Wyoming Department of Health Care Management Entity Program SFY 2021 External Quality Review Technical Report

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Contents

Appendices *(attached separately)*

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 concurrent 1915(b) and 1915(c) waivers 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 with Guidehouse Inc. (Guidehouse) as the external quality review organization (EQRO) to perform the EQR of Magellan for services delivered in State Fiscal Year (SFY) 2021 and produce this Technical Report as set forth in 42 CFR § 438.364.

Scope of EQR Activities Conducted

At the request of WDH, Guidehouse performed the four mandatory EQR activities, and the Information Systems Capabilities Assessment (ISCA), as set forth in 42 CFR § 438.358:

- **Protocol 1**: Validation of Performance Improvement Projects (PIPs)
- **Protocol 2**: Validation of Performance Measures
- **Protocol 3**: Review of Compliance with Medicaid Managed Care Regulations
- **Protocol 4**: Validation of Network Adequacy

In addition to the four EQR protocols listed above, Guidehouse also conducted at the request of WDH, an effectiveness review of the State Medicaid Managed Care Quality Strategy in accordance with 42 CFR § 438.340. The effectiveness review served to evaluate Magellan's implementation and compliance with requirements set forth in the State's Quality Strategy and recommend steps for further alignment with the Quality Strategy.

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 the CME Program, which provides targeted case management services only.

Overall Review Findings

Guidehouse's review of Wyoming's CME Program resulted in identification of:

- 11 areas of strength
- 12 areas of needed improvement
- 18 recommendations in relation to quality, timeliness, and access to services

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 Medicaid's 1915(c) Children's Mental Health Waiver (CMHW). Table 1 below demonstrates the youth served in the CME Program since the program's inception.

Table 1. CME Enrollment[1]

Year	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
CME Youth Served	328	431	494	402	402	385

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 child and family team (CFT) 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) and 1915(c) Waiver Programs

The CME Program operates via authority granted under concurrent waivers – Wyoming Medicaid's Youth Initiative 1915(b) waiver and the CMHW 1915(c) waiver. Youth enrolled in Wyoming Medicaid who meet the 1915(b) waiver's clinical eligibility criteria may enroll with the CME and receive the program's care coordination benefits. Youth who are not eligible for Wyoming Medicaid but meet the clinical and financial eligibility criteria specified in the 1915(c) waiver may also access CME services and must participate in the CME Program to maintain waiver eligibility.

The CMHW 1915(c) waiver was initially approved by CMS in July 2006. When Wyoming Medicaid implemented the 1915(c) waiver, the wraparound approach to care coordination was still in its infancy. Wraparound was not considered an evidence-based model at that time but had proven successful across a variety of settings in preventing admission to and decreasing the length of stay for children and youth with complex behavioral health needs who had traditionally been served in more restrictive, out of home settings. Currently the 1915(c) waiver offers the Youth and Family Training and Support service, which is unique to youth enrolled through the 1915(c) waiver.

[1] CME Program Snapshot, SFY 2021. Received from the Wyoming Department of Health, November 19, 2021.

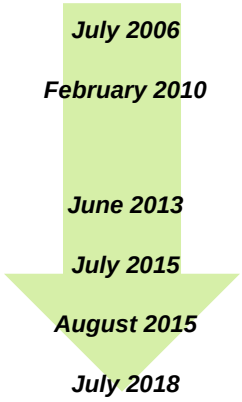
Wyoming's involvement with the Children's Health Insurance Program Reauthorization Act (CHIPRA) grant, as well as guidance from CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) regarding coverage of behavioral health services for youth with mental health conditions, helped guide Wyoming's creation of the CME Program. Wyoming added the 1915(b) waiver in combination with the existing 1915(c) waiver in order to contract with a single accountable CME.

In August 2015, 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 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 members (approximately 200 members in a given month) with varying periodic changes in direct service uptake, utilization, and provider network development.

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

Figure 1. CME Implementation Timeline



July 2006	CMS approves WDH's 1915(c) waiver application.
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.
July 2018	CME Program shifts from capitated payment to FFS payment.

Special Considerations for SFY 2021

There were numerous special considerations which impacted EQR activities for SFY 2021:

- **COVID-19 Public Health Emergency (PHE)**: As part of the State's response to the COVID-19 public health emergency, WDH filed a Section 1915(c) Emergency Preparedness and Response Appendix K waiver in March 2020 in conjunction with the Medicaid Agency's 1135 waiver for State Plan services and eligibility.[2] The Appendix K waiver temporarily replaced all in-person services with services delivered via telehealth for the duration of the PHE. Required use of telehealth services within the CME Program represented a significant shift in program operations and delivery in SFY 2020 and continued in SFY 2021. Additionally, the COVID-19 PHE

[2] Wyoming Department of Health. *Wyoming Combined Appendix K Waiver*. March 31, 2020 Available at: https://health.wyo.gov/wy-combined-appendix-k-3-31-2020/

necessitated the completion of review discussions as part of EQR activities virtually, per WDH's request of the external quality review organization (EQRO).

- **Contract Changes in Calendar Year (CY) 2021**: WDH entered into a new Statement of Work (SOW) with Magellan Healthcare beginning January 1, 2021. The new SOW outlined revised operational requirements, outcome measures, performance goals, and other program requirements for the Contractor. Since both versions of the SOW were in effect during this review period, the EQRO has incorporated all eligible requirements within the review.

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 of, and access to health care services provided to Medicaid recipients. An EQR Technical Report must be completed and made available to CMS, the public, and posted on the State's website by April 30 of each year.

The EQR consists of four mandatory and six optional activities, as listed in Table 2 below:

Table 2. EQR Activities and Protocols

	Activity
Mandatory	Protocol 1: Validation of Performance Improvement Projects
	Protocol 2: Validation of Performance Measures
	Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations
	Protocol 4: Validation of Network Adequacy
Optional	Protocol 5: Validation of Encounter Data Reported by the MCP
	Protocol 6: Administration or Validation of Quality of Care Surveys
	Protocol 7: Calculation of Additional Performance Measures
	Protocol 8: Implementation of Additional Performance Improvement Projects
	Protocol 9: Conducting Focus Studies of Health Care Quality
	Protocol 10: Assist with the Quality Rating of Medicaid and CHIP MCOs, PIHPs, and PAHPs

The activities described below align with Sections III through VIII of this EQR Technical Report.

- **EQR Protocol 1: Validation of Performance Improvement Projects**: MCOs, PIHPs, and PAHPs are required to implement performance improvement projects (PIPs) that focus on both clinical and non-clinical aspects of care. Protocol 1 specifies procedures for EQROs to use in assessing the validity and reliability of a PIP (42 CFR § 438.358(b)(i)).
- **EQR Protocol 2**: **Validation of Performance Measures**: Managed care plans (MCPs) must report standard performance measures as specified by the State. The State must provide to the EQRO and the MCP the performance measures to be calculated, the specifications for the measures, and the State reporting requirements. Protocol 2 tells the EQRO how to:
    - Evaluate the accuracy of the Medicaid/CHIP MCP reported performance measures based on the measure specifications and State reporting requirements; and
    - Evaluate if the MCP followed the rules outlined by the State agency for calculating the measures (42 CFR § 438.358(b)(ii)).

- **EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations**: The EQR is required to include a federal and State regulation compliance review of each MCP once in a three-year period. Protocol 3 specifies procedures to determine the extent to which MCPs comply with standards set forth at 42 CFR § 438.358(b)(iii), State standards, and MCP contract requirements.

  Note that states may meet the three-year requirement in different ways: for example, some review all MCPs at the same time once every three years; others conduct a complete compliance review on a subset of plans each year on a three-year cycle. While a full compliance review is only required for each MCP once every three years, the State must address any EQR findings in the next reporting year.

  Due to the SOW change effective January 1, 2021, the SFY 2021 compliance review encompassed all federal requirements, including requirements which were fully met in the previous year's review.

- **EQR Protocol 4: Validation of Network Adequacy:** The EQR must validate MCO, PIHP, or PAHP network adequacy during the review period to comply with requirements set forth in 42 CFR § 438.68 which requires the State to develop and enforce network adequacy standards.

- **Information Systems Capabilities Assessment (ISCA):** States must assess MCPs' information system capabilities to ensure that each MCP maintains a health information system that collects, analyzes, integrates, and reports data for areas including, but not limited to, utilization, grievances and appeals, and disenrollments for reasons other than the loss of Medicaid eligibility.

WDH contracted with Guidehouse Inc. (Guidehouse) as the EQRO to conduct the four mandatory EQR activities in a manner consistent with the protocols established by CMS to evaluate Magellan's provision of health care services during SFY 2021 (July 1, 2020 to June 30, 2021). WDH had previously contracted with Guidehouse to conduct the EQR to evaluate Magellan's activities during SFY 2018 (July 1, 2017 to June 30, 2018), SFY 2019 (July 1, 2018 to June 30, 2019), and SFY 2020 (July 1, 2019 to June 30, 2020). This EQR relies on interviews with WDH and Magellan staff, documentation provided by WDH and Magellan, and Guidehouse's industry experience working with CMS and health and human services agencies across the country. This report summarizes the findings of the EQR and provides recommendations for Magellan and WDH to improve operational and program performance.

Results of SFY 2020 External Quality Review

Guidehouse's SFY 2020 review of Wyoming's CME Program resulted in identification of 10 areas of strength, 13 areas of needed improvement, and 16 recommendations in relation to quality, timeliness, and access to services.

Of the 16 recommendations for WDH and/or Magellan:

- 6 recommendations have been fully addressed
- 3 recommendations have been partially addressed
- 3 recommendations have not been addressed
- 4 recommendations were not applicable or evaluated as part of SFY 2021 EQR Protocol selected by WDH

Table 3 below provides the distribution of recommendations across EQR protocols, as well as the number of recommendations by status as of SFY 2021 ("Fully Addressed", "Partially Addressed", "Not Addressed", or "Not Applicable"). Please refer to Appendix B for more information regarding details on specific recommendations from the SFY 2020 review period.

Table 3. Status of SFY 2020 Recommendations

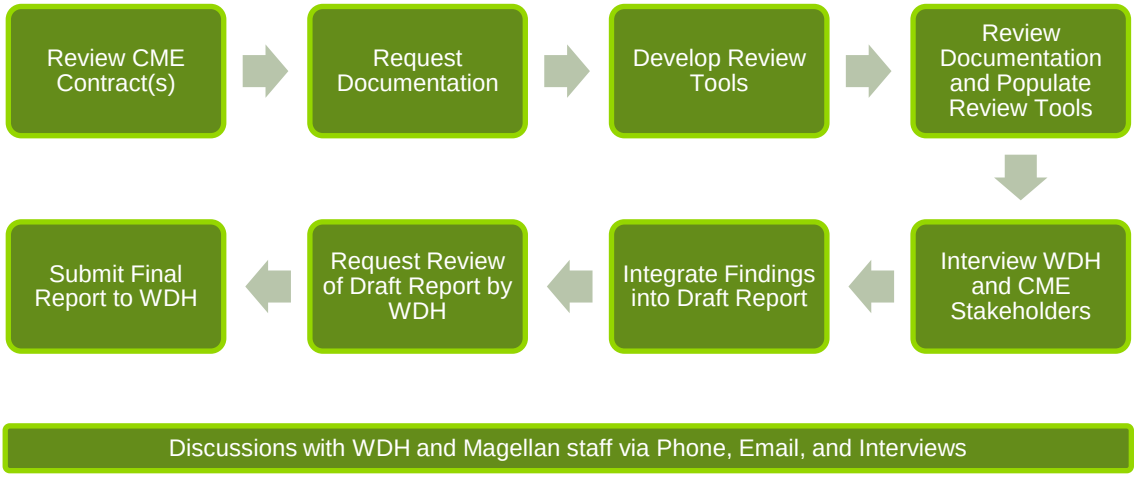
EQR Protocol	SFY 2020 Recommendations for:		Total	Total # of Recommendations, by SFY 2021 Status			
	Magellan	WDH		Fully Addressed	Partially Addressed	Not Addressed	N/A[3]
Protocol 1. Validation of Performance Improvement Projects	2	0	**2**	2	0	0	0
Protocol 2. Validation of Performance Measures	4	2	**6**	1	1	2	2
Protocol 3. Compliance with Medicaid Managed Care Regulations	2	2	**4**	3	1	0	0
Protocol 4. Validation of Network Adequacy	1	1	**2**	0	1	1	0
Protocol 6. Administration or Validation of Quality of Care Surveys	2	0	**2**	0	0	0	2
TOTAL	11	5	**16**	6	3	3	4

[3] Two recommendations made by Guidehouse in the SFY 2020 EQR Technical Report pertained to optional EQR Protocol 6, which at the direction of WDH was not evaluated during SFY 2021. Additionally, two recommendations pertained to performance measures that were discontinued with the SFY 2021 Statement of Work. These recommendations were considered "not applicable" when reviewing SFY 2020 recommendations.

Section II. Methodology

Guidehouse's methodology and associated review tools for all mandatory activities were adapted from the CMS established protocols and encompassed the following key steps, visualized in Figure 2. The methodology for all protocols relied heavily upon review of documentation and interviews with Magellan and WDH staff.

Figure 2. Key Assessment Steps



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 2021 SOW which operationalized the relevant federal code requirements, Guidehouse 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 2021 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

- Wyoming Medicaid Managed Care Quality Strategy

Interviews with WDH and Magellan

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

- Weekly telephone meetings between Guidehouse and WDH staff from July 2021 to January 2022
- Virtual interviews and review sessions with Magellan staff on November 1 - 5, 2021
- 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 2021 SOW. Section IV also reviews designated “outcome” measures consistent with EQR Protocol 2.

Section III. Validation of Performance Improvement Projects

Objective: EQR Protocol 1, Validation of Performance Improvement Projects assesses the validity and reliability of select PIPs. Per CMS EQR protocol guidance, this mandatory EQR activity validates the PIPs that the MCP was required to conduct as part of its QAPI program. The EQRO reviews the PIP design and implementation using documents provided by the MCP, which may be supplemented with interviews of MCP staff and reports to the State on findings from reviewing and validating the PIP(s) in the EQR Technical Report.

Per WDH's direction, Guidehouse reviewed the following three PIPs which were active during SFY 2021:

- Enrollment Initiative PIP that began during SFY 2019
- Minimum Contacts PIP that began during SFY 2018 and was revised for SFY 2021
- Engagement and Implementation (Provider Scorecard) PIP that began during SFY 2018

Magellan provided a Quality Improvement Activity (QIA) form for each PIP, which describes the activity selection and methodology, data and results, and analysis cycle.

Methodology

Guidehouse's validation process and the identification of areas of strength and needed improvement for each PIP were based on the structure set forth in EQR Protocol 1 Worksheets developed by CMS. Guidehouse's validation process included review of:

1. Acceptable project design (Worksheets 1.1-1.5);
2. Accurate data analysis and interpretation (Worksheets 1.6 -1.7); and
3. Evidence of significant improvement (Worksheets 1.8-1.9).

Appendix C includes the complete EQR worksheets with additional details for each PIP. The worksheets also provide the validation rating assigned by Guidehouse for the overall design, methodology, and impact of each PIP. Validation ratings for SFY 2021 are summarized in Table 4. Possible validation ratings include:

- ***High Confidence***: Strong project design / few areas of improvement in Worksheets 1.1-1.5; clear data analysis plan and methodology, and evidence of statistically significant improvement directly linked to interventions;
- ***Moderate Confidence***: Moderate project design / few areas of improvement in Worksheets 1.1-1.5; data analysis plan and methodology provided, and evidence of improvement linked to interventions;
- ***Low Confidence***: Weak project design / multiple areas of improvement in worksheets 1.1-1.5; unclear data analysis plan and methodology, and little evidence of improvement / weak link to interventions; and
- ***No Confidence***: Incomplete project design / multiple areas of improvement in worksheets 1.1-1.5; unclear or missing data analysis plan and methodology, and no evidence of improvement.

Table 4. SFY 2021 PIP Validation Ratings

Performance Improvement Project (PIP)	Intervention	Validation Rating
Enrollment Initiative PIP	Educated potential members about Wyoming's high-fidelity wraparound (HFWA) program when eligible youth are first enrolled in a Psychiatric Residential Treatment Facility (PRTF) level of care.	Moderate Confidence
Minimum Contacts PIP	Tracked FCCs' compliance with requirements to maintain regular in-person and telephone contact with members and caregivers.	Moderate Confidence
Engagement and Implementation (Provider Scorecard) PIP	Evaluated the impact of improvement strategies on discharged youth fully engaged in the CME Program and fully implemented within the program.	Moderate Confidence

This section describes an overview of each PIP, including areas of strength and needed improvement. Appendix C provides additional details for each PIP, including completed EQR Protocol 1 Worksheets.

Enrollment Initiative PIP

The Enrollment Initiative PIP seeks to educate potential members about Wyoming's high-fidelity wraparound (HFWA) program when eligible youth are first enrolled in a Psychiatric Residential Treatment Facility (PRTF) level of care. The program intended to prepare youth and their families for earlier member reintegration into the community to help decrease average length of stay in PRTFs and reduce readmissions to a PRTF-level of care. WDH and Magellan prioritized this PIP topic based on evidence of the limited effectiveness of longer term stays in PRTF settings and difficulties faced by youth with longer stays in reintegrating to community settings.

Table 5 evaluates the Enrollment Initiative PIP based on criteria specified in CMS protocol.

Table 5. Enrollment Initiative PIP Evaluation

Evaluation Category	Findings
Topic and PIP Selection	• The Enrollment Initiative PIP is required in the 2021 SOW between Magellan and WDH. • According to the QIA form, Magellan selected the Enrollment Initiative PIP based on growing research indicating that youth with longer stays in PRTF settings face significant challenges and difficulties reacclimating to home and community-based settings. ○ In conjunction with WDH, Magellan identified a potential opportunity to shorten length of stay by engaging potential CME members earlier (when first entering a higher level of care). • The PIP topic directly aligned with national priority areas and goals, including U.S. Department of Health and Human Services (HHS) National Quality Strategy aims (*Healthy People / Healthy Communities*), CMS Quality Strategy priorities (*Promote Effective Communication and Coordination of Care, Work with Communities to Promote Best Practices of Healthy Living, Make Care Safer by Reducing Harm Caused in the Delivery of Care, Promote Effective Prevention and Treatment of Chronic Disease*), as well as numerous CME program goals.
Aim Statement	• Magellan developed the following aim statements for the PIP:

Evaluation Category	Findings
	○ "Will early engagement attempts with Wyoming State Medicaid members (aged 4-20 years old) admitted to a PRTF level of care, (10/01/19 – 09/30/20) result in a decreased readmission rate (PRTF and acute inpatient settings)?" ○ "Will early engagement attempts with Wyoming State Medicaid members (aged 4-20 years old) who opt in for the enrollment initiative have a decreased length of stay (LOS) during the initial PRTF stay compared to those members who opt-out of the program for the measurement timeframe of 10/01/19 – 09/30/20?" • The aim statements met all requirements identified by CMS in the PIP Review Worksheet, including requirements for statement specificity, measurability, answerability, conciseness, and time restrictions.
Population	• The population for this PIP included all Wyoming State Medicaid members (aged 4-20 years old) that were enrolled within the PRTF level of care for the measurement timeframe of 10/01/19 – 09/30/20. • During the virtual EQR process, Magellan clarified that if Medicaid enrollment is lost during the measurement period, the youth is excluded from the PIP as Medicaid enrollment is required to participate in the CME Program. • The population description statement met all requirements identified by CMS in the PIP Review Worksheet.
Sampling Method	• The entire eligible population was included in the Enrollment Initiative PIP. • The QIA form clearly identified that sampling was not used for the PIP.
Variables and Performance Measures	• Magellan outlined two performance measures for this PIP: ○ **Measure #1:** "Mean number of readmissions to a higher level of care (HLOC) (inpatient and/or PRTF) within 30/90/180 calendar days after discharge from PRTF for Enrollment Initiative members and opt-out youth." ○ **Measure #2:** "Average length of stay (LOS) for members during the initial PRTF stay for members in the Enrollment Initiative compared to youth who opt-out of the Initiative." • Magellan specified objective, time-specific continuous variables for each performance measure: ○ **Measure #1:** ***Numerator:*** *"*The number of unduplicated members aged 4-20 years old who were readmitted to an inpatient psychiatric facility or PRTF within 30/90/180 calendar days of the original discharge." ***Denominator:*** *"*The total number of unduplicated members aged 4-20 years old who were discharged from a PRTF during the measurement period." ○ **Measure #2:** ***Numerator:*** *"*Sum of days in PRTF (discharge date minus admission date) during measurement period." ***Denominator:*** *"*Number of discharges for participants in group." • Performance measures aim to assess the number of readmissions and average length of stay within PRTF settings. A larger number of readmissions and longer stays may impact a member's ability to re-integrate into a community setting. • Magellan met all criteria for selected PIP variables and performance measures for this PIP.

Evaluation Category	Findings
Data Collection	• In the Enrollment Initiative QIA form, Magellan indicated that data is collected from claims / encounter files in the Wyoming Cognos system via a programmed pull using a SQL program. Collection is conducted by a Senior Reporting Manager. • Data was pulled quarterly and annually for review, analysis, and monitoring of progress. • Magellan identified data collected in the QIA form. Data includes: All eligible occurrences of PRTF-level care, Admission and discharge date (10/01/2019 or later), and other data for members aged 4-20 years old at time of admission. • During the virtual EQR process, Magellan confirmed that one data analyst on staff maintains a data analysis plan, however, no shared plan / standard operating procedure (SOP) is maintained by Magellan.

Data Analysis	• Magellan compared data for the performance measures across a baseline period as well as one remeasurement period:
	  ○ **Measure #1:** "Mean number of readmissions to a higher level of care (HLOC) (inpatient and/or PRTF) within 30/90/180 calendar days after discharge from PRTF for Enrollment Initiative members and opt-out youth":
	  ▪ Baseline (10/01/2018 - 09/30/2019): 61%
	  ▪ Remeasurement 1 (10/01/2019 - 09/30/2020): 41%
	  • Opt-out group: 59%
	  ▪ The measure is described as a mean number in the QIA form (i.e., days); however, it is reported as a percentage. Additionally, the measure description lists three measurement periods (i.e., 30, 60, and 90 calendar days) but only reports one value. It is unclear which period aligns with the reported value.
	  ○ **Measure #2:** "Average length of stay (LOS) for members during the initial PRTF stay for members in the Enrollment Initiative compared to youth who opt-out of the Initiative":
	  ▪ Baseline (10/01/2018 - 09/30/2019): 87.1 calendar days
	  ▪ Remeasurement 1 (10/01/2019-09/30/2020): 77.4 calendar days
	  • Opt-out group: 86.6 calendar days
	• Magellan excluded members that lost Medicaid eligibility at any point during the 180 calendar days post PRTF discharge date from analysis. Active Medicaid enrollment is required to be included in the PIP; however Magellan did not specify PIP inclusion status if Medicaid status is regained within the year.
	• To determine statistical significance, Magellan conducted a Fisher's Exact Test. Magellan found neither measure's results to be statistically significant.
	  ○ Fisher's Exact Test is typically used to determine whether there is a statistically significant association between two categorical variables (i.e., two groups or categories). However, the Enrollment Initiative PIP measures determine whether there is a statistically significant relationship between group membership (i.e., opt-in and opt-out groups, categorical data) and "mean number of readmissions" and "average length of stay", both of which are also numerical data. Magellan should explore using different statistical tests, such as t-tests, to correctly measure statistical significance of improvement for this PIP.

Evaluation Category	Findings
	• Magellan presented primary Baseline and Remeasurement calculations and findings in a concise and easily understood manner. However, opt-out group data and readmission data were difficult to locate within the document.

Improvement Strategies	• The Enrollment Initiative was designed to address four barriers:
	  ○ "Guardians / parents refusal to accept the program/opting out."
	  ○ "Some guardian / parents may feel overwhelmed and stressed with youth being placed in PRTF in the early stages and not feel like deciding at that time."
	  ○ "PRTF admissions seem to be cyclical with high and low times throughout the year."
	  ○ "Limited knowledge and understanding of the HFWA Program."
	• Magellan selected six interventions / improvement strategies to address these barriers:
	  ○ "Upon admission to PRTF, Magellan Family Support Specialist will reach out to the parents / guardians within three [calendar] days of auto-referral regarding the HFWA program to provide education and coordinate transfer to a network FSP [Family Support Partner]."
	  ○ "FSP will work with the family during the youth's stay at the PRTF to educate about the benefits of HFWA."
	  ○ "FSP will begin coordinating with a network Family Care Coordinator to ensure that supports are in place upon discharge from the PRTF."
	  ○ "Initial training for providers on the Protocol for Service Coordination-education for how to work with PRTF and the treatment team."
	  ○ "Website posting about the Enrollment Initiative on the provider website."
	  ○ "Provider update sent out on the Enrollment Initiative."
	• Magellan identified in the QIA form that they followed Institute for Healthcare Improvement's (IHI) Plan Do Study Act (PDSA) rapid cycle approach to develop improvement strategies and ensure cultural and linguistic appropriateness within strategies. The development process and appropriateness review were conducted by a workgroup of Wyoming CME employees that included the General Manager, the Senior Director of Operations, the Director of Program Innovation and Outcomes, the Quality Improvement Director, the HFWA trainer, and the Clinical Contract Advisor.

Likelihood of Significant Improvement	• The intervention was only conducted twice (baseline and the remeasurement year). However, Magellan and the State determined that the impact was not significant enough to continue implementing the initiative.

Recommendations

To further align with guidance provided in CMS EQR Protocols and improve design and implementation of the PIP, Magellan should:

- Formalize a standardized data analysis process and plan that is maintained centrally by Magellan (as opposed to locally by individual data analysts) to ensure accessibility and continuity.
  - During the virtual EQR process, Magellan confirmed that one data analyst maintains a data analysis plan, however, no shared plan / SOP is maintained by Magellan. The absence of an SOP leaves the CME Program vulnerable to continuity issues and project delays in the event of an emergency, staff change, or employee turnover.

- Clearly identify and document all data points collected for the PIP, including comparison group measurements.
    - Magellan presented primary Baseline and Remeasurement calculations and findings in a concise and easily understood manner. However, opt-out group data and readmission data were not clearly identified and difficult to locate in the document.
- Better align performance measure descriptions and data results reported in the QIA form.
    - For Measure #1 ("Mean number of readmissions to a higher level of care (HLOC) (inpatient and/or PRTF) within 30/90/180 calendar days after discharge from PRTF for Enrollment Initiative members and opt-out youth"), the target measure is described as a mean number in the QIA form (i.e., days); however, the measure result is reported as a percentage in data tables. Additionally, the measure description lists three measurement periods (i.e., 30, 60, and 90 calendar days) but QIA forms only include one reported value. It is unclear which period aligns with the reported value.

Minimum Contacts PIP

The Minimum Contacts PIP tracks the performance of measures OP-10 (CY 2020) and EM 9-20 (CY 2021), which assess FCCs' compliance with requirements to maintain regular in-person and telephone contact with members and caregivers. The minimum contacts requirement is an integral part of the HFWA process, as it ensures members and caregivers are consistently engaged and able to fully benefit from the program. WDH and Magellan prioritized this PIP as an opportunity to improve provider and member engagement in Wyoming's CME Program.

Table 6 evaluates the Minimum Contacts PIP based on criteria specified in CMS protocol.

Table 6. Minimum Contacts PIP Evaluation

Evaluation Category	Findings
Topic and PIP Selection	• Minimum Contacts PIP is required in the 2021 SOW between Magellan and WDH. • During the virtual EQR process, Magellan clarified that meeting Minimum Contact requirements is a critical principle of HFWA and enables youth to obtain full benefit from the CME Program. • The Minimum Contact goals align with CMS Aims (i.e., *Better Care*) and Priorities (i.e., *Strengthen Person and Family Engagement as Partners in their Care*, and *Promote Effective Communication and Coordination of Care*).
Aim Statement	• Magellan developed the following aim statement for the PIP: ○ "Will the use of education, training, and coaching, improve provider adherence to the minimum contact requirement to 100 percent of the time for the metric that all CME enrolled youths (with a full month of enrollment; aged 4-20 years old) / guardians / caregivers must be contacted at least two (2) times per month based on the family's preferred contact method by their HFWA provider during for calendar year 2021?" • The aim statement met all requirements identified by CMS in the PIP Review Worksheet, including requirements for statement specificity, measurability, answerability, conciseness, and time restrictions.
Population	• Magellan lists the population for the Minimum Contacts PIP as "All WY CME enrolled youths with a full month of enrollment, ages 4-20 during the measurement period."

Evaluation Category	Findings
	• The population description statement met all requirements identified by CMS in the PIP Review Worksheet.
Sampling Method	• The entire eligible population was included in the Minimum Contacts PIP. • The QIA form clearly identified that sampling was not used for the PIP.

Variables and Performance Measures	• Magellan outlined one performance measure for the baseline data collection period for this PIP:
	  ○ "Rate of members/caregivers contacted at least two times per month based on the family's preferred contact type."
	• Magellan specified objective, time-specific continuous variables for the performance measure:
	  ○ **Numerator:** "Number of enrollees contacted in format of youth/caregiver's choice minimum of two times a month"
	  ○ **Denominator:** "Number of WY CME enrollees, aged 4-20 years old, with a full month of enrollment during the measurement period"

Data Collection	• In the Minimum Contact QIA form, Magellan stated that data is collected from medical/treatment records (FidelityEHR). They also listed a detailed eight-step data pull process. • Data is pulled monthly for trending and reporting processes and pulled annually for the PIP review and reporting. • Magellan identified data collected in the QIA form. Data includes: Member and enrollment data, Plan of Care (POC) data, and service note data (including Wyoming CME provider contacts and the type of contact). • During the virtual EQR process, Magellan confirmed that an individual data analyst maintains a data analysis plan, however, no shared plan / SOP is maintained by Magellan.

Data Analysis	• At the time of review, Magellan was in the baseline data collection period for the Minimum Contacts PIP (1/1/2021 - 12/31/2021).
	  ○ Measure: "Will the use of education, training, and coaching, improve provider adherence to the minimum contact requirement to 100 percent of the time for the metric that all CME enrolled youths (with a full month of enrollment; aged 4-20 years old)/guardians/caregivers must be contacted at least two (2) times per month based on the family's preferred contact method by their HFWA provider during calendar year 2021?"
	  ▪ Magellan provided calculations in the QIA form for the first 6 months of baseline data collection (i.e., 1/1/2021 - 6/30/2021): 81.45 percent
	• According to the QIA form, Magellan reviewed the analysis and identified no instances that threatened the reliability or validity of the PIP. However, Magellan did identify the ongoing COVID-19 PHE and lack of provider familiarity with the new Electronic Health Record (EHR) system (implemented in 2021) as barriers that may impact provider ability to meet Minimum Contact requirements during the first half of the measurement period.

Evaluation Category	Findings
	• Magellan confirmed that the two comparison groups for the PIP are members that met Minimum Contact requirements and members that did not meet Minimum Contact requirement. • All calculations and findings were presented in a concise and easily understood manner.
Improvement Strategies	• Magellan conducted a provider survey to identify barriers for providers to meet Minimum Contact requirements. Based on the results of the survey, a Minimum Contacts Workgroup identified barriers to meeting minimum contact requirements: o Limited awareness of how to resolve engagement issues they may encounter o Provider agencies do not have standard operating procedures outlining how to achieve minimum contacts with members / caregivers o Solo / individual providers do not have backup FCCs to provide services during an absence o Limited awareness of overall rate of achievement of minimum contacts in relation to the Network of providers o COVID-19 restrictions o A lack of developed processes to address contact requirements if there is a planned sickness or emergency for the FCC (resolved) o Confusion with how to properly fill out the progress note template on the Provider Portal to obtain credit for meeting requirements (resolved) o Insufficient education on the minimum contact requirements (resolved under previous requirements but may prove to be a barrier gain with the change for 2021) • Based on the barriers, the workgroup identified and executed on the following interventions to help providers meet Minimum Contact Requirements: o Developed Minimum Contact Report through the EHR for 2021 o Reviewed minimum contacts to determine how to assist specific providers with meeting minimum contact requirements o Communicated with providers concerning minimum contact expectations o Utilized Provider Scorecard with providers to raise awareness o Reviewed overall network status on minimum contacts and reiterated minimum contact requirements during the monthly provider calls o Posted Magellan of Wyoming High Fidelity Wraparound Provider Requirements and Timelines to provider website as a reference for understanding minimum contact requirement timelines o Developed 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 o Developed internal process where the Clinical Department in the CME will not process reauthorization requests unless providers are demonstrating that they are meeting the requirements of minimum contacts with the member/caregiver o Approved a back-up FCC when the primary FCC is unable to make the visits to the family

Evaluation Category	Findings
	○ Approved virtual contact through ZOOM/virtual platform • Intervention 1 (Development of Minimum Contact Report through the EHR for 2021) and Intervention 3 (Provider communications concerning minimum contact expectations) were implemented in 2021. All other interventions were implemented prior to SFY 2021. • Magellan identified in the QIA form that they followed IHI's PDSA rapid cycle approach to develop improvement strategies and ensured cultural and linguistic appropriateness within strategies. The development process and appropriateness review were conducted by a workgroup of Wyoming CME employees that included the General Manager, the Senior Director of Operations, the Director of Program Innovation and Outcomes, the Quality Improvement Director, the HFWA trainer and the Clinical Contract Advisor
Likelihood of Significant Improvement	• The Minimum Contact PIP Baseline collection period ended 12/21/2021, which is outside the timeframe of review for this EQR. Due to the lack of complete data, sustained impact is unable to be measured.

Recommendations

To further align with guidance provided in CMS EQR Protocols and improve design and implementation of the PIP, Magellan should:

- Identify in the QIA document the significance of the Minimum Contacts PIP for the CME population, including why minimum contact requirements are considered an evidence-based practice and how not meeting requirements can impact functionality of the population.
    - During the virtual EQR process, Magellan clarified that minimum contact requirement is a key part of the HFWA program. If providers do not meet the requirements, members may not experience the full benefits of the program. Language highlighting the importance of meeting minimum contact requirements was not included in the QIA form.
- Remove reliance on an individual employee for historical knowledge and process. Formalize a standardized data analysis process and plan that is maintained centrally by Magellan to ensure accessibility and continuity.
    - During the virtual EQR process, Magellan confirmed that one of their data analysts maintains a data analysis plan, however, no shared plan / SOP is maintained by Magellan. The absence of an SOP leaves the CME Program vulnerable to continuity issues and project delays in the event of an emergency or staff change.

Engagement and Implementation PIP

The Engagement and Implementation PIP engages additional youth in the CME Program and promotes full implementation of program benefits. The PIP evaluates the impact of improvement strategies on the share of discharged youth fully engaged in the CME Program (defined as greater than 60 calendar days of service) and fully implemented within the program (defined as greater than 180 calendar days of service). WDH and Magellan prioritized this topic after reviewing numerous SFY 2017 reports, including the Committee Data File, Quarterly Reports, and internal management reports, and identified several opportunities for improvement in areas of face-to-face contacts, Strengths, Needs, and Culture Discovery (SNCD) completion timeliness, Plan of Care (POC) development timeliness, and Child and Adolescent Needs and Strengths (CANS) severity, as well as low rates of full implementation of program benefits for enrolled youth.

Table 7 evaluates the Engagement and Implementation PIP based on criteria specified in CMS protocol.

Table 7. Engagement and Implementation PIP Evaluation

Evaluation Category	Findings
Topic and PIP Selection	• Magellan clarified during the virtual EQR review process that the Engagement and Implementation PIP is required in the 2021 Statement of Work between Magellan and WDH. • Magellan also clarified during the virtual EQR process that achieving engagement and implementation thresholds is a key factor / principle of the HFWA program and is required for youth to obtain full benefit of the CME Program. • According to the QIA form, the strategy was developed to address areas of improvement for providers identified in various reports generated for SFY 2017 including the Committee Data File, Quarterly Reports, and internal management reports. Measures identified for improvement were engagement (>60 calendar days), and implementation (>180 calendar days). Magellan included specific input and feedback from both members and providers in selecting this PIP topic. • The Engagement and Implementation PIP aligns with CMS Aims and Priorities (i.e., *Strengthen Person and Family Engagement as Partners in their Care*, and *Promote Effective Communication and Coordination of Care*).
Aim Statement	• Magellan developed the following aim statements for the PIP: ○ "Does the change in authorization process improve the percent of Wyoming CME youth (aged 4-20 years old who were discharged during the measurement period) and their families reach engagement threshold (>60 calendar days) for SFY 2021?" ○ "Does the change in authorization process improve the percent of Wyoming CME youth (aged 4-20 years old who were discharged during the measurement period) and their families reach implementation threshold (>180 calendar days) for SFY 2021?" • The aim statements met all requirements identified by CMS in the PIP Review Worksheet, including requirements for statement specificity, measurability, answerability, conciseness, and time restrictions.
Population	• Magellan lists the population for the Minimum Contacts PIP as "All Wyoming CME youths aged 4-20 years old discharged during the measurement period (SFY 2021)." • The population description statement met all requirements identified by CMS in the PIP Review Worksheet.
Sampling Method	• The entire eligible population was included in the Engagement and Implementation PIP. • The QIA form clearly identified that sampling was not used for this PIP.
Variables and Performance Measures	• Magellan outlined two performance measures for this PIP: ○ **Measure #1:** "Engagement: percent of youth and families not reaching engagement threshold (>60 calendar days)" ○ **Measure #2:** "Implementation: percent of youth and families reaching implementation threshold (>180 calendar days)" • Magellan specified objective, time-specific continuous variables for each performance measure in the SFY 2021 QIA form: ○ **Measure #1: *Numerator*:** "Count of youth >60 calendar days of HFWA ("not engaged")." ***Denominator*:** "Count of discharged youth HFWA."

Evaluation Category	Findings
	○ **Measure #2: *Numerator:*** "Count of youth >180 calendar days of HFWA ("implemented"). ***Denominator:*** Count of discharged youth HFWA." • During the virtual EQR Process, Magellan clarified that both engagement and implementation are key principles of HFWA and need to be met for members to obtain full benefits of the CME Program.
Data Collection	• Data collection was pulled from claims / encounter files in CY 2020 (07/2020 - 12/2020); Data collection switched to pulling data from the Fidelity EHR in calendar year 2021 (i.e., 01/2021 - 06/2021) • To collect data for this PIP in CY 2020, Magellan used a "programmed pull" from all claims / encounter files of all eligible members. Based on discussions with Magellan, Magellan sourced data for this PIP from Magellan's authorization system, which is comprehensive and includes all discharges within the review period. • During the virtual EQR process, Magellan confirmed that an individual data analyst maintains a data analysis plan with an outlined process for data pull from the EHR, however, no shared plan / SOP is maintained by Magellan. • Data collected for the PIP include member data, enrollment status and discharge data, and Plan of Care data, including provider name.
Data Analysis	• Magellan compared data for the performance measures across a baseline period as well as three remeasurement periods: ○ **Measure #1 Engagement:** "Percent of youth and families not reaching engagement threshold (>60 calendar days)" ▪ Baseline (May 2018 – August 2018): 16% ▪ Remeasurement 1 (SFY 2019, July 2018 – June 2019): 16% ▪ Remeasurement 2 (SFY 2020, July 2019 – June 2020): 15% ▪ Remeasurement 3 (SFY 2021, July 2020 – June 2021): 15% ○ **Measure #2 Implementation:** "Percent of youth and families reaching implementation threshold (>180 calendar days)" ▪ Baseline (May 2018 – August 2018): 59% ▪ Remeasurement 1 (SFY 2019, July 2018 – June 2019): 62% ▪ Remeasurement 2 (SFY 2020, July 2019 – June 2020): 61% ▪ Remeasurement 3 (SFY 2021, July 2020 – June 2021): 64% • Magellan tested for statistical significance using Fisher's Exact Test for each measurement period. Out of the two measures and three remeasurement years, a statistically significant difference was only observed for Measure #2 (Implementation: Percent of youth and families reaching implementation threshold (>180 calendar days)) between Remeasurement 2 (SFY 2020) and Remeasurement 3 (SFY 2021); p-value = 0.000. ○ Although the p-value for Measure #2 Remeasurement 3 in the document was listed as 0.000 (a highly significant value), the measure was listed in the QIA document as "ns" or non-significant. ○ Fisher's Exact Test was used to determine whether there is a statistically significant association between two categorical variables (i.e., two groups or categories). However, the Engagement and Implementation PIP measures determine whether there is a statistically significant relationship between group membership (i.e., opt-in and opt-out groups, categorical data) and "percent of youth and families not reaching engagement threshold" and "Percent of youth and families reaching implementation threshold", both of

Evaluation Category	Findings
	which are also numerical data. Magellan should explore using a different statistical test, such as t-tests, to correctly measure statistical significance for the PIP. • Magellan used the original baseline measurements for data analysis until improved performance on the measures was observed. Magellan has standards of excellence for both Measure 1 and Measure 2 (i.e., 10 percent or fewer of families/youth to not reach engagement thresholds and 80 percent or more of families/youth to reach implementation thresholds). Based on the assumption that performance on both measures will improve, Magellan updated the baseline for data analysis to match Remeasurement 2 rates in SFY 2019. The engagement measure's original baseline was 16 percent and remained 16 percent in SFY 2019. The implementation measure's original baseline was 59 percent and increased to 62 percent in SFY 2019. There was no change in baseline for 2021.
Improvement Strategies	• PIP performance and potential improvement strategies were identified by a Magellan workgroup on an ongoing basis and documented by fiscal year in the QIA form. Magellan identified the following improvements and strategies for Remeasurement 3 (SFY 2021). ○ "There were some challenges for the providers with changing from the provider portal to the new EHR system. Support has been provided by team members to answer questions from the providers on the EHR and training information provided." ○ "One barrier that was noted to be no longer an issue was transparency on measures for all stakeholders. The Provider Scorecard measures which includes engagement and implementation are shared with the providers on a regular basis to aid in their understanding and awareness. During these discussions, providers are able to ask questions and provide any feedback on the Provider Scorecard and measures." • Magellan included a comprehensive table in the QIA form that included all interventions implemented from SFY 2018 to SFY 2021 and the identified barrier that each intervention addressed.
Likelihood of Significant Improvement	• Magellan has not observed sustained improvement with the Engagement and Implementation PIP. During the virtual EQR process, Magellan stated that because the Engagement and Implementation PIP is required in the SOW, the PIP will continue to be a part of the CME Program despite poor performance.

Recommendations

To further align with guidance provided in CMS EQR Protocols and improve design and implementation of the PIP, Magellan should:

- Formalize a standardized data analysis process and plan that is maintained centrally by Magellan (as opposed to locally by individual data analysts) to ensure accessibility and continuity.
    - During the virtual EQR process, Magellan confirmed that one data analyst maintains a data analysis plan, however, no shared plan / SOP is maintained by Magellan. The absence of an SOP leaves the CME Program vulnerable to continuity issues and project delays in the event of an emergency, staff change, or employee turnover.
- Develop a quality assurance process for the QIA PIP form to check for data discrepancies as identified with the conflicting statistical significance measurements and analysis.

- Although the p-value for Measure #2 Remeasurement 3 in the document was listed as 0.000 (a highly significant value), the measure was listed in the QIA document as “ns” or non-significant.

- Identify strategies to improve the effectiveness of Engagement and Implementation PIP to meet engagement and implementation thresholds.
    - Magellan has not seen a sustained improvement with the Engagement and Implementation PIP. During the virtual EQR process, Magellan stated that because the Engagement and Implementation PIP is required in the SOW, the PIP will continue to be a part of the CME Program despite poor performance.

Areas of Strength and Needed Improvement

Magellan’s reviewed PIPs demonstrate several strengths and areas for improvement, described below.

Strength: Documentation maintained for PIPs aligns directly with CMS requirements.

As part of the SFY 2020 External Quality Review, Guidehouse recommended that Magellan provide consistent and comprehensive documentation for PIPs through the Quality Improvement Activity (QIA) forms. Suggested areas for improvement identified during the 2020 EQR included clearly defining aim statements and performance measures, documenting Magellan’s approach to intervention development and barriers analysis, and including all relevant PIP information in the QIA form.

The QIA forms provided for the SFY 2021 EQR included clearly labeled items and sections, comprehensive data tables, and identification of the IHI’s PDSA process used to develop performance improvement project development. Specific strengths observed during the SFY 2021 review included:

- Across all PIPs, Magellan clearly identified the PIP aim statement, population, and sampling method, meeting all requirements in the CMS PIP Review Worksheet.
- The Minimum Contacts and Engagement and Implementation PIP included clearly documented data points from the beginning of the respective PIP through 06/30/2021. The Enrollment Initiative PIP only included data through 09/30/2020, but clearly identified that data collection ended at that point due to a joint decision between Magellan and WDH.
- Magellan included all written information on the PIPs in the QIA form, representing a significant improvement from PIP documentation provided for the SFY 2020 EQR process, which spanned across multiple documents.

Needed Improvement: Magellan does not have a standardized data analysis plan for reviewing PIP progress year over year.

Magellan does not maintain a written data analysis plan as a shared SOP in either QIA forms or an external document. During the virtual EQR process, Magellan confirmed that data analysis plans were maintained locally by individual data analysts. Individual ownership of plans or SOPs can cause continuity issues and project delays in the event of an emergency, staff change, or employee turnover.

> ***Recommendation for Magellan:*** Develop a standardized data analysis process that is made available in a central, shared location for all involved Magellan business units. WDH should be provided with the initial and all subsequent versions of the plan.
>
> Magellan should develop a standardized data analysis plan that is directly affiliated with the Wyoming CME workstream. The plan should be implemented with review and approval from both the Magellan leadership team and WDH, stored in a location accessible to both WDH and all involved Magellan staff, and should include a process for regular updating.

Needed Improvement: Magellan has data discrepancies in the QIA forms.

Data and related analyses in the QIA documents contain errors that limit ability to draw accurate conclusions and identify next steps to pursue continuous quality improvement. Discrepancies include:

- Measure #1 of the Enrollment Initiative PIP is described as a mean number in the QIA form (i.e., days), however, it is reported as a percentage in the data / results table. Additionally, the measure description lists three measurement periods (i.e., 30, 60, and 90 calendar days) but only reports one value. It remains unclear which timeframe aligns with the reported value. [4]
- When testing for statistical significance in the Engagement and Implementation PIP, Magellan listed a p-value of 0.000 as "ns" or non-significant despite 0.000 being a highly significant value.
- Magellan used Fisher's Exact Test to determine whether there was statistically significant improvement in remeasurement years for the Enrollment Initiative PIP and the Engagement and Implementation PIP. Since Fisher's Exact Test is conventionally used to measure statistical significance across categorical variables, Magellan should explore using different statistical tests, such as t-tests, to correctly measure statistical significance for PIPs incorporating continuous variables.

Recommendation for Magellan: Identify a quality assurance process to review data collection processes and analyses for accuracy.

A quality assurance process should include reviewing data accuracy at multiple times throughout the collection and analysis process. The process should also include review by multiple different individuals to minimize bias during the process.

Needed Improvement: Magellan has reported minimal statistically significant improvement across PIPs.

While documented effectively and according to federal standards, none of the PIPs executed by Magellan during the SFY 2021 period made statistically significant improvements (as determined using Fisher's Exact Test). Specifically:

- The Enrollment Initiative PIP was only conducted twice (baseline and the measurement year), and Magellan and WDH jointly determined that the impact was not large enough to continue implementing the initiative.
- The Minimum Contact PIP recently completed the baseline data collection phase and will not have a full year of remeasurement data to gauge impact until December 2022.
- The Engagement and Implementation PIP has generated minimal improvement in providers reaching engagement and implementation thresholds, despite numerous improvement strategies to improve provider performance in effect from 2018 – 2021.

[4] Subsequent to Guidehouse's interviews with Magellan and identification of deficiencies, Magellan resubmitted the CME Quality Annual Program Evaluation, including QIA documentation, in January 2022. The updated and resubmitted files showed that Magellan fully remediated data discrepancies related to measure reporting for the Enrollment Initiative PIP. However, other items noted in this area of needed improvement remain unresolved.

Recommendation for Magellan: Conduct an updated formal evaluation of barriers impacting the effectiveness of PIPs.

Currently, barriers to meeting PIP goals are identified by PIP workgroups comprised of representation from the Clinical, Quality, Training, and Network Departments, collected during calls with providers and members, or based on results from a provider survey (last conducted in 2019 for the Minimum Contacts PIP). Magellan should organize and conduct a formal barriers analysis and evaluation to enable targeted collection of feedback on the impact of current PIPs and identification of any other barriers that may benefit from a targeted PIP.

Recommendation for Magellan: Identify additional areas of improvement to implement new PIPs that could lead to health and functional status improvements within the CME population.

All PIPs active during SFY 2021 are required in the 2021 SOW, including two PIPs (Minimum Contact PIP and Enrollment and Implementation PIP) based on the core values of the HFWA model. Through a review of published literature on improvement strategies for the target population and analysis of patient data, Magellan should identify additional areas of need which may lead to further improvement of the patient experience in the CME Program and help to illustrate the effectiveness of the CME Program.

Recommendation for WDH: Include language in the SOW that gives Magellan the opportunity to adjust a PIP if no improvement is seen.

To encourage continuous quality improvement and responsiveness to developing and emergent issues, WDH should include language in the SOW enabling the Contractor to make essential, ad-hoc adjustments to PIP design and implementation. Clearly establishing performance requirements and a process to adjust PIPs when improvements are not observed across multiple measurement periods also will allow the Contractor to maximize feedback and insights on PIP performance to produce effective programs with positive outcomes for CME members.

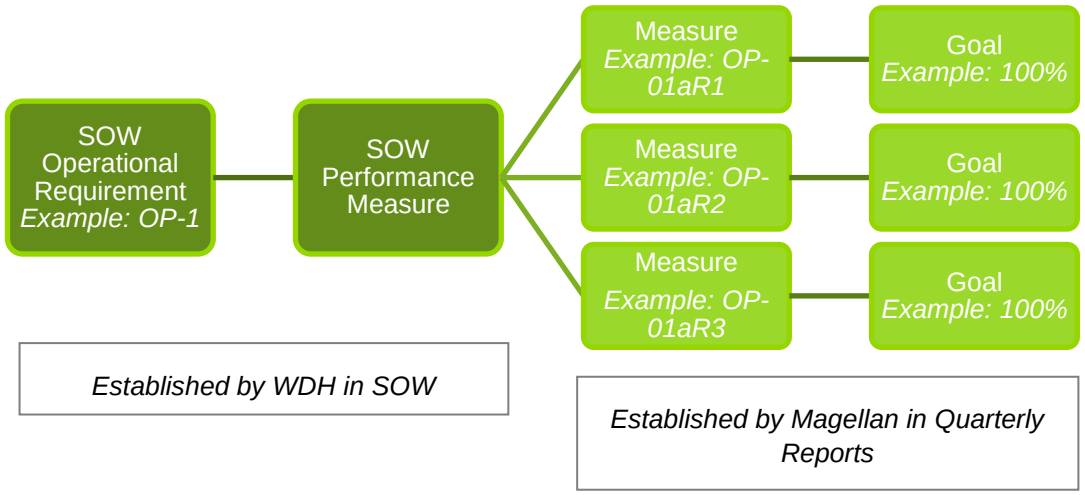
Section IV. Validation of Performance Measures

Objective: EQR Protocol 2, Validation of Performance Measures evaluates the accuracy and appropriateness of measures reported by Magellan and the extent to which the measures follow WDH's specifications and reporting requirements.

Methodology

Each SOW operational requirement is given an OP number ("OP" abbreviates "operational requirement") and is assigned to categories (HFWA, Operations, Project Management, Provider Network, System of Care, Technical, or Financial). Each SOW operational requirement corresponds to one SOW performance measure. Magellan subsequently developed additional measures, approved by WDH, for how it would measure and report its performance for each SOW operational requirement. Magellan's measures include naming conventions which correspond to the associated SOW operational requirement – for example, Magellan's measure "OP-01aR1" corresponds to SOW operational requirement "OP-1." The SOW also directs Magellan to include goals for each measure within the quarterly reports, which are reviewed and approved by WDH (the SOW does not explicitly establish goals). Data included in quarterly reports to WDH provided the largest source of information for validation of measures. Figure 3 displays the relationship between SOW operational requirements, SOW performance measures, measures, and goals.

Figure 3. SOW Requirements, Performance Measures and Goals



For SFY 2021, review and validation of reported data included 143 measures established by Magellan for 54 SOW operational requirements (inclusive of both SOW versions in effect during the review period). There were also factors that impacted the methodology for the SFY 2021 review of performance measures:

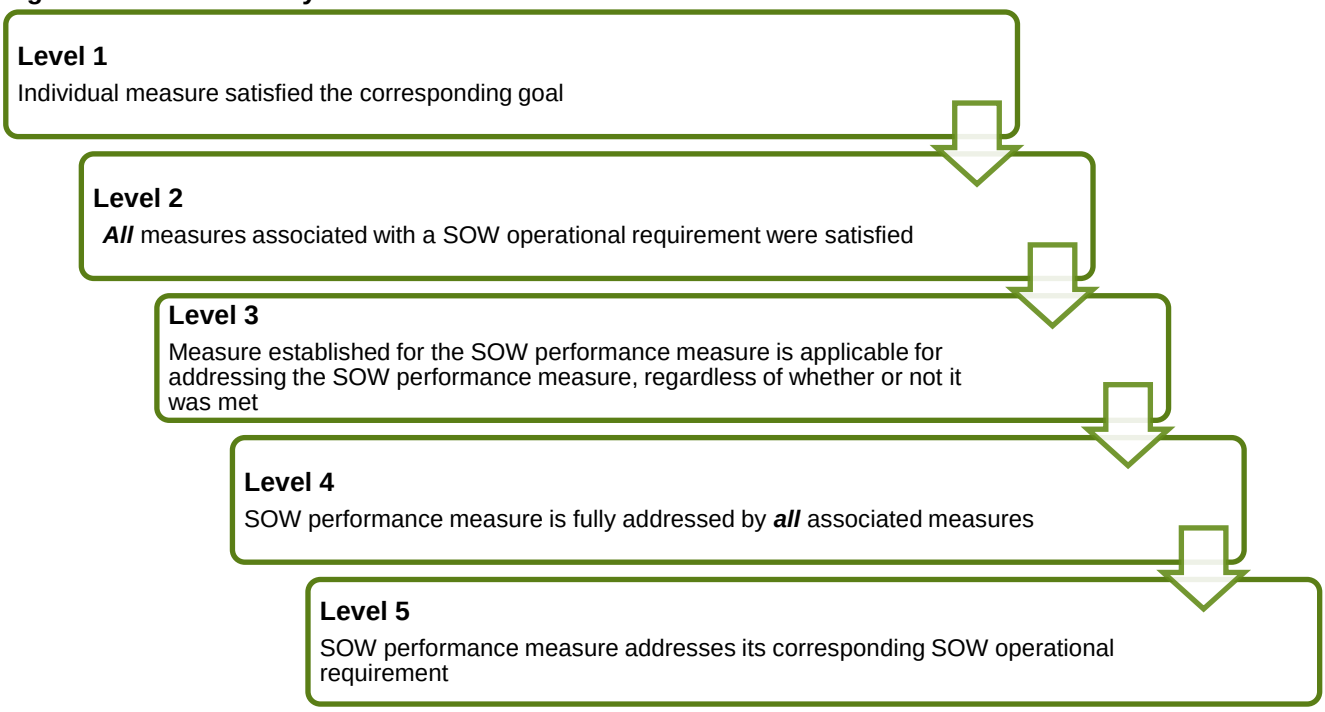
- **Contract Changes in CY 2021**: Due to the updated SOW in effect starting January 1, 2021, Magellan reported on new performance measures and categories during the second half of the review period. Guidehouse has reviewed both sets of performance measures within this technical report.
- **Performance Goals**: Guidehouse observed that Quarterly Reports provided by Magellan omitted key performance goals for measures specified in the updated CY 2021 SOW. While discussed with both WDH and Magellan during virtual review sessions, missing goals inhibited Guidehouse's ability to conduct a complete analysis for Protocol 2 in full (as noted by "Insufficient

Data" and "Not Applicable" rows in Levels of Analysis tables). Please see "Areas of Strength and Needed Improvement" for Section IV below for further detail and recommendations for improvement regarding performance goals.

Levels of Analysis

Guidehouse conducted five levels of analysis for the measures and SOW operational requirements, displayed in Figure 4 below. Please refer to Appendix E for additional detail regarding how SOW operational requirements, SOW performance measures, measures, and goals interact as well as example walk-throughs of the levels of analysis.

Figure 4. Levels of Analysis



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 SOW 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 SOW operational requirements and their associated measures, Guidehouse evaluated 143 measures and 54 operational requirements. Appendix E includes Guidehouse's review tool for validating SOW operational requirements.

Outcome Measures

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

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

Performance on Operational Requirements

Magellan's Performance on Measures

Guidehouse assessed data from Magellan's quarterly reports to evaluate Magellan's performance on 143 measures and 54 operational requirements, across both SOWs active during the review period. Table 8 below provides findings from Guidehouse's Level 1 analysis described previously, which assesses Magellan's performance on measures and the extent to which they satisfy their corresponding goals.[5, 6]

Table 8. Level 1 – Assess whether Magellan satisfied individual goals as set in the annual report

Level 1 Evaluation	Percent of Measures *(n=143)*
Goal Met	15.4%
Goal Not Met	14.0%
Not Applicable	22.4%
Insufficient Data	48.3%
Total	100.0%

Table 9 below provides findings from Guidehouse's Level 2 analysis described previously, which assesses Magellan's performance satisfying *all measures associated with a SOW performance measure* (i.e., Magellan's performance meeting the SOW performance measures themselves).

[5] Throughout this section "Not Applicable" indicates there was no applicable data in SFY 2021 for this measure.

[6] Throughout this section, "Insufficient Data" indicates that Magellan did not include performance goals for measures. This item is further addressed in "Areas of Strength and Needed Improvement" for Protocol 2.

Table 9. Level 2 – Assess whether Magellan fully met all measures associated with a performance measure

Level 2 Evaluation	Percent of PMs *(n=54)*
Yes	13.0%
No	22.2%
Not Applicable	22.2%
Insufficient Data	42.6%
Total	100.0%

Relationship Between Goals and Performance Measures

Table 10 provides findings from Guidehouse's Level 3 analysis described previously, which assesses whether a particular measure is applicable for addressing the associated SOW performance measure.

Table 10. Level 3 – Assess whether a particular measure addresses its SOW performance measure, regardless of whether or not it was met

Level 3 Evaluation	Percent of Measures *(n=143)*
Yes	49.7%
Partially[7]	1.4%
No	49.0%
Total	100.0%

Table 11 provides findings from Guidehouse's Level 4 analysis described previously, which assesses whether the listed measures fully address their associated SOW performance measure.

Table 11. Level 4 – Assess whether the SOW performance measure is fully addressed by all associated measures

Level 4 Evaluation	Percent of PMs *(n=54)*
Yes	44.4%
No	55.6%
Total	100.0%

[7] Indicates that the particular measure addressed part of its SOW performance measure, but not all aspects of the measure.

Relationship Between SOW Performance Measures and SOW Operational Requirements

Guidehouse assessed the appropriateness of the SOW performance measures in relation to the SOW operational requirements. WDH developed both the SOW operational requirements and the associated SOW performance measures. Table 12 provides findings from Guidehouse's Level 5 analysis, which assesses the adequacy of SOW performance measures in addressing and operationalizing the intention of the SOW operational requirement.

Table 12. Level 5 – Assess whether a particular SOW performance measure addresses its SOW operational requirement

Level 5 Evaluation	Percent of PMs *(n=54)*
Yes	77.8%
Partially[8]	20.4%
No	1.9%
Total	100.0%

Validation of Selected Measures

Guidehouse conducted a detailed review of the data analysis and collection methods for three SOW operational requirements and their associated measures, as selected by WDH for validation. None of the three SOW operational requirements were divided into multiple sub-parts for further validation. Selected SOW operational requirements include the following:

- **OUT 13-5:** Primary Care Practitioner Access (EPSDT)
- **OUT 13-7:** Fidelity to the high-fidelity wraparound (HFWA) Model (Survey Score)
- **OUT 13-8:** Fidelity to the high-fidelity wraparound (HFWA) Model (Surveys Received)

Table 13. Validation of Protocol 2 Performance Measures

Performance Measure	Measure Steward	Data Collection Method	Findings				Confidence Rating
			N	D	S	Total	
OUT 13-5: Primary Care Practitioner (PCP) Access	WY Custom	EHR	5	3	5	13	Moderate
OUT 13-7: Fidelity to the high-fidelity wraparound (HFWA) Model	WY Custom	Survey	5	5	5	15	High
OUT 13-8: Fidelity to the high-fidelity wraparound (HFWA) Model	WY Custom	Survey	5	5	5	15	High

Guidehouse evaluated the information provided throughout the review, including virtual interviews in which both the technical and clinical measure creation experts responded to questions and provided reviews of logic and documentation required for measure creation. For each measure, Guidehouse

[8] Indicates that the SOW performance measure addressed parts of its SOW operational requirement, but not all.

provided a score for each of three elements: Numerator (N), Denominator (D), and Source (S) Data as described in Table 14 below.

Table 14. Scoring Scheme for Protocol 2 Performance Measures

Score	Element Rating	Definition
5	Fully Met	Accurately retrieved, determined, and/or calculated the element.
3	Partially Met	Met essential requirement of the element but displayed deficiency or error in some areas.
1	Not Met	Did not meet essential requirements of the element.
0	N/A	Not Applicable to this measure/element. If N/A selected, calculate total based on number of available non-zero ratings.
Score	**Confidence Rating**	**Definition**
14+	High	High confidence that the calculation of the performance measure adhered to acceptable methodology.
10 – 13	Moderate	Moderate confidence that the calculation of the performance measure adhered to acceptable methodology.
4 – 9	Low	Low confidence that the calculation of the performance measure adhered to acceptable methodology.
<=3	No	No confidence that the calculation of the performance measure adhered to acceptable methodology.

Table 15 describes results of the measure validation and indicates that Magellan:

- Fully met two of the three SOW operational requirements (OUT 13-7 and OUT 13-8).
- Did not meet one of the three SOW operational requirements (OUT 13-5).

A SOW operational requirement's 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 numerator; Magellan staff must also properly demonstrate the steps to generate the numerator for the measure during virtual review sessions.
- **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 measure during virtual review sessions.
- **Accurate Source Data** – Magellan has properly defined and identified the data source used to generate the measure.

For measures that were not met, Guidehouse identified issues, including, but not limited to:

- Lack of written step-by-step procedures for manual data manipulation following extract from source system.
- Inconsistencies in definition and/or calculation of the value "number of youth enrolled in network" between the SOW, which indicates *newly* enrolled youth, and measure creation documentation and logic, which indicate *all* enrolled youth.

Table 15. Protocol 2 Measures and Findings

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
OUT 13-5: Primary Care Practitioner (PCP) Access • **Numerator**: Number of youth enrolled in CME Program with an identified Primary Care Practitioner • **Denominator**: Number of youth enrolled in CME Program			
The measure owner has backup staff trained to use the available documentation to extract data from Izenda, the source for Fidelity Electronic Health Records (FEHR) effective January 1, 2021. Following the data extract from Izenda, this measure calculation process is entirely manual using Excel (no SQL code or other extract programming). The Quality Improvement Committee has expressed concern with the low rate of PCP identification among enrolled youth, and while the data entry of the non-required value(s) may be part of the issue, detailed review indicates the measure is calculated incorrectly, and therefore further under-reported. Overall Findings: • The numerator and denominator are disparate comparisons. The numerator counts only those *newly* enrolled in the current quarter, while the denominator is a count of *all* youth in the CME Program at the point in time. The result is an under-reported rate of youth having identified a PCP. The denominator should count only youth newly enrolled during the same quarter. ○ Note that the measure creator displayed report documentation where the denominator is clearly defined as "# youth enrolled in the CME". • Measure creation team currently does not have access to the raw data or a data warehouse, so they rely on what they can request from the limited query features from Izenda. With this limitation, the team cannot write a reusable, version-controlled, SQL query. • While the measure creation team has access to Izenda's YouTube channel for training videos of common report creation tasks and a generic reports user manual, they do not have a written training plan. • The measure creator demonstrated the manual processes in Excel, including de-duplication, reformatting, determining the maximum record count, tab copies, and pivot tables. Each person on the measure creation team knows how to perform the steps, however the team has no written documentation on the manual portion of the process. • The process for manual de-duplication, formatting, and counting has potential for error.	Yes	No	Yes

Table 15. Protocol 2 Measures and Findings

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
OUT 13-7 Fidelity to the high-fidelity wraparound (HFWA) Model • **Numerator**: Average score of all HFWA caregiver surveys received • **Denominator**: 100 (possible points for perfect score) • **Goal**: 72%			
Magellan demonstrated the use of the FEHR interface to determine the average caregiver survey score for the selected timeframe. • Caregivers submit online surveys directly to a third-party, and the Total Fidelity Score is calculated using University of Washington's nationally recognized methodology. Magellan does not have access to the scoring logic and cannot alter the scoring of its surveys. • One measure expert generates the score report quarterly while another measure expert generates the score report annually. In the event of a discrepancy, the team can prove that the annual average includes additional surveys reported for a quarter but received following that quarter's initial report date. The measure owner: • Explained that the value for this measure is the average score of acceptable surveys received and counted per Measure OUT 13-8, and includes only those submitted by the caregiver. ○ This explanation included the rule excluding scoring of surveys where the exact same response value is reported for all questions. The measure owner was able to find and display the one survey excluded for this reason. • Confirmed that the survey can only be completed one time for each youth during his/her CME Program involvement, ideally on the 180th calendar day. • Demonstrated use of the FEHR system to retrieve the data values. • Confirmed receipt of only four caregiver surveys in the first quarter, and the low volume is attributed to both system and process changes during this timeframe. Magellan identified and trained backup staff for measure creation and confirmed that the values are reviewed by both the quality and clinical teams. The average caregiver score values reported are accurate for OUT 13-7 based upon the available data.	Yes	Yes	Yes

Table 15. Protocol 2 Measures and Findings

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
OUT 13-8: Fidelity to the high-fidelity wraparound (HFWA) Model • **Value**: There is no numerator or denominator; only a single value for the number of surveys received			
The measure owner: • Explained that the value for this measure is equal to the count of surveys received. Note that the total count of surveys received may include submissions from the caregiver, facilitator, youth, or youth team member. • Confirmed that the respondent is made aware of the deadline, and the survey can only be completed one time per respondent for each youth during his/her CME Program involvement, ideally at the 180th calendar day. • Demonstrated use of the FEHR system to retrieve the survey count values. Magellan identified and trained backup staff for measure creation and confirmed that the values are reviewed by both the quality and clinical teams. The survey counts reported are accurate for OUT 13-8 based upon the available data.	Yes	Yes	Yes

Performance on Outcome Measures

Guidehouse assessed data provided by Magellan to evaluate compliance with 10 outcome measures. Table 16 provides a summary of the outcome measure results based on performance throughout SFY 2021. The requirement for compliance with each outcome measure was simply for Magellan to report or provide the data; therefore, all applicable outcome measures were met, and Magellan will not be subject to payment penalties.

Table 16. Status of Outcome Measures

Outcome Measure	Guidehouse Determination
OUT 13-1: 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 Requirements
OUT 13-2: Decreased Length of Stay (LOS) for Inpatient and Residential Treatment admissions The Contractor shall report the overall LOS for inpatient and residential treatment for youth enrolled in the CME.	Partially Meets Requirements
OUT 13-3: 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.	Meets Requirements

Outcome Measure	Guidehouse Determination
OUT 13-4: Recidivism Level of Care (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.	Partially Meets Requirement
OUT 13-5: Primary Care Practitioner Access (EPSDT) The Contractor must report the number of CME enrolled youth who have an identified Primary Care Practitioner.	Meets Requirement
OUT 13-6: Cost Savings (Healthcare Costs) The Contractor shall report healthcare costs to Medicaid for the CME enrolled youth.	Meets Requirement
OUT 13-7, 13-8: Fidelity to the high-fidelity wraparound (HFWA) Model • 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.	Meets Requirement
OUT 13-9: Family and Youth Participation at State-level Steering Committees The Contractor shall report family and youth participation on State-level Steering Committees.	Does Not Meet Requirements
OUT 13-10: 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.	Does Not Meet Requirements

Areas of Strength and Needed Improvement

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

Strength: Clinical team is knowledgeable, engaged, and invested.

The clinical teams for the PCP and HFWA measures have years of experience with the CME Program, understand the measures and work to ensure compliance in terms of data submission. In particular, the team makes the effort to reach out to both providers and the families of enrolled youth to identify and resolve any barriers to PCP selection and documentation.

(This is a continued strength from SFY 2020).

Strength: Documentation describing measure result creation has improved.

The analysts calculating the OUT 13-5 PCP measure are all fairly new to the team, each joining in CY 2021, but they have worked to document the query portion of the measure creation and have a complete data dictionary. Magellan showed detailed measure creation documentation for OUT 13-7 and OUT 13-8.

Strength: Measure creation staff are cross-trained.

For each SOW operational requirement and measure reviewed, the creation staff noted the person(s) provided with documentation describing the query steps for the measure and/or job shadowing to observe the primary staff creating the measure. This will result in fewer issues in the event of an emergency or staffing changes. More specifically, the OUT 13-5 and OUT 13-8 teams each have three people experienced in creating the measure.

(This is a continued strength from SFY 2020).

Strength: Use of WFI-EZ WrapTrack and FidelityEHR ensures accurate reporting of submitted surveys.

The University of Washington WFI-EZ tool is in use for CME programs throughout the nation and provides Wyoming with a standard process, secure data storage and access, and proven calculation methods. With the survey responses submitted electronically and directly to the system, the measure calculation process leaves little room for error and consistently provides a high level of confidence. Magellan HFWA staff are familiar with the tool, the data, and the measure creation process.

Strength: Caregiver HFWA Fidelity scores are consistently above the goal.

The Wyoming CME Program reports caregiver survey scores for OUT 13-7 above the goal as determined by the SFY 2016 baseline of 72 percent which is the national fidelity average.

Needed Improvement: Manually generated measure results did not include process documentation.

While the overall assessment found sufficient documentation for use of the Izenda query tool, and the three team members know how to perform the complete process, the team could benefit from having clear documentation for the final manual Excel steps describing the process from start to finish. Magellan should ensure adequate documentation for the analytics team in the event of an emergency or staff change.

> ***Recommendation for Magellan:*** Develop documentation describing the processes for manual (non-SQL) measure result creation, specifically for OUT 13-5.
>
> Magellan staff responsible for manual measure result creation have identified staff who can serve in a backup role as needed to generate measure results; however, Guidehouse recommends developing documentation to support acquisition of input data, de-duplication, formatting, calculation of numerator, denominator, and rate for the measures that are not generated via SQL.

Needed Improvement: Key performance goals were unclear for measures required as part of the CY 2021 SOW.

Previously, Magellan had used consistent file and formatting for performance measures across all review periods starting in SFY 2017. As part of implementation of the updated SOW in effect starting January 1, 2021, Magellan reported new performance measures (including operational requirements and outcome measures) using a revised format and file. Guidehouse observed that unlike previous review periods, operational requirements were missing key performance goals during SFY 2021. Since performance goals are critical for monitoring program performance and are required for continuous quality improvement, missing goals poses a major risk for quality of care delivered to CME youth.

> ***Recommendation for Magellan:*** Set numeric goals for each performance measure required by the SOW.
>
> Per the SOW, Magellan receives operational requirements and outcome measures from WDH and is required to set performance goals for each (see *Figure 3. SOW Requirements, Performance Measures and Goals*). Magellan should aim for compliance with this requirement and ensure each metric can be tracked numerically against a goal or threshold. We recommend that Magellan work with WDH to determine appropriate goals to encourage continuous quality improvement.
>
> ***Recommendation for WDH:*** Include goal “ranges” or “minimums” within SOW requirements.
>
> To encourage compliance with federal requirements for Protocol 2, WDH should consider including recommended “ranges” or “minimums” for performance measure goals within the SOW with Magellan. For example, WDH may recommend that for critical performance measures, Magellan may not set a performance goal less than 95 percent for a review period.

Section V. Compliance with Medicaid Managed Care Regulations

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

Guidehouse followed CMS' *EQR Protocol 3 Compliance Review Worksheet* to collect information from WDH, establish compliance thresholds, and perform review of Magellan's compliance across 85 elements applicable to the CME Program.[9] The compliance review encompassed the standards listed in Table 17.

Table 17: Compliance Standards Reviewed by the EQRO

Standard Reviewed by the EQRO	Subpart D and QAPI Standard	Last Reviewed
MCP Standards, including Enrollee Rights and Protections: Includes standards for content and distribution of enrollee materials and State laws on enrollee rights.	**42 CFR § 438.56.** Disenrollment: Requirements and limitations	SFY 2021
	42 CFR § 438.100. General compliance, including enrollee rights and protections; information requirements for all enrollees	SFY 2021
	42 CFR § 438.102. Provider-enrollee communications	SFY 2021
	42 CFR § 438.114. Emergency and post-stabilization services	SFY 2021
	42 CFR § 438.206. Availability of services; Access and cultural considerations; Furnishing of services and timely access	SFY 2021
	42 CFR § 438.207. Assurances of adequate capacity and services	SFY 2021
	42 CFR § 438.208. Coordination and continuity of care	SFY 2021
	42 CFR § 438.210. Coverage and authorization of services	SFY 2021
	42 CFR § 438.214. Provider selection	SFY 2021
	42 CFR § 438.230. Subcontractual relationships and delegation	SFY 2021
	42 CFR § 438.236. Practice guidelines	SFY 2021
	42 CFR § 438.242. Health information systems	SFY 2021

[9] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *CMS External Quality Review (EQR) Protocols*. October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf

Standard Reviewed by the EQRO	Subpart D and QAPI Standard	Last Reviewed
	42 CFR § 440.230. Sufficiency of amount, duration, and scope	SFY 2021
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.	**42 CFR § 438.330**. Quality Assessment and Performance Improvement; Performance improvement projects	SFY 2021
Grievance and Appeals System: Includes standards for resolution and notification of grievances and appeals and communication to providers and enrollees regarding the grievance system.	**42 CFR § 438.228.** Grievance and appeal systems	SFY 2021
	42 CFR § 438.402. General requirements	SFY 2021
	42 CFR § 438.404. Timely and adequate notice of adverse benefit determination	SFY 2021
	42 CFR § 438.406. Handling of grievances and appeals	SFY 2021
	42 C.F.R. §438.408. Resolution and notification, Grievances and appeals	SFY 2021
	42 CFR § 438.410. Expedited resolution of appeals	SFY 2021
	42 CFR § 438.414. Information about the grievance and appeal system to providers and subcontractors	SFY 2021
	42 CFR § 438.416. Recordkeeping requirements	SFY 2021
	42 CFR § 438.420. Continuation of benefits while the MCO, PIHP, or PAHP appeal and the state fair hearing are pending	SFY 2021
	42 CFR § 438.424. Effectuation of reversed appeal resolutions	SFY 2021

For the compliance evaluation, Guidehouse 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 Guidehouse 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 Guidehouse reviewers, but required documentation is unavailable, incomplete, or inconsistent with practice; or all documentation listed under a regulatory provision, or component thereof, is present, but Magellan staff are unable to consistently articulate evidence of compliance.
- **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.

Table 18 provides an overview of Magellan's compliance by topic. Magellan fully met 93 percent of applicable elements and partially met seven percent in SFY 2021. No applicable elements were considered "not met" in SFY 2021.

Full compliance reviews are only required once every three years. Guidehouse conducted a full review in 2019, and a follow-up review to accommodate updated CMS EQR Protocols in SFY 2020. However, due to the updated SOW between Magellan and WDH, Guidehouse reviewed all compliance elements in SFY 2021.

Appendix G includes Guidehouse's review tool for EQR Protocol 3.

Table 18. Extent of Compliance with EQR Protocol 3 Elements, by MCP Requirement Section

Compliance Level	Enrollee Rights and Protections *(438.56 – 438.230)*		Quality Assessment and Performance Improvement *(438.330)*		Grievance and Appeals System *(438.402 – 438.420)*		TOTAL	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Fully Met	50	91%	13	100%	16	94%	**79**	**93%**
Partially Met	5	9%	0	0%	1	6%	**6**	**7%**
Not Met	0	0%	0	0%	0	0%	**0**	**0%**
Total Applicable	**55**	**100%**	**13**	**100%**	**17**	**100%**	**85**	**100%**
Not Applicable[10]	5	--	1	--	0	--	6	--

Additionally, there are six total elements of the compliance review worksheet that are not applicable to the CME Program and were excluded from review. The excluded compliance elements are summarized in Table 19.

Table 19: Compliance Review Elements Not Applicable to the CME Program

Elements Not Applicable to the CME Program	Subpart D and QAPI Standard
Regulations and descriptions regarding long-term services and supports (LTSS): LTSS does not apply to the CME Program population; CME Program delivers care coordination to children aged 4-20 years old.	**42 CFR § 438.208.** Coordination and continuity of care

[10] "Not Applicable" refers to elements of the compliance review worksheet that were not applicable to the CME Program and were excluded from review. Please see the above "Objective" section for further information.

Elements Not Applicable to the CME Program	Subpart D and QAPI Standard
Regulations and descriptions regarding advanced directives: Advanced directives do not apply to the CME Program population; CME Program does not deliver medical services.	**42 CFR § 438.100.** General compliance, including enrollee rights and protections; information requirements for all enrollees
Identification of individuals with special health care needs: All CME Program members fall under this category.	**42 CFR § 438.208.** Coordination and continuity of care
Standards regarding subcontractor monitoring: The CME Program does not utilize subcontractors.	**42 CFR § 440.230.** Sufficiency of amount, duration, and scope
Regulations regarding the dual eligible population*:* The CME Program member population does not qualify for Medicare.	**42 CFR § 438.208.** Coordination and continuity of care

Within each topic, Magellan's policies indicate compliance with several State-established standards, including:

- MCP Standards, including Enrollee Rights and Protections
    - Standards for information made available through the Magellan Wyoming Care Management Entity Family and Youth Guide to High Fidelity Wraparound (herein referred to as the member handbook), including information on enrollee rights and responsibilities and the enrollee grievances, appeals, and State fair hearing processes
    - Standards for maintaining documentation to comply with requirements for availability and accessibility of services, including provider directories and provider location geo-maps
    - Quality assurance and utilization review standards, including definition of medical necessity
    - Standards for maintaining enrollee health records
    - Standards for disenrollment policy
- Quality Assessment and Performance Improvement
    - Specifications for Performance Improvement Projects
    - Requirements for detection of over- and under-utilization
    - Standards for performance measure calculation
- Grievance and Appeals System
    - Standards for handling of grievances and appeals, including compliance with State-established timeframes for request and disposition of grievances, appeals, and State fair hearings
    - Requirements for continuation of benefits while pending appeal and State fair hearings

Areas of Strength and Needed Improvement

MCP Standards, including Enrollee Rights and Protections

Needed Improvement: Magellan did not calculate and provide a map of referral and subsequent enrollment patterns as part of the performance evaluation process.

According to the 2021 SOW between Magellan and WDH, Magellan is required to calculate and provide the State with a map of referral and subsequent enrollment patterns as part of the Contractor's performance evaluation. Magellan must provide the map to be fully compliant with requirements set forward in the SOW.

Recommendation for Magellan: Expand current calculation and map reporting for performance evaluation process to include referral and enrollment patterns.

Magellan is already providing provider and member maps as part of the performance evaluation for network adequacy and tracking referrals to the CME Program for individuals in PRTF level of care as part of their Enrollment Initiative PIP. Magellan should identify a process to track referrals to the CME Program and utilize current calculation and mapping capabilities to report patterns for annual performance evaluation. Magellan should also collaborate with WDH to identify other potential data gaps in their mapping process and have the updated reporting process approved by WHD.

Needed Improvement: Minimal access to PCPs among CME youth was reported in Q3 and Q4 of SFY 2021.

Magellan is responsible for assisting members and their families to identify a PCP and tracking PCP status in the member's health record. The Committee Data file indicated a high rate of members with an identified PCP in Q1 and Q2 of SFY 2021 (OP-11 in the 2020 SOW), >93 percent, but low compliance in Q3 and Q4 (OUT 13-5 in the 2021 SOW), 15 percent and 13 percent respectively. To fully comply with SOW requirements, Magellan must take steps to increase the rate of members with an identified PCP.

Recommendation for Magellan: Identify whether additional training on PCP assistance and tracking is needed for providers.

Between SFY 2021 Q2 and Q3, Magellan and WDH introduced a new EHR system to collect and manage member data. The time between Q2 and Q3 also saw a dramatic decrease in PCP compliance among CME members. This decrease indicates a potential documentation barrier or lack of provider knowledge on how to indicate PCP status. Magellan should evaluate whether additional training is needed to increase documentation of PCP status for CME members.

Recommendation for WDH: Update PCP performance measure to capture potential barriers more accurately.

As previously stated, the PCP measure compliance subsequently dropped following the implementation of a new EHR system. Updating the performance measure to capture more detailed data related to assessing and identifying PCP status may help to identify barriers to reaching compliance. Additional aspects could include assessing whether the provider discussed PCP access with the CME member, or the number of times PCP access was discussed with a member and their family / caregivers.

Needed Improvement: The SOW lacks a requirement for the results of Magellan's assessments to be regularly shared with the State.

As outlined in 42 CFR § 438.208, Magellan is required to share the results of any assessment with the State to minimize duplication of efforts. The SOW between Magellan and WDH does not specify a requirement to regularly share the results of assessments with the State. However, on January 1, 2021,

midway through the EQR period, the implementation of the FidelityEHR system provided WDH with new access to assessment results of CME members.

Recommendation for WDH: Add language to the SOW to explicitly require Magellan to share all assessment results with WDH.

WDH should formalize in the SOW a requirement ensuring the State's receipt of and access to the functional status assessments conducted for CME youth.

While assessment results used for CME member functional determinations are program-specific and may not be fully transferrable between State programs, WDH and Magellan should determine which (if any) assessment processes are duplicative, and which stakeholders would benefit from assessment results sharing.

Needed Improvement: The SFY 2021 SOW did not include specifications for how Magellan should collect data elements for electronic transmission of data.

According to 42 CFR § 438.242***,*** WDH needs to identify how Magellan "should collect data elements necessary to enable the mechanized claims processing retrieval systems to provide for electronic transmission of claims data in the format consistent with the Transformed Medicaid Statistical Information System (T-MSIS)." However, the specification for data collection for transmission are not identified in the SFY 2021 SOW.

Recommendation for WDH: Develop specifications for how Magellan should collect data elements for electronic submission of data. Include specifications in the SOW.

WDH should identify elements of data collection necessary for electronic transmission of data and include language explaining the requirements in the SOW.

Quality Assessment and Performance Improvement

Strength: Magellan "fully met" all compliance metrics for the Quality Assessment and Performance Improvement (QAPI) program required by both CMS and WDH.

Magellan was fully compliant with all 12 of the requirements set forth in 42 CFR § 438.330(b), the Quality Assessment and Performance Improvement Projects section of the compliance assessment. Magellan also met all the requirements for this section during the last compliance assessment conducted for SFY 2020. Magellan manages the Wyoming CME Quality Program, which designs, measures, and evaluates the performance of clinical care and patient safety, disease management, preventive health services, and member services. Magellan's Quality Program includes:

- **Performance Improvement Projects (PIPs)**: Magellan provided documentation for three required PIPs during the review period: Enrollment Initiative PIP, Minimum Contacts Requirement PIP, and Engagement and Implementation PIP.
- **Mechanisms to Detect Over- and/or Under-Utilization of Services***:* As part of the Quality Program, Magellan reported number of enrollments, encounters, authorizations, and paid claims for FCCs, FSPs, YSPs, Youth and Family Training, and Respite Care. If extremes in utilization are detected, the Clinical, Network, and Quality Teams at Magellan work together to review possible causes of the utilization and address the root cause.

Magellan outlined the process it uses to evaluate the impact of their quality assessments and PIPs, which includes close collaboration with WDH through regular reporting and meetings.

(This is a continued strength from SFY 2020).

Grievance and Appeals System

Strength: Magellan strengthened the program's grievance and appeals system based on feedback from SFY 2020 EQR process.

In SFY 2020, an area for improvement identified for the CME Grievance and Appeals System was the definition of OP-22 ("Complaints against Contractor") which had conflicting definitions. Guidehouse recommended for Magellan to clarify the purpose definition and purpose of OP-22.

During the SFY 2021 review, OP-22 was clearly defined across multiple documents to include all complaints against Magellan and defined a timeframe for response. Aligning definitions across multiple documents helps to improve data collection and analysis processes and facilitates effective ongoing monitoring of performance measures.

Section VI. Validation of Network Adequacy

Objective: EQR Protocol 4, Validation of Network Adequacy, assesses the MCP's network adequacy during the review period to comply with requirements set forth in 42 CFR § 438.68 which requires the State to develop and enforce network adequacy standards.

Guidehouse reviewed Magellan's network adequacy during SFY 2021 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 2021 SOW.

Based on these federal and State standards, Guidehouse identified 30 distinct elements to evaluate Magellan's compliance with network adequacy; however, only 12 of those elements are applicable to the CME Program. Appendix H includes Guidehouse's review tool for validating the adequacy of Magellan's provider 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 during normal, in-person operations nor during full virtual operations which began during the COVID-19 public health emergency. During standard operations, the community-based nature of the HFWA model involves providers traveling to the members at a time and location that works best for members, rather than members traveling to a clinic or facility. Therefore, travel time and distance do not impact enrollee access.
- **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 members, 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.

Table 20 provides an overview of Magellan's compliance levels with the applicable elements. Overall, Magellan and WDH met all applicable elements for network adequacy.

Table 20. Network Adequacy Assessment

42 CFR § 438.68 Standards	# Elements Met	# Elements Not Met	Total # Applicable Elements	# Elements Not Applicable
General Rule	1	0	**1**	**0**
Provider-Specific Network Adequacy Standards	1	0	**1**	**10**
Development of Network Adequacy Standards	9	0	**9**	**4**
Network and Coverage Requirements	0	0	**0**	**1**
Exceptions Process	0	0	**0**	**3**
Publication of Network Adequacy Standards	1	0	**1**	**0**
Total	**12**	**0**	**12**	**18**

Areas of Strength and Needed Improvement

WDH and Magellan fully complied with all federal and State-established network adequacy standards, in areas including:

- 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 members with limited English-proficiency. Per the member and provider handbooks, Magellan provides free interpreters and information written in other languages for members whose primary language is not English.

Strength: Improved administration of provider trainings led to consistent compliance with provider training and certification requirements.

During SFY 2021, Magellan consolidated all provider trainings within the Rise Training Platform, an online hub for all CME-related trainings and certifications. Through the platform, Magellan can track provider compliance with required training "tiers" (Tier 1, Tier 2), assign additional and ad-hoc trainings based on provider performance, and monitor engagement and performance on individual trainings.

The improved administration of provider trainings enabled Magellan to report consistently strong compliance with network-related training requirements in SFY 2021. For example:

- **OP-01a** (*Rate of providers in network meeting all requirements*): >99 percent compliance across all applicable months
- **OP-01c** (*Rate of new providers completing initial provider training*): 100 percent compliance across all applicable months

- **PM 10-3** (*Conduct initial provider training and certification as an FCC, FSP, YSP, or respite provider prior to being activated to provide CME service):* 100 percent compliance across all applicable months

Strength: Magellan has maintained consistent enrollment and program effectiveness amid the substantial policy changes associated with the COVID-19 public health emergency.

Magellan has historically used telehealth to allow continued care coordination when youth and providers are not in the same physical location. With the emergency Section 1915(c) Appendix K filed by WDH, Magellan's youth and providers were mandated to use telehealth during the review period due to the COVID-19 public health emergency. Continuing from the previous review period, Magellan extended telehealth offerings to all providers and removed key barriers for providers in delivering services to youth. Specifically, Magellan created Health Insurance Portability and Accountability Act (HIPAA)-compliant Zoom accounts for all youth and providers and launched numerous telehealth-related trainings on the Rise training platform. As evidence of success of Magellan's telehealth program, Magellan staff reported that multiple youth and providers have opted to maintain telehealth service offerings once the emergency order expired.

(This is a continued strength from SFY 2020).

Needed Improvement: Total provider enrollment for the CME Program ultimately declined across the period and ended at a 12-month low count.

While Magellan largely met provider ratio requirements during applicable reporting months, including >96 percent compliance for all months during 2020 within the review period, total CME provider enrollment declined dramatically in 2021 and ended at a 12-month low. Table 21 shows total provider enrollment in the CME Program across the review period:

Table 21: Total Provider Enrollment, SFY 2021

Year	2020						2021					
Month	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Total Provider Count	74	74	79	79	84	84	81	75	80	73	71	69
Percent Change	N/A	0%	7%	0%	6%	0%	-4%	-7%	7%	-9%	-3%	-3%

The significant decline in provider enrollment observed during the first six months of 2021 threatens overall program network adequacy. During the virtual interviews, Magellan noted numerous potential driving factors for declining provider enrollment, including (1) technical and claims payment issues; (2) lagging reimbursement rates; and (3) dissatisfaction with virtual delivery of services. Magellan also recognized the issue of exiting providers in their 2021 Network Development Plan:

"Historical provider turnover since initial implementation, July 2015, has been approximately one provider leaving for every two new providers to the network. While some turnover is expected, Magellan continues to look towards improving the quality of recoupment and retention of seasoned providers."

Additionally, as the Contractor for a behavioral health program, Magellan must provide a sufficient provider network which enables enrolled youth to select a provider based on shared experiences, interests, and trust. Enrolled youth may encounter barriers to selecting an appropriate provider if provider enrollment continues to decline at rates higher than historical averages.

Recommendation for Magellan: Focus and diversify provider retention strategies to maintain an adequate provider network.

To date, Magellan has primarily discussed efforts to diversify provider recruitment strategies. These include streamlining cross-certification of providers in CME services and other behavioral health services (e.g., Quality Recruitment Initiative, Blended Network Model); conducting targeted recruitment within tribal and underserved communities; and partnering with community advisory groups to recruit new providers. However, the Network Development Plan does not list retention strategies intended to maintain an adequate provider network and avoid declines in provider enrollment. Magellan would benefit from convening a workgroup specifically for developing retention strategies for existing and seasoned providers and integrating strategies as part of the Network Development Plan or program PIPs.

Needed Improvement: Network adequacy documentation provided by Magellan contained conflicting or incomplete information.

Magellan provided several documents describing the provider network, which often had inconsistencies or incomplete information. Provider network documents and subsequent inconsistencies include:

- **Member Location Geo-Mapping**: Magellan provided geo-maps of members and providers for each HFWA provider type, including FCC, FSP, YSP, and Respite. Magellan has providers throughout all regions of Wyoming -- including the Southeast, Southwest, Northeast, Northwest, and Central regions. However, while FCC, FSP, YSP, and Respite providers served all regions of the State during the review period, total provider counts offered via geo-mapping did not convey a clear representation of network adequacy with duplicative counts across service areas and cross-certified providers included.

Figure 5: Excerpt from Member Location Geo-Mapping

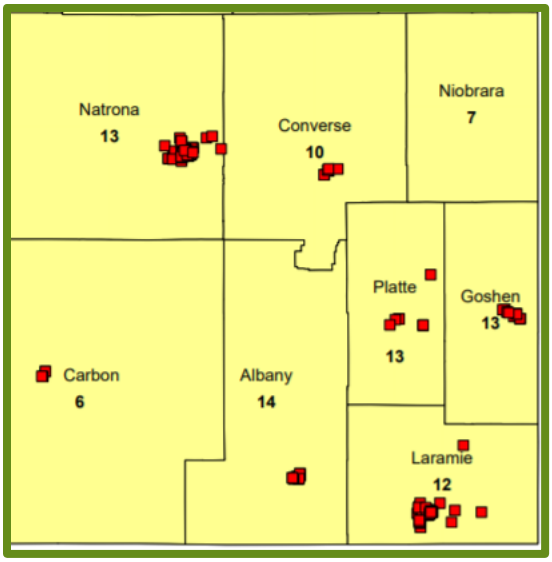


Figure 5: Geo-mapping provided by Magellan does not accurately represent unique provider counts. The excerpt from Figure 5 implies that 14 distinct providers serve Albany County when 14 statewide providers simply include Albany County within their catchment area (but may actively serve other counties).

Guidehouse was unable to determine regional, non-duplicative provider counts from the geo-mapping provided for FCC, FSP, YSP, or Respite providers, which were needed to make determinations on timely access, coordination/continuity of care, and coverage.

Guidehouse also identified needed improvements in design and formatting of Magellan's member location geo-mapping documentation. As seen above in Figure 5, Magellan used boxes to map the location of individual members, but whole numbers to represent total number of providers serving each county. These data elements can be easily misconstrued as repetitive. Additionally, Magellan utilized a heat-scale design to represent provider enrollment within each county,

incorporating ranges of 0-19, 20-49, and 50+ providers. However, all counties fall within the first range (0-19 providers) across all geo-maps, which undermines the impact of the heat-scale design.

- **Committee Data Files**: In accordance with the SFY 2021 SOW, Magellan provided quarterly data reporting to the State in Committee Data Files. Multiple inconsistencies existed across performance measures within the files, notably in youth enrollment count.[11] Table 22 compares total youth enrollment count reported by Magellan across numerous performance measures for the month of January 2021:

Table 22. Youth Enrollment Count Comparison, Jan 2021

	Measure 1	Measure 2	Measure 3
Category	**EM 9-16: FCC & Plan of Care (POC)**	**EM 9-20: FCC & Contact with Parent and Youth twice a month in a quarter**	**EM 9-22: Routine readiness assessments based on the pre-approved Transition Readiness Scale**
Total Number of Enrollees or Youth	No Data	124	223

Recommendation for Magellan: Clearly define quality control and assurance processes to ensure data integrity.

Magellan would benefit from establishing improved record-keeping practices to support succession planning and staff transitions. It is important to ensure that more than one staff member has the knowledge and understanding needed to maintain consistent, accurate processes.

Recommendation for WDH: Require consistent reporting and dashboarding of data elements essential to program operations.

Data elements including total youth enrollment and total provider enrollment are required for determining network adequacy and can be considered "essential" for overall program monitoring. As part of the SOW with the CME Contractor, WDH should require reporting and dashboarding of distinct data points for youth and provider enrollment on a consistent basis (at least monthly). Data reporting can be included as part of Committee Data Files currently generated by Magellan or using a separate format.

Recommendation for Magellan: Streamline design of geo-mapping to facilitate analysis.

Magellan can improve and streamline design of the member location geo-mapping to facilitate ongoing monitoring by WDH. Magellan can adjust the heat-scale design to better reflect current

[11] Subsequent to Guidehouse's interviews with Magellan and identification of deficiencies, Magellan resubmitted the Q3-Q4 Committee Data Files, including operational requirements and outcome measures, in January 2022. The updated and resubmitted files showed that Magellan remediated numerous data inconsistencies outlined above, including provider and enrollee counts. Magellan indicated the new data was a result of a change in their reporting logic however supporting documentation including updated policies and procedures were not provided to Guidehouse and could not be validated. Additionally, other items noted in this area of needed improvement remain unresolved.

ranges of provider enrollment reported in each county (e.g., ranges of 0-5, 5-10, and 10+ providers). Magellan also has the opportunity to add and / or differentiate data elements, including physical location of providers within maps.

Section VII. Implementation and Effectiveness of State Quality Strategy

At the request of WDH, Guidehouse conducted an evaluation of Magellan's implementation of the 2020 State Medicaid Managed Care Quality Strategy, in effect during SFY 2021. The Quality Strategy covered topics pertaining to the CME Program operations, as required per 42 CFR § 438.340. Topics covered in the Quality Strategy include:

- Network adequacy and availability of services standards
- Goals and objectives for continuous quality improvement
- Quality metrics and performance measures
- Performance improvement projects
- External quality review
- Transition of care policy
- Plans to identify, evaluate, and reduce health disparities
- Use of intermediate sanctions (applies to managed care organizations (MCOs) only)
- Assessment of performance and quality outcomes (applies to primary care case management (PCCMs) entity only)
- Identification of persons who need long-term services and supports or persons with special health care needs
- Nonduplication of EQR activities
- Definition of "significant change"

Since Magellan does not maintain documentation specific to the Quality Strategy, Guidehouse conducted interviews with Magellan staff to assess the effectiveness of the implementation of the Quality Strategy. Magellan did not have any recommendations for WDH in improving the Quality Strategy.

Areas of Strength and Needed Improvement

Strength: Magellan reviewed and disseminated the 2020 State Medicaid Managed Care Quality Strategy and is actively taking steps to align with guidance.

Magellan confirmed in virtual review that the 2020 State Medicaid Managed Care Quality Strategy was disseminated and reviewed by all relevant staff. Additionally, Magellan outlined steps taken during the review period to align with objectives of the Quality Strategy, including hosting Quality Improvement Committee (QIC) meetings, developing Quarterly and Annual Reports, conducting targeted provider recruitment, and addressing programmatic health disparities.

Needed Improvement: Magellan does not maintain documentation related to the 2020 State Medicaid Managed Care Quality Strategy to structure response to guidance set forth in the Quality Strategy.

While Magellan is actively taking steps to align with guidance set forth in the Quality Strategy, most steps are related to HFWA program principles and / or SOW requirements and were active before the Quality Strategy was implemented by WDH (e.g., outcome measures tracking; external quality review). Magellan does not maintain documentation to exemplify how the program has responded directly to Quality Strategy guidance.

Recommendation for Magellan: Develop comparative analyses to document response to Quality Strategy guidance.

Magellan's QIC should develop crosswalks and other comparative analyses aligning Quality Strategy guidance to steps actively taken by Magellan to better document compliance with requirements and resulting program improvements.

Section VIII. Information Systems Capabilities Assessment (ISCA)

EQR Protocols 1, 2, 3, 4, 5, and 7 require states to assess their MCP's information system capabilities. Per 42 CFR § 438.242 and 42 CFR § 457.1233(d), states must ensure that each MCP maintains a health information system that collects, analyzes, integrates, and reports data for areas including, but not limited to, utilization, grievances and appeals, and disenrollments for reasons other than the loss of Medicaid eligibility.

Guidehouse assessed the integrity of Magellan's information system and the completeness and accuracy of the data in accordance with the ISCA. Guidehouse'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. Due to an architecture change and mid-year transition to a new system, our assessment focused on January 1, 2021 – June 30, 2021.

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, Magellan's 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 with additional recruitment and cross-training of staff, and systems demonstrate no areas for concern.

Staffing

Magellan's staffing level for those who support adjudication and reporting is appropriate for processing claims and generating measures. Measure owners reported obtaining support from team members who have access to instructions for measure generation. Additionally, 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 98 percent accuracy on a 100 percent sampling for two consecutive weeks.
- 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 member'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. Magellan clarified that it runs duplicate edits against both paid and denied claims. They also provided a report showing 100 percent accuracy for both paid and denied fee-for-service (FFS) claims included in the two percent audit sample during the assessment review period.
- **Data flows through system:** Magellan uses several systems and programs to store and process data. Magellan loads all data into a data warehouse. The team provided process flow documentation and described the use of SQL Server Integration Services (SSIS) packages including encryption for data both at rest and in-transit.
- **Data reporting:** Magellan populates quarterly, and annual report data based on claims data, authorizations data, fidelity survey data, and Wyoming Medicaid's Cognos system. In addition to internal data sources, Magellan uses third-party reporting software Izenda, Fidelity EHR Reporting, to generate results for the measures included in the EQR Protocol 2 review.
- **Verification and approval of data:** Magellan validates performance measure data using their internal subject matter experts, whom Magellan calls "data owners." The team reviews some measure results on a weekly basis, while all are reviewed during the monthly QIC meeting. 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 based on the plan designed to meet and/or exceed client specific Recovery Time Objective (RTO) and Recovery Point Objective (RPO). Magellan performs "rehearsals" or tests to confirm the disaster recovery plan annually at minimum.

Section VIII. Conclusion

Guidehouse's review of Wyoming's CME Program resulted in identification of 11 areas of strength, 12 areas of needed improvement, and 18 recommendations in relation to quality, timeliness, and access to services. Overall, major strengths of the CME Program include, but are not limited to:

- Improved processes for federally required documentation development, including for Performance Improvement Projects and performance measure creation, when compared to previous review periods;
- Improved grievance and appeals reporting policies and process;
- Consolidated trainings into a single user platform, which enabled targeted training deployment and development of additional training modules; and
- Successfully managed delivery of CME services via telehealth for a second year.

However, there are also areas of needed improvement including, but not limited to, the following:

- Missing performance goals for operational requirements and outcome measures
- Poorly defined and inconsistently reported performance measures (e.g., numerators, denominators) across the review period
- Declining provider enrollment in the CME network, which may threaten network adequacy and ease of service access

Appendix I provides a consolidated listing of Guidehouse's findings for the CME Program as they relate to strengths and areas of needed improvement and their associated domain (e.g., quality, timeliness, or access to care).

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