19).	1, 2, 3, 7
F	Review overall network status on minimum contacts and reiterate minimum contact requirements during the Monthly Provider Calls	2, 3, 7
G	Magellan of Wyoming High Fidelity Wraparound Provider Requirements & Timelines posted to provider website as a reference for understanding minimum contact requirement timelines.	2, 3
H	Development and implementation of a Provider Education Desktop Procedure to identify providers consistently failing to meet minimum requirements and follow through the education process to the potential for escalation to a formal corrective action for failure to demonstrate improvement.	2
I	Developed an internal process where the clinical department in the CME will not process reauthorization requests unless providers are demonstrating that they are meeting the requirements of minimum contacts with the enrollee / caregiver.	2, 7

Magellan also established internal thresholds to indicate when to monitor a provider more closely. For example, if any of the measures fall below 80 percent, Magellan will intervene and follow up regarding provider performance. Magellan staff and providers discuss any provider performance issues during monthly one-on-one meetings.

Data Analysis and Interpretation of Results

The goal of the Minimum Contacts PIP is to improve the frequency in which FCCs contact enrollees / caregivers. To assess improvement, Magellan compared the rate at the end of the review period to the rate at the beginning of the review period. Magellan developed and provided Figure 5 and Figure 6 below to display the results of the data for measures 1 and 2, respectively.

Figure 5. Measure 1 – Rate of enrollees / caregivers contacted by telephone at least once a week over the review period July 2018 to July 2019

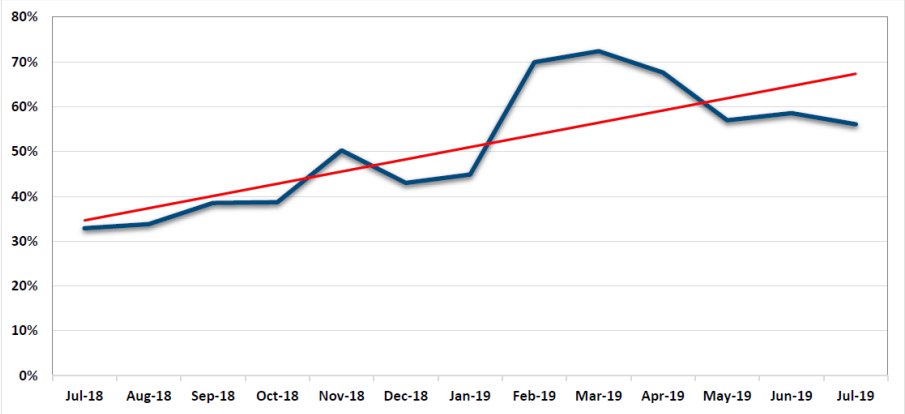
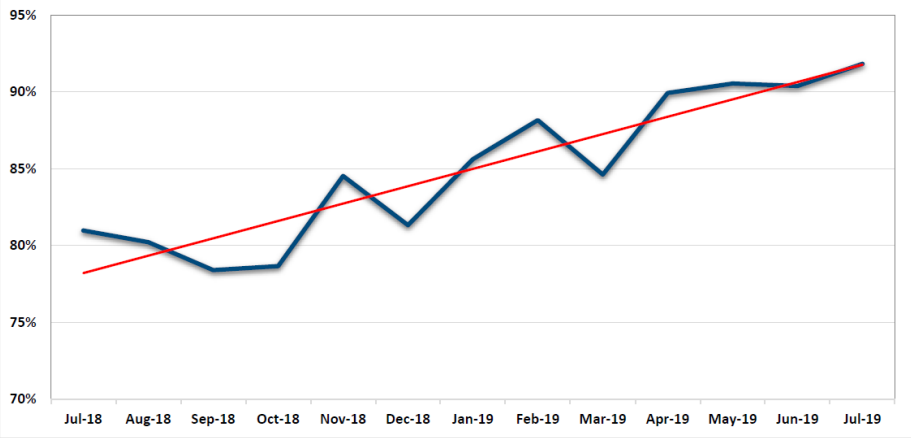


Figure 6. Measure 2 – Rate of enrollees / caregivers contacted in person at least twice a month over the review period July 2018 to July 2019



As indicated by the positive-sloping regression lines, providers demonstrated overall improvement from baseline to the end of the reporting period for both Measure 1 and Measure 2.

Assessment of Improvements

Analysis of the data trends indicated overall improvement for both Measures 1 and 2, as demonstrated in Table 17 and summarized on the following page.

- For Measure 1, the rate of enrollees / caregivers contacted by telephone at least once a week increased from 33 percent in July 2018 to 56 percent in July 2019. This is an overall improvement of 23 percentage points.
- For Measure 2, the rate of enrollees / caregivers contacted in person at least twice a month increased from 81 percent in July 2018 to 92 percent in July 2019. This is an overall improvement of 11 percentage points.

Goals for both measures are 100 percent compliance; therefore, technically Magellan did not meet the 100 percent compliance goal, but did demonstrate overall improvement.

Table 17. Minimum Contacts Data Trends

Measure	Measure Data		HFWA Goal	Overall Improvement Toward Goal Since Baseline
	Baseline	July 2019		
Measure 1: Rate of enrollees / caregivers contacted by telephone at least once a week.	33%	56%	100%	Yes
Measure 2: Rate of enrollees / caregivers contacted in person at least twice a month.	81%	92%	100%	Yes

Magellan did not provide evidence to determine if the observed performance improvement is statistically significant and did not conduct analyses to indicate if the change in performance was due to the intervention or by random chance.

While Magellan did demonstrate overall improvement, Magellan has not demonstrated repeated measurements over time to confirm sustained improvement. However, the PIP was only in place for one review period which does not yet allow for long-term analysis.

Provider Scorecard PIP

Overview

WDH selected Magellan's Provider Scorecard initiative for review. As part of the Provider Scorecard initiative, Magellan distributes a scorecard to the Magellan Wyoming provider network once per quarter. Magellan believes the scorecards help quantify the work of the CME program and tell the story of how HFWA impacts Wyoming's CME youth and families served. The provider scorecard is de-identified and shows providers how they are performing on selected measures compared to their network counterparts. The selected measures focus on quality process, fidelity to wraparound principles, administrative efficiency, and outcomes of wraparound. The inaugural provider scorecard was developed June 2018 and released to providers in August 2018, and Magellan has continued to release provider scorecards on a quarterly basis.

Study Topic

As noted in the 2018 EQR, Magellan selected the Provider Scorecard study topic based on opportunities for improvement identified through retrospective data analysis and consideration of stakeholder input. WDH and Magellan decided to continue the Provider Scorecard PIP for SFY 2019.

Magellan had considered input from stakeholders (including enrollees and providers) when developing the PIP study topic:

- **Enrollees**: Magellan did not directly request enrollees' input on the provider scorecards; however, Magellan took enrollee input from other sources into consideration when developing the scorecards. Specifically, Magellan considered enrollee input obtained via the family satisfaction survey, Wraparound Fidelity Index-Short Form (WFI-EZ), which directly informs one of the "Family Response" measures in the scorecard.
- **Providers**: At the February 2018 Provider Retreat, providers in attendance requested "access to data." This request was one of the factors contributing to the development of the scorecards, and the providers' lack of specificity in their request led Magellan to include monthly provider education as part of the scorecard initiative.

Study Questions

Magellan and WDH indicate that provider scorecard serves several purposes:

- Demonstrate accountability and program integrity for HFWA
- Increase transparency on provider performance, as well as performance of the CME program overall
- Inform where individual providers, Magellan, and WDH need to focus attention to improve quality, fidelity, efficiency, and outcomes

Magellan confirmed the study questions have stayed the same from SFY 2018 to SFY 2019:

- Does the change in authorization process improve the percent of youth and families reaching engagement threshold (>60 days)?
- Does the change in authorization process improve the percent of youth and families reaching implementation threshold (>180 days)?

Magellan's study questions were measurable and confirmed during onsite discussions. The questions directly correspond to two of the study indicators described below.

Study Indicators

The provider scorecards focus on quality process, fidelity to wraparound principles, administrative efficiency, and outcomes of wraparound. Magellan selected these categories based on a balanced scorecard model and the HFWA model.

Throughout SFY 2018, Magellan held scorecard meetings to explore and evaluate possible measures for inclusion in the scorecard. Meetings consisted of cross-functional leads with subject matter expertise in the following areas:

- Network / Provider Relations
- Coaching / Training
- Family Support
- Care Management
- Quality
- Reporting
- Analytics
- Communications
- Administration

Magellan selected at least one measure for each category based on provider improvement potential, target for change, and usability of existing reporting. See Table 18 below for the specific scorecard measures.

Table 18. Provider Scorecard Categories and Measures

Category	Measures
Quality Process	**Face-to-face Contacts per Family**: Percentage of youth with two face-to-face contacts per month for youth and/or family
	HFWA ALOS (Average Length of Stay): The average number of days in an authorization of HFWA of engaged youth who have been discharged.
	Engagement and Implementation: The percent of youth with fewer than 60 days of HFWA ("not engaged") and percent of youth with 180 or more days of HFWA ("implemented").
Fidelity to Wraparound Principles	**Family Survey Response**: This is the percent of youth with a Caregiver Survey response from the expected survey completions.
Administrative Efficiency	**Authorization Documentation**: Percentage of authorizations approved with complete documentation
Outcomes of Wraparound	**Improved Functioning**: Percent of youth with improved, same, and newly identified need scores on the CANS global sum quarter over quarter.
	Successful Graduation from HFWA: The percentage of engaged youth who have a successful discharge coded at graduation from formal HFWA.

Study Population and Sampling Methods

The initial iterations of the provider scorecards included HFWA agencies but did not include solo providers on the published provider scorecard due to lack of volume. In June 2019, Magellan added solo providers (with two quarters worth of data) to the published scorecard. The data for

the measures incorporates all enrollees active in the program during the review period. Magellan did not focus on a specific sample of the enrollee population.

Data Collection Procedures

Magellan re-purposed data reports that were already in use for other quality monitoring, such as the quarterly reports to WDH. Table 19 lists the data sources below.

Table 19. Data Sources for Scorecard Measures

Category	Measure	Source
Quality Process	Face-to-face Contacts per Family	FCC progress notes type 2 (CFT) or 11 (bi-monthly face-to-face)
	HFWA ALOS (Average Length of Stay)	FCC LOS Report by HFWA Tier
	Engagement and Implementation	FCC LOS report
Fidelity to Wraparound Principles	Family Survey Response	Wraptrack (Wraparound Fidelity Assessment System) and WFI-EZ Survey Completion Tracker
Administrative Efficiency	Authorization Documentation	Magellan authorization report
Outcomes of Wraparound	Improved Functioning	MagellanProvider.com CANS application and Assessment Score Tracker
	Successful Graduation from HFWA	Disenrollment Reasons Report

Data sources may be populated by providers and Magellan clinical staff through the provider portal, or by caregivers and youth through survey responses. Magellan ensures the data is valid and reliable via automated reporting with defined rules and quality assessment of the scorecard results.

Improvement Strategies

Magellan has released a provider scorecard every quarter since the inception of the Provider Scorecard initiative in June 2018. During this time, Magellan has confronted several barriers to data collection and analysis and has implemented interventions accordingly. For example, to improve responses for the WFI-EZ survey which serves as a data source, Magellan implemented two key interventions:

1. Reviewed tracking tools monthly to confirm each survey had a response and recorded reasons why surveys were not returned.

2. Assigned a survey coordinator to call providers directly to offer assistance with survey completion and problem solving. The survey coordinator staff helped providers facilitate conversations with the enrollee and their family to encourage survey completion.

Data Analysis and Interpretation of Results

To determine provider performance for each measure, Magellan established thresholds for provider performance. The provider scorecard shows a list of de-identified provider codes and their performance on all measures for the time period. Performance data is color-coded to demonstrate a short-hand evaluation of performance based on Magellan's goals and thresholds (e.g., green indicates good range, red indicates needs improvement, yellow indicates approaching good range).

Assessment of Improvements

For SFY 2019, Magellan submitted provider scorecards dated September 2018, December 2018, March 2019, and June 2019. Table 20, on the following page, shows the summarized scorecard data results, which compares the most recent scorecard within the reporting period (the June 2019 scorecard) against the baseline. For the full dataset of quarterly data (from September 2018 to June 2019), please refer to Appendix G.

Analysis of the data trends over time indicates overall improvement in most measures, as summarized below:

- Five of seven applicable measures showed improvement toward goals since baseline. One measure decreased in performance since baseline and one measure did not change since baseline.
- Three of eight measures were within target range during the most recent scorecard within the reporting period and five of eight measures did not reach target range as defined initially.

Table 20. Scorecard Data Results[18]

Measure	Measure Data		HFWA Goal	Overall Improvement Toward Goal Since Baseline[19]	Met Target Range (HFWA Goal)[20]
	Baseline	Jun-19			
Family Contact	72%	84%	100%	Yes	No
ALOS	340	325	270-450 days	N/A	Yes
Not Engaged (<60 days)	16%	16%	<10%	No	No
Implemented (>180 days)	59%	62%	>80%	Yes	No
Family Response	50%	73%	>70%	Yes	Yes
Complete Documentation	97%	90%	100%	No	No
CANS Improved %	53%	60%	>50%	Yes	Yes
Graduation Success	38%	45%	>75%	Yes	No

Magellan did not provide evidence to determine if the observed performance improvement is statistically significant, and did not conduct analyses to indicate if the change in performance was due to the intervention or by random chance.

Areas of Strength and Needed Improvement for Selected Improvement Projects

Magellan's SFY 2019 PIPs demonstrate several strengths and areas for improvement, described below.

Strength: Magellan maintains ongoing communication and continuously incorporates provider input to address barriers and implement interventions.

Magellan's staff demonstrates a concerted effort around connecting and communicating with providers regarding areas for improvement, areas of strength, and identification of barriers. Creating multiple streams of communication allows for continuous feedback and reassessment, and therefore strengthens the program. Examples of ongoing communication and incorporation of input include:

[18] Percentages were rounded to integers.

[19] Indicates whether the most recent scorecard measure was closer to the goal than it was at baseline.
[20] Indicates whether the most recent scorecard measure stayed within the target range (HFWA Goal).

- Across both PIPs, Magellan staff made a targeted effort to address provider performance and create actionable steps (e.g., additional training and reassessment) during monthly one-on-one conversations with the provider.
- For the Minimum Contacts PIP, Magellan created a provider survey to identify challenges and implement strategies to address these challenges. The survey results identified several barriers described previously, and Magellan took a targeted approach by implementing nine interventions intended to address several of the identified barriers.
- For the Provider Scorecard PIP, Magellan releases a provider scorecard every quarter. Magellan monitors performance and continuously reviews the results of the scorecard during one-on-one conversations with providers.

Needed Improvement: The data analysis process for the selected PIPs is not clearly documented.

Magellan staff demonstrated extensive institutional knowledge on how to create the data reports, analyze the reports for errors, and discover trends in the data for both PIPs. Many of these processes are established informally, but not documented in writing.

Recommendation for Magellan: Develop a data analysis plan for internal tracking and external communication.

It is important to create a roadmap for organizing and analyzing the data. For sustainability of the PIPs, Magellan should consider recording these processes in a clear plan of action. The data analysis plan should clearly define:

- Goals for data analysis and tracking
- Roles and responsibilities for staff members, including data quality control
- Data collection instruments will be used
- Data sources
- How and when data will be consistently and accurately collected

A data analysis plan is helpful for Magellan to confirm that the data analysis method follows the prescribed procedures and ensures reliability and consistency in the data. Furthermore, a clearly defined roadmap facilitates future replication of the data and clarifies processes for external validation. If there is clear documentation about the data analysis method, others may be able to replicate the results reliably using the same data. Clear documentation may also reveal any flaws in the approach, and therefore prevent inaccurate results in the future.

Needed Improvement: Magellan did not provide a formal assessment of barriers and related interventions for the provider scorecard PIP.

For the Minimum Contacts PIP, Magellan intentionally sought out barriers and implemented mitigation efforts. However, Magellan did not create a formal assessment of barriers and related interventions for the Provider Scorecard PIP.

Recommendation for Magellan: Formally document barriers and related interventions for all PIPs.

Magellan should identify and document barriers to provider performance by considering stakeholder engagement and data analysis. This will allow Magellan to identify strategies to address the major barriers found during the research phase. Magellan should consider interventions that address system changes, which are likely to induce permanent change. Additionally, Magellan may standardize and continuously monitor successful interventions and incorporate revisions if the original interventions are not successful.

Section VI. Validation of Network Adequacy

Navigant reviewed Magellan's network adequacy during SFY 2019 in accordance with:

- Requirements set forth in 42 CFR § 438.68 for Wyoming to develop and enforce network adequacy standards.
- WDH requirements included in the SFY 2019 SOW.

Based on these federal and State standards, Navigant identified 30 elements to evaluate Magellan's compliance with network adequacy; however, only 11 of those elements are applicable to the CME program. Appendix H includes Navigant's review tool for validating the adequacy of Magellan's network. The following network adequacy standards are not applicable to the CME program:

- **Time and distance standards:** Time and distance standards do not apply to the CME program. For example, the community-based nature of the HFWA model involves providers traveling to the enrollees rather than enrollees traveling to a clinic or facility. The enrollee's team decides meeting location and all meetings are scheduled at a time/place that works best for enrollees. Therefore, travel time and distance do not impact enrollee access. Rather, Magellan measures provider capacity and network adequacy through provider-to-beneficiary ratios.
- **Capacity of certain provider types:** The CME program provides care coordination services only and does not provide any clinical services. Providers must be certified in HFWA, but do not fall into typical clinical provider categories. Therefore, clinical provider categories (e.g., primary care, specialists, hospital, pharmacy, etc.) do not apply to the CME program.
- **Long-term services and supports (LTSS):** Requirements around LTSS do not apply to the CME program, which delivers care coordination services to children with complex behavioral needs.
- **Indian health care providers (IHCPs):** Although Magellan serves tribal enrollees, IHCPs are not involved because the program does not offer clinical services.
- **Exceptions process:** The provider-specific network adequacy standards do not apply to this program, and therefore there are not exceptions to the provider-specific network standards.
- **Publication of network adequacy standards:** The requirement to publish network adequacy standards online applies to States who dictate time and distance standards for specific providers LTSS providers, neither of which apply to the CME program.

See Table 21, on the following page, for an overview of Magellan's compliance levels with the applicable elements.

Table 21. Network Adequacy Assessment

Category from 42 CFR § 438.68	# Elements Met	# Elements Not Met	Total # Elements
General Rule	0	1	**1**
Provider-Specific Network Adequacy Standards	1	0	**1**
Development of Network Adequacy Standards	8	1	**9**
Total	**9**	**2**	**11**

Overall, Magellan and WDH met nine of the 11 applicable elements and did not meet two of the applicable elements.

Areas of Strength and Needed Improvement

WDH and Magellan fully satisfied the majority of network adequacy standards.

WDH sufficiently considered the following elements in its SOW, and Magellan's policies indicate compliance with these State-established standards:

- Anticipated Medicaid enrollment
- Expected utilization of services
- Characteristics and health care needs of specific Medicaid populations covered in the PAHP contract
- Numbers and types of network providers required to furnish the contracted Medicaid services
- Numbers of network providers who are not accepting new Medicaid patients

Additionally, Magellan's provider network meets preferred language and communication standards for enrollees with limited English-proficiency. Per the enrollee and provider handbooks, Magellan provides free interpreters and information written in other languages for enrollees whose primary language is not English.

Finally, Magellan has built the use of telehealth into its program. When the enrollee and provider are not in the same physical location, enrollees and providers can meet via telehealth to allow care coordination to continue. Magellan may use this option at any time, and especially when there is severe weather or other issues which prevent a provider and enrollee from meeting in person.

Strength: Magellan provides several opportunities for provider training and development.

Magellan has a robust training program for new and existing providers. As providers enter the CME program's network, they must undergo two levels of training (Tier 1 and Tier 2) before becoming fully certified. Tier 1 training incorporates classroom-based learning and covers the following areas:

- Overview and phases of HFWA
- Required documentation (e.g., plan of care; Strengths, Needs, and Culture Discovery (SNCD); Child and Adolescent Needs and Strengths (CANS))
- Provider portal
- Working with the Wyoming court system
- Abuse, neglect, exploitation and ethics

During Tier 2, providers begin working with families and coordinating care under a coach's supervision. Providers begin to receive on-the-job training and must also demonstrate the following competencies during Tier 2 assessments:

- Ability to orient the family, prepare the family, conduct a child and family team (CFT) meeting, and conduct a crisis plan meeting
- Ability to complete wraparound documentation, including SNCD, crisis plan, progress notes, transition plan, etc.

In addition to initial trainings, providers demonstrate their skills as part of annual re-certifications. Providers also have access to twice monthly learning opportunities and can provide input regarding the training topics.

Strength: Magellan maintains consistent and ongoing communication with providers.

Magellan provides several opportunities for open communication between Magellan staff and providers:

- **Monthly one-on-one calls:** The network manager and meets with providers to discuss performance and any issues.
- **Monthly all-provider calls:** Magellan provides relevant updates and reminders to the provider network.
- **Weekly e-newsletters:** Magellan provides updates and reminders to the provider network.
- **Informal communication:** Providers may also communicate frequently with other staff they come into contact with, such as the training manager. Some Magellan staff indicated they try to serve as an additional resource to providers by being available and accessible.

Needed Improvement: There are discrepancies in provider enrollment data between WDH and Magellan.

Navigant reviewed provider network listings from both WDH and Magellan to confirm the listings align for SFY 2019. There were inconsistencies in the provider enrollment data between WDH and Magellan, including the following:

- In some instances, providers appeared on one list but not the other.
- The total number of providers did not align.

- In some versions of Magellan's provider listing, the listing included provider applicants who were not fully certified as active network providers. Magellan acknowledged this issue and has been making appropriate corrections.

WDH indicated that discrepancies between the provider listings are to be expected, and that Magellan's provider listing is more accurate and up-to-date. While slight discrepancies may be anticipated, one would expect the listings to be in closer alignment since several months have passed since the review period (i.e., any differences in system timing should no longer be an issue).

Recommendation for WDH: Implement regular validation checks of provider enrollment data.

WDH should implement regularly scheduled validation checks of the data Magellan provides to confirm it aligns with information in WDH's system, with a small margin for differences in real time. To confirm accurate recordkeeping and consistent provider enrollment reconciliation efforts, WDH should clearly document these validation efforts and acceptable margins for differences. Additionally, WDH and Magellan should work together to determine criteria for removing disenrolled providers from both WDH and Magellan's listing.

Needed Improvement: There is a lack of clear direction and strategy for enrollee recruitment.

According to Magellan, enrollee recruitment occurs via two main methods – most enrollments come from active providers and a minority come from referrals. When providers are new to Magellan's network, they are responsible for "creating their own business" by connecting with resources in the communities they serve. Providers are expected to obtain their own "clients" and also do not receive payment if they are not actively serving enrollees.

While WDH provides Magellan with a listing of potential enrollees who appear to meet the CME program's eligibility criteria, WDH has not outlined any expectations for Magellan or providers regarding enrollee recruitment. Magellan has also indicated that it is difficult to reach the enrollees on the listing due to outdated or incorrect information.

Although there is potential for the CME program to serve more enrollees, the current enrollment methods may make this difficult.

Recommendation for WDH: Facilitate a more targeted recruitment strategy.

WDH may facilitate a more targeted recruitment strategy by requiring use of the listing of potential enrollees. WDH may consider incorporating targets for outreach and develop/promote best practices for Magellan and providers for enrollee recruitment. However; this would require WDH to ensure the listing stays up to date with accurate information.

Needed Improvement: Magellan's network does not satisfy full geographic coverage.

Although Magellan has provider coverage in all *regions* of Wyoming, Magellan does not have provider coverage in all *counties* of Wyoming. Geographic mapping of SFY 2019 provider coverage indicates where providers have committed to serve; providers typically commit to an area they are physically in and have discretion to decide the extent of the state they will cover. According to the geographic maps provided:

- CME program enrollees resided in 14 of Wyoming's 23 counties during the review period.
- Almost all counties with enrollees also had FCCs and FSPs; however, one county, Hot Springs, had one enrollee but no FCCs nor FSPs committed to serve this county.

Magellan indicates that the Hot Springs example was resolved due to a provider from a different county stepping in to serve the enrollee via telehealth. However, this action was not clearly documented.

For instances when providers and enrollees cannot meet face-to-face, they may use telehealth, which counts as a face-to-face visit to Magellan. Magellan may use this option at any time, and especially when there is severe weather or other issues which prevent a provider and enrollee from meeting in person. If an enrollee has a preference for in-person meetings, but only telehealth is available, the enrollee would need to wait until another option became available.

Recommendation for Magellan: Document strategies to expand provider geographic coverage.

Although Magellan acknowledges facing challenges due to Wyoming's unique geography and climate, Magellan does not clearly indicate strategies for reaching under-served areas of the state. Magellan may be better prepared by documenting a plan of action for geographic areas that are not covered and taking into consideration alternate approaches if telehealth is not the enrollee's preference.

Needed Improvement: Magellan does not track information which may be beneficial to better understanding the provider network.

Magellan staff do not formally track the following information regarding the provider network:

- **Full time employment status:** Magellan indicated that providers have the ability to work full-time, half-time, or quarter-time. When Navigant requested documentation, Magellan referred to other documents to inform this information, such as caseload limits and geographic mapping. However, it appears there is not a place Magellan staff can quickly refer to in order to determine a provider's employment status and availability.
- **Potential enrollee waiting time:** Magellan indicated that although the CME program does not have a waitlist, potential enrollees who request a certain provider may choose to wait if that provider is at capacity. Magellan staff were not sure of how long this wait could last or how many of these enrollees that choose to wait eventually enroll with the program.
- **Reasons for provider separations:** Magellan is able to explain reasons that providers leave the network, but the information is based on informal discussions with staff. For

example, Magellan indicated there may be a higher turnover rate for providers who are just starting the training/certification phase.

Recommendation for Magellan: Track certain information about the provider network to facilitate improved provider recruitment and retention.

Magellan would benefit from establishing ways to track providers' full-time employment status, potential enrollee waiting time, and reasons that providers leave the network (via exit interviews or surveys). It is important for Magellan to track this information in a formal manner so that other staff, or future staff, will be able to easily obtain this information.

Exit interviews or surveys may also inform why Magellan has providers who do not finish the initial training/certification, which could provide Magellan with ways to improve the onboarding process. Additionally, being able to track information on provider turnover may benefit Magellan's recruitment and retention efforts.

Needed Improvement: There is a lack of accountability for network providers.

Magellan encourages a flexible work environment for providers; however, too much flexibility may make it difficult to hold providers accountable. There are two main areas where providers lack accountability:

- **Training timelines:** The Provider Handbook indicates that Tier 1 training should be completed within 30 days and Tier 2 should be completed within 60 days. However, Magellan indicated that these timeframes are flexible; some providers may take longer or may pause and re-start.
- **Provider directory:** Providers have the ability to update the provider directory and indicate whether they are accepting new enrollees, but it is an optional task for providers. Therefore, providers may often neglect to keep the directory up to date. The provider directory appears to be the main source that an enrollee would use to select a provider (via referral), so it is important that the information is accurate. Additionally, potential enrollees would not select a provider who is at capacity if the enrollee can clearly see whether the provider is accepting clients from the website. Currently, Magellan staff must spend additional time confirming whether a provider has capacity when the provider is requested.

Recommendation for WDH and Magellan: Incentivize providers to operate in alignment with requirements and best practices.

It is important for Magellan to balance provider accountability with the realities of the CME program's network – providers are unfamiliar with documentation requirements and do not receive compensation during initial trainings. For this reason, WDH and Magellan may find it more beneficial to incentivize providers rather than impose penalties. WDH may consider adding language to the SOW to address areas where providers should be held more accountable or may choose to address performance issues in the future using the pay for performance tiered rates that are currently under development.

Needed Improvement: Provider materials do not clearly indicate how to access translation services.

The provider and member handbooks clearly indicate that interpreters and translation services are available for Magellan communications and resources are available for individuals with disabilities. However, documentation does not clearly indicate how providers would obtain assistance for translation services. Per discussions with Magellan, providers would contact a member of the clinical team to request translation over the phone.

Recommendation for Magellan: Clarify how providers can access translation services.

Providers may benefit from clear instructions on how to access translation services for enrollees whose primary language is not English.

Section VII. Conclusion

Navigant's review of Wyoming's CME program resulted in identification of six areas of strength, 16 areas of needed improvement, and 17 recommendations in relation to quality, timeliness, and access to services. Overall, major strengths of the CME program include, but are not limited to:

- Magellan has robust systems in place to assure that enrollee rights and protections are safeguarded and communicated via enrollee materials.
- The CME program incorporates cultural competency into nearly every aspect of its program and delivery of services to enrollees.
- Most of the Magellan-identified goals from quarterly reports adequately address the performance measures outlined in the SOW.
- Magellan staff are knowledgeable, engaged, and invested in the youth and providers of the CME program.
- Magellan maintains ongoing communication with providers, continuously incorporates provider input, and provides ample opportunities for provider training and development.

However, there are also areas of needed improvement in the following:

- Both Magellan and WDH have areas where more documentation, record-keeping, and establishment of formal processes would be helpful and could lead to better coordination and more meaningful information.
- There are discrepancies in terminology and timeframes regarding grievances, appeals, and adverse benefit determinations.

Following WDH's review of this report, WDH and Magellan will need to determine which opportunities for improvement they anticipate moving forward with to improve operation of the CME program.

Appendices

Appendix A: Abbreviations and Acronyms

ASL	American Sign Language
CANS	Child and Adolescent Needs and Strengths
CAP	Corrective Action Plan
CAPS	Claims Adjudication Payment System
CASII	Child and Adolescent Service Intensity Instrument
CFR	Code of Federal Regulations
CFT	Child and Family Team
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMHW	Wyoming's 1915(c) Children's Mental Health Waiver
CME	Care Management Entity
CMS	Centers for Medicare & Medicaid Services
DHCF	Division of Healthcare Financing
EDW	Enterprise Data Warehouse
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ESCII	Early Childhood Service Intensity Instrument
FCC	Family Care Coordinator
FFS	Fee-For-Service
FSP	Family Support Partner
HFWA	High Fidelity Wraparound
HIPAA	Health Insurance Portability and Accountability Act
IHCP	Indian Health Care Provider
ISCA	Information System Capabilities Assessment
IT	Information Technology
LOC	Level of Care
LOS	Length of Stay
LTSS	Long-Term Services and Supports
OOH	Out-of-Home
OP	Operational Requirement
PAHP	Prepaid Ambulatory Health Plan
PCCM	Primary Care Case Management
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
PMPM	Per-Member Per-Month
PRTF	Psychiatric Residential Treatment Facility
SCH	Seattle Children's Hospital

SED	Serious Emotional Disturbance
SFY	State Fiscal Year
SNCD	Strength, Needs, and Culture Discovery
SOC	System of Care
SOP	Standard Operating Procedure
SOW	Statement of Work
SPMI	Serious and Persistent Mental Illness
SQL	Structured Query Language
TMTMTY	Too Much, Too Many, Too Young (Medication Standards)
WDH	Wyoming Department of Health
WFI-EZ	Wraparound Fidelity Index-Short Form
YSP	Youth Support Partner

Appendix B: EQR Protocol 1 Review Tool

See attached.

Appendix C: SFY 2019 Performance Measures

This appendix outlines the 31 operational requirements and performance measures from the SFY 2019 contract Navigant reviewed in accordance with EQR Protocol 2.

Table 22. State Fiscal Year 2019 Operational Requirements

OP Number	Contract Requirement	Performance Measure
Category:	High Fidelity Wraparound (HFWA)	
OP-01	The Contractor must provide a provider network certification process focusing on ethical practices. Training components may be included within the required SOC and HFWA values training. Contractor should address ethical issues on a case-by-case basis and at re-credentialing.	The Contractor must provide percent of HFWA providers in the network who complete training including ethics. The AGENCY reserves the right to request additional information be included. Requested data must be included on the next quarterly report.
OP-02	The Contractor must notify the youth and/or the families of admission to the CME. All successful and attempted contacts should be documented by the Contractor.	The Contractor must notify a child and/or family of enrollment within two (2) working days of the final eligibility determination [1915(b) waiver] or date of the notification email from the State [1915(c) waiver]. Data showing compliance with this requirement shall be included in the quarterly data report.
OP-03	The Contractor must ensure Family Care Coordinators (FCC) complete a Strengths Needs and Cultural Discovery (SNCD) for each family according to the HFWA process.	The Contractor must provide a complete SNCD submitted prior to the first child and family team (CFT) meeting. Data showing compliance with this requirement shall be included in the quarterly data report.
OP-04	After the family has selected their FCC, the Contractor must ensure the FCC contact the family timely.	The Contractor must ensure that the FCC must contact every youth and/or family within three (3) working days after being chosen as the FCC to begin the HFWA process.
OP-05	The Contractor must ensure the FCC works with the family, youth, and CFT at the start of the wraparound process to develop a Plan of Care (POC) based on the individual family and child or youth needs, strengths and preferences. All POCs must include team member signatures, specifically youth (if age appropriate) parent/guardian, along with FCC at a minimum. The FCC must collaborate with child and family serving agencies that are involved with the child or youth and his or her family.	The Contractor must ensure that a POC must be developed within forty-six (46) calendar days of initial youth enrollment. Data showing compliance with this requirement shall be included in the quarterly data report.
OP-06	The Contractor must ensure each FCC establishes a crisis plan as part of the child's overall POC to assist in stabilizing the child and family while helping to manage crises. The initial crisis plan shall be developed during the	The Contractor must develop a crisis plan with the HFWA team, which must be included with every POC for all enrolled youth. Data showing compliance with this requirement shall be included in the quarterly data report.

OP Number	Contract Requirement	Performance Measure
	initial SNCD process and updated with the POC.	
OP-07	The Contractor must ensure the FCC invites the chosen Family Support Partner (FSP) and/or Youth Support Partner (YSP) to participate in the wraparound process and CFT meetings.	The Contractor must provide the current number of enrollees and the percentage of youth enrolled with FSP and the percentage of youth enrolled that have YSP. Data showing compliance with this requirement shall be included in the quarterly data report.
OP-08	The Contractor must ensure the FCC/FSP to youth ratio is no more than one (1) FCC/FSP for a total of ten (10) youth (1:10), regardless of the youth's program or referral source. The YSP to youth ratio should be no more than one (1) YSP for a total of twenty-five (25) youth (1:25).	The Contractor must ensure that the FCC will not have more than ten (10) enrolled youth at a time. A provider will not have more than ten (10) enrolled youth as an FSP and will not have more than twenty-five (25) enrolled youth as a YSP. Percentage of individual providers showing this requirement is met will be reported quarterly.
OP-09	The Contractor must ensure the FCC holds regularly scheduled CFTs and updates to the POC based on the needs of the family, in accordance to the AGENCY-defined timeframes.	The Contractor must hold a CFT and update the POC within the last thirty (30) days of a ninety (90) day authorization. Data showing compliance with this requirement shall be included in the quarterly data report.
OP-10	The Contractor must ensure the FCC maintains regular in-person and telephone contact with both the youth and his or her caregiver based on the AGENCY-defined timeframes. The CFT is considered face-to-face contact.	The Contractor must ensure that after HFWA enrollment begins, the FCC shall contact both the youth, dependent upon age, and his/her caregiver at least one (1) time per week via phone and shall have face-to-face contact with the child and his caregiver a minimum of two (2) times per month. Data showing compliance with this requirement shall be included in the quarterly data report.
OP-11	The Contractor must document whether or not an enrolled youth has an identified primary care provider (PCP).	The Contractor must demonstrate the percentage of enrolled youth with a PCP. Percentages of data showing compliance with this requirement shall be included in the quarterly data report.
OP-12	The Contractor must ensure the FCC engages representatives from other child serving systems that have involvement within their community. Example: DFS, permanency planning, foster care, changes in custody, are evident in the POC.	The Contractor must provide a quarterly report showing the percentage of CFTs held with invited formal supports.
OP-13	The Contractor must ensure FCCs communicate an out-of-home placement and work with children and youth who are in out-of-home placements to determine if services and supports can be safely, effectively, and appropriately provided in the community.	The Contractor must provide the number of enrolled youth in out-of-home placement during the reporting period and the percentage of youth disenrolled due to out-of-home placement.
OP-14	The Contractor shall ensure that children and youth placed out-of-home settings are evaluated through the Child	The Contractor must demonstrate the following:

OP Number	Contract Requirement	Performance Measure
	and Adolescent Service Intensity Instrument (CASII) and Early Childhood Service Intensity Instrument (ESCII) and level of care (LOC).	Total number of enrollees with a documented level of care satisfying AGENCY criteria for participation in the program/Total number of enrollees. This metric shall be reported as a percentage. Total number of annual re-evaluations conducted on or prior to the expiration date of the previous evaluation/assessment/Total number of re-evaluations conducted. This metric shall be reported as a percentage. New evaluations are required, a new CASII/ECSII upon return to community. Show the percent of youth returned to the community from out-of-home, with a new evaluation. Report showing number of new evaluations quarterly.
OP-17	The Contractor must ensure FSPs hold monthly family support group meetings with enrolled youth in every county/region in Wyoming; and YSPs hold monthly youth support meetings in all counties/regions. During the monthly meetings, FSPs should include information regarding family voice and choice.	The Contractor must provide a quarterly report identifying all FSP and YSP support group meetings held in the previous quarter including the location and attendees.
Category:	Operations	
OP-15	The Contractor must ensure each FCC has knowledge of the current medications for children and youth they serve. If there is a concern, CME will consult with Seattle Children's Hospital (SCH).	The Contractor must provide a quarterly report with the number of consultations CME has with SCH.
OP-16	The Contractor must assist families with the application or admission process for children and youth referred to the Contractor. Report quarterly to the AGENCY on the number of children and youth referred, and turnaround time for referrals.	The Contractor must report quarterly to the AGENCY on the number of children and youth referred, the referral source, and turnaround time for referrals. The Contractor must respond to any referral or request for enrollment within three (3) working days. The AGENCY reserves the right to request that additional information be included. Requested data must be included on the next quarterly report.
OP-18	The Contractor must serve all geographic areas and target populations within the State. Contractor will have staff physically available throughout the regions of the State as indicated by the growth and needs of the Contract. Additional populations may be added or modified as appropriate and agreed upon by both parties in writing.	The Contractor must provide a quarterly report of all enrolled youth and families served in the reporting period and a report of Contractor's staff's presence in each geographic region.
OP-19	The Contractor will only conduct prior authorization (PA)/utilization management (UM) of HFWA, respite	The Contractor must issue service authorizations and/or adverse action notifications as a result of the concurrent

OP Number	Contract Requirement	Performance Measure
	and Youth and Family Training (YFT) and Support Services provided to enrolled youth. The AGENCY currently has an alternate agreement in place for conducting PA and UM for children and youth requiring a PRTF level of care or acute psychiatric stabilization according to the AGENCY's criteria. The Contractor must work with this vendor frequently to ensure timely and efficient referral between programs. The PA/UM process referenced above will require the Contractor to implement Medical Necessity reviews and decisions for eligibility into the CME. During the approved period this will include a concurrent review process to monitor clinical intervention tied to eligibility justification, delivery of benefits (HFWA, Respite, and YFT) and adherence to any benefit limitations. The mechanism and documents to be reviewed for the concurrent review will include the plan of care (POC), crisis plan, CASII, and CANS.	review no later than fourteen (14) calendar days after receipt of the plan, with a possible extension of fourteen (14) calendar days if the provider or enrollee requests an extension or the Contractor justifies the need for additional information and how the extension is in the enrollee's best interest. If the Contractor extends the fourteen (14) calendar day service authorization notice timeframe, it must give the enrollee written notice of the reason for the extension and inform the enrollee of the right to file a grievance in he or she disagrees with the decision. If the provider indicates or the Contractor determines, that following the standard authorization and/or adverse action decision time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an authorization decision and provide notice no later than three (3) working days after receipt of the request for service. This may be extended up to fourteen (14) calendar days if the enrollee requests an extension or the Contractor justifies a need for additional information and is able to demonstrate how the extension is in the enrollee's best interest. If the Contractor's review results in an adverse action, the Contractor shall provide a thirty (30) calendar day advance notification to the enrollee and the enrollee's family care coordinator prior to implementing a change in program eligibility and/or service amount, duration or frequency. The Contractor must report quarterly on the status of the Contractor's relationship with the PA/UM vendor. The AGENCY reserves the right to request that additional information be included. Requested data must be included on the next quarterly report.
OP-20	Flex funds are funds used for expenditures in support of the youth and family's POC for a youth and family receiving services from providers. A reasonable cost for flex funding is one that, in its nature and amount, does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. Unallowable costs include, but are not limited to the following: A. Alcoholic Beverages;	The Contractor must provide a quarterly report describing how flex funds were spent. The report should include the recipient, the amount, reason for the flex fund distribution, and a brief description of the flex funds use/purpose.

OP Number	Contract Requirement	Performance Measure
	B. Bad Debts; C. Contributions and Donations; D. Defense and prosecution of criminal and civil proceedings, claims, appeals and patent infringement; E. Entertainment Costs (unless specific written approval has been provided in advance by the AGENCY); F. Fines and Penalties; G. Interest on Borrowed Capital/Lines of Credit; H. Costs of Organized Fundraising; I. Costs of Investments Counsel/Management; J. Lobbying; and K. Renovation/remodeling and Capital Projects (unless specific written approval has been provided in advance by the AGENCY).	
OP-21	The Contractor must notify the AGENCY immediately and in writing of the following: Any event that affects the health, safety, and welfare of an individual, as well as administrative and quality of care complaint.	The Contractor shall notify the AGENCY within two (2) working days of any critical incident. Data showing compliance with this requirement shall be included in the quarterly data report.
OP-22	The Contractor must send complaints received about the Contractor to the AGENCY.	The Contractor must respond to any complaint received directly or by the AGENCY in regard to Contractor performance within five (5) working days after receiving the complaint. Data showing compliance with this requirement shall be included in the quarterly data report.
OP-23	The Contractor is responsible for the accurate and timely submission of all quarterly reporting requirement metrics outlined in the following sections of the Quality Monitoring, Improvement, Assessment, and Federal Reporting Requirements in Attachment A: Statement of Work: A. Initial and Re-evaluation for Enrolled Enrollees: Level of Care B. Application of Evaluation Instruments: CASII, ECSII, CANS, and Level of Care C. Qualified Providers D. Service Coverage and Individual Plan of Care E. Health and Welfare	The Contractor must provide quarterly reports to the AGENCY that demonstrates alignment with reporting metrics in the identified sections. In addition, the Contractor must submit an annual report that summarizes all quarterly findings to the AGENCY.
Category:	Project Management	

OP Number	Contract Requirement	Performance Measure
OP-24	The Contractor must report all critical incidents.	The Contractor must report all critical incidents in accordance to Wyoming State Statute and processes defined in the 1915 (b) and 1915 (c) program waivers. Data showing compliance with this requirement shall be included in the quarterly data report.
Category:	Provider Network	
OP-25	The Contractor must ensure all providers within its provider network are enrolled Medicaid Providers.	The Contractor must ensure new and existing providers are enrolled as Medicaid Providers. Data showing compliance with this requirement shall be included in the quarterly data report.
Category:	System of Care	
OP-26	The Contractor must provide an annual report to the AGENCY detailing the Contractor's expanding availability and service capacity from the past year.	The Contractor must provide an annual report to the AGENCY detailing the Contractor's expanding availability and service capacity from the past year. Data reported annually.
OP-27	The Contractor must demonstrate a relationship with multiple agencies, organizations and resources (at the State and local level), including, but not limited to: A. Family-based or family-run organizations; B. State and local agencies serving population of focus; C. Community-based organizations; D. Schools; E. Informal resources in the community, including SOC resources; F. Child Welfare and Juvenile Justice stakeholders and systems; and G. Current resources such as 211 (resource to human services referrals).	The Contractor must provide quarterly progress reports that include number of meetings with stakeholders, agencies, and resources across the state. This includes all QIC and Advisory council meetings.
OP-28	The Contractor must work closely with the AGENCY for referring children and youth to the appropriate waiver.	The Contractor will demonstrate that the Contractor will make referrals to the AGENCY for all youth in need of CMH waiver within two (2) calendar days of discovery.
Category:	Technical	
OP-29	The Contractor must use its IT System track and report encounter data via line level detail per unit of service. Data shall be submitted to the AGENCY's MMIS.	The Contractor must track utilization data at least monthly. Report the percent of providers submitting claims within ninety (90) calendar days. Data showing compliance with this requirement shall be included in the quarterly data report.
OP-30	The Contractor must conduct satisfaction surveys for both enrolled enrollees and all network providers.	The Contractor must provide results of enrollee satisfaction surveys to the AGENCY for guardians/parents and youth 18 or older upon transition from HFWA asking specifically if they

OP Number	Contract Requirement	Performance Measure
		would recommend HFWA to anyone else. These results will be required annually and utilized to inform the performance improvement process. The Contractor will also provide results of provider satisfaction surveys to all current network providers throughout Wyoming, annually.
Category:	Financial	
OP-31	The Contractor must submit, annually, an independently audited financial statement that attests to the fair and accurate presentation of the Contractor's financial position.	The Contractor must provide an audited financial statement, which includes, but is not limited to, cash flow statement, statement of activities/income statement and statement of financial position, or balance sheet and expenses specific to this contract to demonstrate solvency. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards and to the AGENCY on an annual basis.

Appendix D: Operational Requirements Review Tool

See attached.

Appendix E: Outcome Measures Review Tool

See attached.

Appendix F: Goals with Underperforming Data

This appendix provides additional information from EQR Protocol 2 relating to goals with underperforming data.

Goals marked as "declining" reported a metric for Quarter 4 which was at least five percentage points lower than the metric for the same goal in Quarter 1, indicating that the goal moved further from its target during the review period.

Table 23. Goals with Declining Performance

Goals	Q1	Q4
OP-01a: Rate of providers in network meeting all requirements	100%	87%
OP-01b: 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	102%[21]	87%
OP-01d: Rate of new providers completing initial provider training	100%	79%
OP-04: Rate of new referrals contacted by chosen FCC within 3 working days	56%	50%
OP-05: Rate of enrollments with POCs developed within 46 days of enrollment	86%	76%
OP-09a: Rate of CFT meetings held during the last 30 days (two weeks prior to 7/1/2018) of the authorization period	71%	65%
OP-09c: Rate of POCs in which services authorized and reflect participants' needs	98%	90%
OP-09d: Rate of POCs with participant/guardian signature affixed	98%	90%
OP-09e: Rate of POCs where services and supports are provided in type, scope, amt, duration, frequency	98%	90%

[21] The measure creator explained that this measure is greater than 100 percent because some providers who received training were not counted in the provider network at that time. However, Magellan may need to refine this measure to confirm it only captures *in network* providers.

Appendix G: Scorecard Data Trends (Full Quarterly Data from September 2018 to June 2019)

Table 24. Scorecard Data Trends during SFY 2019

Measure	Measure Data					HFWA Goal	Overall Improvement Toward Goal Since Baseline[22]	Met Target Range (HFWA Goal)[23]
	Baseline	Sep-18	Dec-18	Mar-19	Jun-19			
Family Contact	72%	68%	73%	84%	84%	100%	Yes	No
ALOS	340	356	312	315	325	270-450 days	N/A	Yes
Not Engaged (<60 days)	16%	13%	15%	14%	16%	<10%	No	No
Implemented (>180 days)	59%	64%	63%	63%	62%	>80%	Yes	No
Family Response	50%	45%	55%	59%	73%	>70%	Yes	Yes
Complete Documentation	97%	98%	93%	92%	90%	100%	No	No
CANS Improved %	53%	51%	64%	59%	60%	>50%	Yes	Yes
Graduation Success	38%	41%	39%	42%	45%	>75%	Yes	No

[22] Indicates whether the most recent scorecard measure was closer to the goal than it was at baseline.
[23] Indicates whether the most recent scorecard measure stayed within the target range (HFWA Goal).

Appendix H: Network Adequacy Review Tool

See attached.