Wyoming Department of Health
Care Management Entity Program
SFY 2022 External Quality Review
Technical Report

April 2023

guidehouse.com/healthcare

Table of Contents

Appendices *(attached separately)*

Appendix A: Abbreviations and Acronyms
Appendix B: Status of SFY 2021 Recommendations
Appendix C: Protocol 1 - PIP Worksheets Combined
Appendix D: Additional Methodology for Protocol 2

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) 2022 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:

- 9 areas of strength
- 10 areas of needed improvement
- 12 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

Year	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
CME Youth Served	328	431	494	402	402	385	366

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.

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.

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 2022 (July 1, 2021 to June 30, 2022). 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), SFY 2020 (July 1, 2019 to June 30, 2020), and SFY 2021 (July 1, 2020 to June 30, 2021). 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 2021 External Quality Review

Guidehouse's SFY 2021 review of Wyoming's CME Program resulted in identification of 11 areas of strength, 12 areas of needed improvement, and 17 recommendations in relation to quality, timeliness, and access to services.

Of the 17 recommendations for WDH and/or Magellan:

- 6 recommendations have been fully addressed
- 2 recommendations have been partially addressed
- 8 recommendations have not been addressed
- 1 recommendation was not applicable or evaluated as part of SFY 2022 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 2022 Recommendations

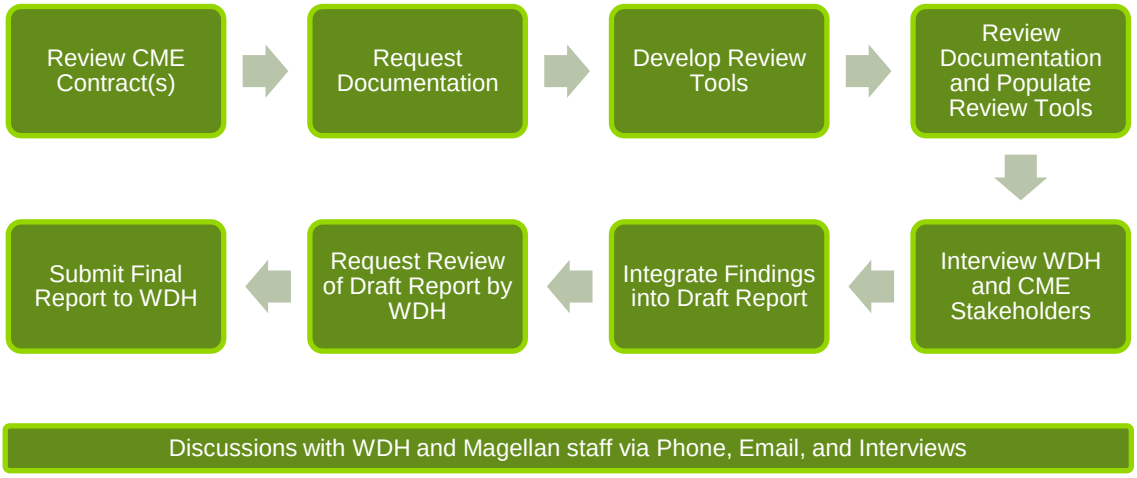
EQR Protocol	SFY 2021 Recommendations for:		Total	Total # of Recommendations, by SFY 2022 Status			
	Magellan	WDH		Fully Addressed	Partially Addressed	Not Addressed	N/A[1]
Protocol 1. Validation of Performance Improvement Projects	4	1	**5**	2	1	2	0
Protocol 2. Validation of Performance Measures	2	0	**2**	2	0	0	0
Protocol 3. Compliance with Medicaid Managed Care Regulations	2	3	**5**	0	0	5	0
Protocol 4. Validation of Network Adequacy	3	1	**4**	2	1	1	0
State Quality Strategy	1	0	**1**	0	0	0	1
TOTAL	12	5	**17**	6	2	8	1

[1] 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 Part 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 2022 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
- Member and provider handbooks
- Outreach and marketing templates and materials
- Quarterly reports to WDH (including SFY 2022 Quarters 1 – 4, with the Quarter 4 report also serving as the annual report)
- Geographic information on member 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 November 2022 to February 2023
- Virtual interviews and review sessions with Magellan staff on February 6 - 10, 2023
- 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 2022 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 two PIPs which were active during SFY 2022:

- 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 2022 PIP Validation Ratings

Performance Improvement Project (PIP)	Intervention	Validation Rating
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.

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 2022 SOW between Magellan and WDH. • The population targeted was altered this year, but during the virtual EQR process, Magellan clarified that the population was not changed and was a reporting error. • 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% of the time for the metric that all CME enrolled youths(with a full month of enrollment; ages 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 discussed the evaluation of the method of preferred contact. They stated they believed the family's desired method of contact was included in the case notes but the comparison to how the provider contacted members was not confirmed.

Data Analysis	• Magellan was in the baseline data collection period for the Minimum Contacts PIP (1/1/2021 - 12/31/2021) however, they terminated the PIP on August 25, 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 - 8/325/2021): 89.30 percent
	  ▪ During the virtual EQR process when questioned for the reasoning of the termination during the baseline period, Magellan stated the PIP had been low performing when previously addressed but due to the high success it was determined with State input to terminate the Minimum Contacts PIP and focus the resources on the other PIP.
	• According to the QIA form, Magellan reviewed the analysis and identified no instances that threatened the reliability or validity of the PIP.

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 again 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 was terminated on August 25, 2021 with input from the State due to high success and the desire to focus more resources on Magellan's other PIP. Due to the early termination, there will be no future improvement.

Recommendations

Although no longer an active PIP, opportunities for Magellan to further align with guidance provided in CMS EQR Protocols and improve design and implementation of the PIP include:

- Identifying 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. Guidehouse also encourages for future PIP documentation that evidence-based research or data-based evaluations be included as justification for PIPs.
- Data validation efforts. Although Magellan provided a detailed data analysis in the submitted QIA forms, there was no discussion of data validation or even simple validity checks that are undertaken to ensure all analyses are credible.
    - During the virtual EQR process, Magellan confirmed that staff spot check all reported data against what is documented in the case notes. This is an important practice and recommended that it be standardized and included in future documentation.

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 2022 Statement of Work between Magellan and WDH. • Magellan also clarified during the virtual EQR process that getting family and youth engaged was critical. Best practice research shows family and youth are most successful when youth are staying out of a higher level of care. When this happens, the youth are less likely to escalate to the point where they need to go to a crisis center. • 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 2022?" ○ "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 2022?" • 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 2022)." • 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)"

Evaluation Category	Findings

	• Magellan specified objective, time-specific continuous variables for each performance measure in the SFY 2022 QIA form:
	  ○ **Measure #1: *Numerator*:** "Count of youth >60 calendar days of HFWA ("not engaged")." ***Denominator*:** "Count of discharged youth HFWA."
	  ○ **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. As raised during the discussion, due to the years of implementation, Guidehouse recommends adding an additional performance measure that evaluates the participants benefits of care.

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. • To collect data for this PIP in CY 2022, 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 the Fidelity EHR system for all included discharges during 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. It was recommended that data validation steps should be included in the QIA forms. • 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 four 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%
	  ▪ Remeasurement 4 (SFY 2022, July 2021 – June 2022): 13%
	  ○ **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%
	  ▪ Remeasurement 4 (SFY 2022, July 2021 – June 2022): 70%
	• Magellan tested for statistical significance using Fisher's Exact Test for each measurement period. Out of the two measures, neither results were statistically significant from last year's to this year's performance.
	• 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

Evaluation Category	Findings
	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. There was no change in baseline for 2022.

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 4 (SFY 2022).
	  ○ Discussion of measures in Monthly Provider calls which also included sharing of best practices by providers to encourage collaboration.
	  ○ Focused on communication outreach through emails, provider website, and additional trainings.
	• Magellan included a comprehensive table in the QIA form that included all interventions implemented from SFY 2018 to SFY 2022 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. It was also recommended that considering the years of implementation that an evaluation of the improvement strategies or follow-up activities to determine the ability to achieve the goal of the PIP.

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 includes data validation or at the very least, simple validity checks to ensure all analyses are credible.
  - During the virtual EQR process, Magellan confirmed that staff complete a simple eye test to evaluate the initial credibility of the data and occasionally compare data to chart documentation. While this is good practice, Magellan should standardize the process, set parameters for chart comparisons, and include in the documentation.
- Develop an annual target (i.e., short-term goal) for the PIP to achieve the long-term goal of the PIP.
  - Magellan has generally seen an increase in performance for each performance measure each year, even it is not statistically significant. By setting annual targets it will encourage the whole staff to achieve and celebrate incremental wins as Magellan achieves the long-term performance target of the PIP.
- 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, Guidehouse recommended that Magellan evaluate the success of the various improvement strategies to determine whether there are any additional activities or initiatives that can be utilized to achieve the goals of the PIP.

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 2022 EQR continued to include clearly labeled items and sections, comprehensive data tables, and identification of the IHI's PDSA process used to develop performance improvement project development. The strengths in documentation exhibited during the SFY 2021 EQR continues to be seen in the SFY 2022 EQR.

Strength: Collaboration with stakeholders is demonstrated by Magellan's continued improvement and engagement of providers.

Throughout the changes to PIPs and the disruptions caused by the COVID-19 Public Health Emergency (PHE), Magellan continued to see engagement with providers and performance improvement with the PIPs. This a success and Magellan should celebrate the fact that the collaborative environment they created among the CME members, providers, and their staff has led to continued success throughout all of the disruptions the health system has encountered the last several years.

Needed Improvement: Magellan does not have a standardized data validation plan for reviewing PIP data that is collected and analyzed.

Although Magellan maintains a detailed written data analysis plan as described in the submitted QIA forms, it lacks a standardized validation plan. During the virtual EQR process, Magellan confirmed that data validation does occur through initial staff reviews for reasonableness and random spot checks against case notes to determine validity. While these steps are commendable, a standardized validation process should be developed and documented to ensure continuity of data processing.

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

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 2022 period made statistically significant improvements (as determined using Fisher's Exact Test). Specifically:

- 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.
- The Minimum Contact PIP was terminated prior to completing the baseline data collection phase and did not have a full year of remeasurement data to gauge impact.

Recommendation for Magellan: Conduct an updated formal data-driven evaluation of barriers impacting the effectiveness of PIPs improvement strategies implemented in the past couple of years.

Currently, barriers to meeting PIP goals are identified by PIP workgroups comprised of representation from the Clinical, Quality, Training, and Network Departments, collected during calls with providers and members, or based on results from a provider survey (last conducted in 2019 for the Minimum Contacts PIP). Magellan should organize and conduct a formal barriers analysis and evaluation to enable targeted collection of feedback on the impact of current PIPs and identification of any other barriers that may benefit from a targeted PIP. This evaluation should include analyses of data available to Magellan and assessment of previously implemented improvement strategies. This level of evaluation will not only identify barriers to success but should provide guidance to what additional steps Magellan can undertake to achieve success for all of their PIPs. Additionally, Magellan should consider routinely surveying providers to obtain feedback and assess barriers.

Recommendation for Magellan: Identify annual improvement targets that will lead to achievement of the long-term target of the PIPs.

Magellan has generally seen improvement for their PIPs, although not statistically significant. It is also clear that Magellan's staff and providers are all engaged and are collaborating in the improvement of the outcomes for the participants while striving to meet the goals of the PIP. To further encourage all stakeholders to achieve the goals of the PIPs, Guidehouse recommends Magellan develop annual performance targets that if achieved will incrementally lead to the ultimate success of their PIPs.

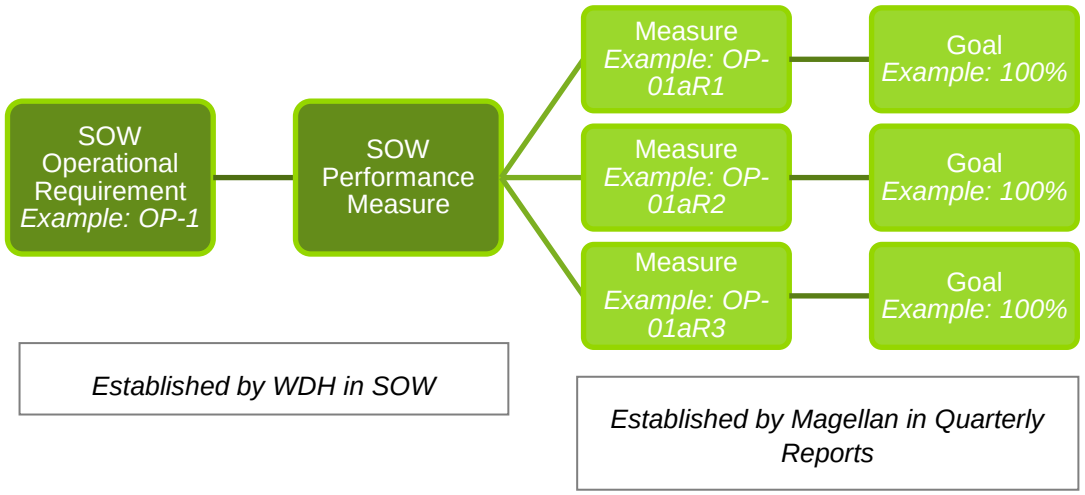
Section IV. Validation of Performance Measures

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

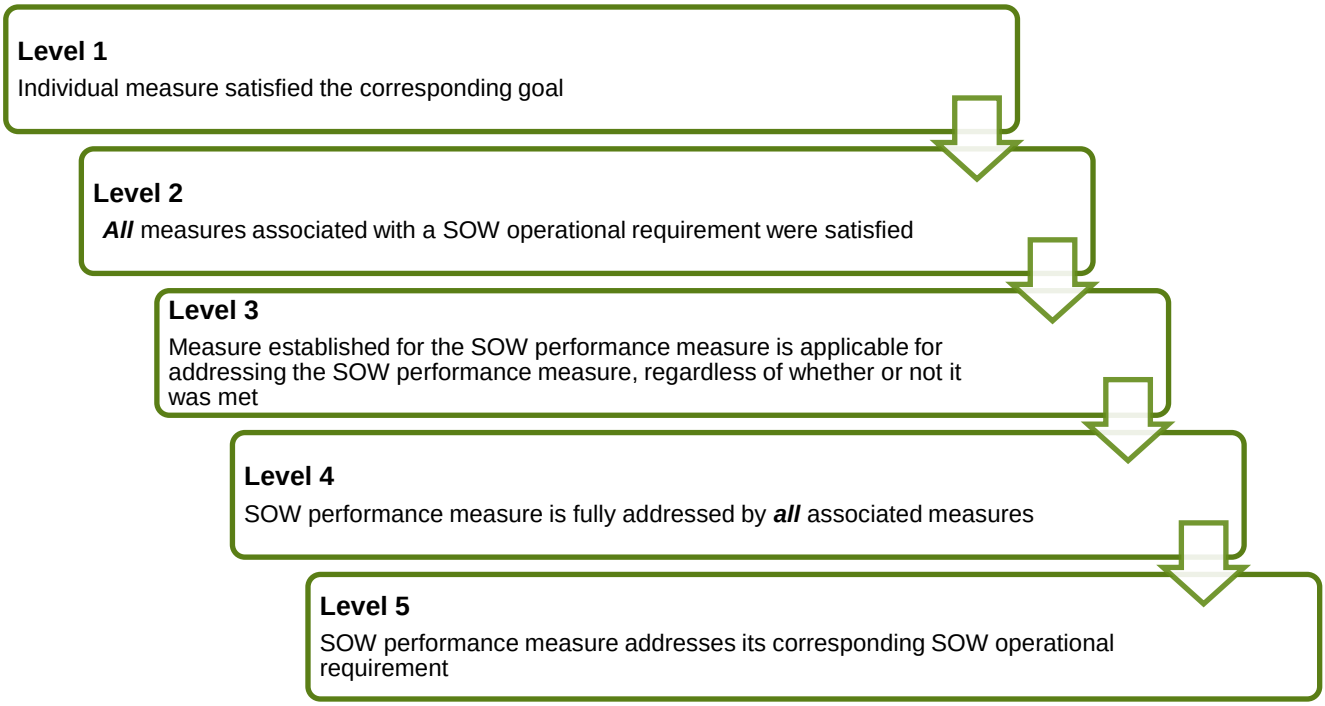


For SFY 2022, review and validation of reported data included 26 measures established by Magellan for 23 SOW operational requirements.

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 23 measures and 26 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 23 measures and 26 operational requirements, as stipulated in the SOW active during the review period. Table 8 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.[2, 3]

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

Level 1 Evaluation	Percent of Measures *(n=26)*
Goal Met	65.4%
Goal Not Met	34.6%
Not Applicable	0.0%
Insufficient Data	0.0%
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).

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

Level 2 Evaluation	Percent of PMs *(n=23)*
Yes	60.9%
No	39.1%
Not Applicable	0.0%

[2] Throughout this section "Not Applicable" indicates there was no applicable data in SFY 2022 for this measure.

[3] 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.

Level 2 Evaluation	Percent of PMs *(n=23)*
Insufficient Data	0.0%
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=26)*
Yes	100.0%
Partially[4]	0.0%
No	0.0%
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=23)*
Yes	100.0%
No	0.0%
Total	100.0%

[4] 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=23)*
Yes	60.9%
Partially[5]	0.0%
No	39.1%
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 13-1**: Out-of-Home (OOH) Placements
- **OUT 13-3:** Recidivism
- **OUT 13-6**: Cost Savings (Healthcare Costs)

Table 13. Validation of Protocol 2 Performance Measures

Performance Measure	Measure Steward	Data Collection Method	Findings				Confidence Rating
			N	D	S	Total	
OUT 13-1: Out-of-Home (OOH) Placements	WY Custom	EHR	5	3	5	13	Moderate
OUT 13-3: Recidivism	WY Custom	EHR	3	3	5	11	Moderate
OUT 13-6: Cost Savings (Healthcare Costs)	WY Custom	EHR	3	3	3	9	Low

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

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

reviews of logic and documentation required for measure creation. For each measure, Guidehouse 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:

- 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 13-1: Out-of-Home (OOH) Placement • **Numerator**: Number of youth enrolled in Out-of-Home (OOH) as Psychiatric Residential Treatment Facility (PRTF) and Acute Psychiatric Facility • **Denominator**: Number of youth enrolled in CME Program (for 6+ months)			

Table 15. Protocol 2 Measures and Findings

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
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), and to complete manual calculation(s) from the Working CDF. **Numerator**: Someone other than the OUT13-1 measure owner creates the "Working_Wyoming_CME_Committee_Data_File" from which the numerator is manually calculated by adding the totals of two tabs (PRTF and Acute). **Denominator**: Following import of the nightly Committee Data File (CDF) data extracts from Izenda, the measure creator executes SAS scripts to trigger Structure Query Language (SQL) scripts which output the result for the denominator to Excel. With the exception of counting only youth in the program 6+ months, the query appears to be accurate, but it cannot be executed in a manner that will recreate the same result for the review quarter(s) at a later point in time. The query has no change log or timestamp, so it is not certain that the same exact code is running for each quarterly creation. **Overall Findings**: • The numerator and denominator are disparate comparisons. The numerator counts only those *PRTF or Acute youth* enrolled 6+ months and still enrolled at the end of the review quarter, while the denominator is a count of all youth in the CME Program, regardless of duration, at the same point in time. If the denominator is overstated, the result would be an under-reported rate of youth in OOH placement. The denominator should count only youth enrolled for 6+ months. This calculation is further complicated with the retroactive enrollment and disenrollment processes, which can run as much as 60 days after the effective date of the change. • Measure creation team now has access to the raw data, so they are not limited to the query features from Izenda. The measure creation team can now extract the data themselves and maintain reusable, version-controlled, SQL queries. • The measure creator demonstrated the manual processes in Excel. Each person on the technical team can perform the steps and has written documentation on the manual portion of the process, however the instructions require updates to properly reference the specific measure and purpose. • The process of accepting the numerator (PRTF and Acute) values from the working CDF, without having access to verify the raw data used to create it, has potential for error. If the working file is incorrect, the measure rate will be incorrect.	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 13-3 Recidivism • **Numerator**: Number of youth enrolled in higher level of care (HLOC) which is PRTF • **Denominator**: Number of youth enrolled in CME Program (for 6+ months)			

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), and to complete manual calculation(s) from the Working CDF. **Numerator**: Someone other than the OUT13-3 measure owner creates the "Working_Wyoming_CME_Committee_Data_File" from which the numerator is obtained by taking the total of the PRTF tab. **Denominator**: Following import of the nightly CDF data extracts from Izenda, the measure creator executes SAS scripts to trigger SQL scripts which output the result for the denominator to Excel. With the exception of counting only youth in the program 6+ months, the query appears to be accurate, but it cannot be executed in a manner that will recreate the same result for the review quarter(s) at a later point in time. The query has no change log or timestamp, so it is not certain that the same exact code is running for each quarterly creation. Overall Findings: • The numerator was calculated incorrectly as including both PRTF and Acute, as done in Measure OUT 13-1, and the measure owner is taking immediate steps to correct the error. For months where the numerator is overstated, the rate is therefore over-reported. • The numerator and denominator are disparate comparisons. The numerator counts only those PRTF youth enrolled 6+ months and still enrolled at the end of the review quarter, while the denominator is a count of all youth in the CME Program, regardless of duration, at the same point in time. If the denominator is overstated, the result would be an under-reported rate of youth recidivism. The denominator should count only youth enrolled for 6+ months. This calculation is further complicated with the retroactive enrollment and disenrollment processes, which can run as much as 60 days after the effective date of the change. The measure creation team believes the PRTF value includes only youth in the program 6+ months and agree that the documentation should be updated to reflect this. • Measure creation team now has access to the raw data, so they are not limited to the query features from Izenda. The measure creation team can now extract the data themselves and maintain reusable, version-controlled, SQL queries. • The measure creator demonstrated the manual processes in Excel. Each person on the technical team can perform the steps and has written documentation on the manual portion of the process, however the instructions require updates to properly reference the specific measure and purpose. • The process of accepting the numerator PRTF value from the working CDF, without having access to verify the raw data used to create it, has potential for error. If the working file is incorrect, the measure rate will be incorrect.	No	No	Yes
OUT 13-6: Cost Savings (Healthcare Costs) • **Numerator**: Total Medicaid Cost (for CME Program)			

Table 15. Protocol 2 Measures and Findings

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
• **Denominator**: Number of youth enrolled in CME Program (for 6+ months) • **Numerator O**: Total Medicaid Cost (for Non-CME Youth) • **Denominator O**: Number of non-HFWA youth enrolled in PRTF (for 6+ months)			

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), and to complete manual calculation(s) from the Working CDF. **Numerators**: Someone other than the OUT13-6 measure owner creates the "Working_Wyoming_CME_Committee_Data_File" from which the numerators are obtained by using the totals from both the Expenditures and CME Expenditures tabs. **Denominators**: The 'O' denominator is copied directly from the PRTF tab of the Working CDF described above. Following import of the nightly CDF data extracts from Izenda, the measure creator executes SAS scripts to trigger SQL scripts which output the result for the primary denominator to Excel. With the exception of counting only youth in the program 6+ months, the query appears to be accurate, but it cannot be executed in a manner that will recreate the same result for the review quarter(s) at a later point in time. The query has no change log or timestamp, so it is not certain that the same exact code is running for each quarterly creation. Overall Findings: • The expenditure values were correct as copied from the Working CDF tabs, but the reviewers had concerns which the CME team believes relate to the involvement of a Family Care Coordinator (FCC) represented by the 'T1016' and mandatory for CME: o For the primary numerator, the number of distinct CME members included for CME Expenditures was *higher* than the distinct number of CME members as reflected in the corresponding primary denominator in each quarter; and o For the 'O' numerator, the number of distinct CME members included for All Expenditures was *lower* than the distinct number of CME members as reflected in the primary denominator in each quarter. • For 'All Expenditures', the reviewers questioned the inclusion of various costs (dental, pharmacy, etc.), and the CME team agreed that the total should include all expenditures for the CME youth. • The CME will also consider the comparison of expenditures since the CME members would have as many as 3 per member per month (PMPM) payments in a given quarter while the non-CME youth would have none, thus falsely inflating the non-PMPM cost comparison for the CME youth. • One additional finding is that calculating this measure quarterly can result in diluting the total cost of full-quarter members by the total enrollment which may include members who enrolled the last few days of the quarter. • Measure creation team now has access to the raw data, so they are not limited to the query features from Izenda. The measure creation team can now extract the data themselves and maintain reusable, version-controlled, SQL queries. • The measure creator demonstrated the manual processes in Excel. Each person on the technical team can perform the steps and has written	No	No	No

Table 15. Protocol 2 Measures and Findings

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
documentation on the manual portion of the process, however the instructions require updates to properly reference the specific measure and purpose. • The process of accepting the numerators and one denominator value from the working CDF, without having access to verify the raw data used to create it, has potential for error. If the working file is incorrect, the measure rate will be incorrect.			

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 2022. 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.	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
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.	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

Outcome Measure	Guidehouse Determination
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 members 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.	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.	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 and technical teams are knowledgeable, engaged, and invested.

Both the clinical and technical teams for the demonstrated measures have years of experience with the CME Program and the data/analysis used for measure creation, understand the measures, and work to ensure compliance in terms of data submission, extraction, and reporting. These traits are further enhanced through the quality and reconciliation processes.

(This is a continued strength from SFY 2021).

Strength: Documentation describing measure result creation continues to improve.

For the measure performance reviews, Magellan provided detailed measure creation documentation for OUT 13-1, OUT 13-3, and OUT 13-6. The documentation now includes specific references to both internal and external file names as well as the SQL source code. Additionally, the documentation describes detailed references to input files and each manual calculation required to determine numerators and denominators.

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 13-1, OUT13-3, and OUT 13-6 teams each have three people experienced in creating the measure.

(This is a continued strength from SFY 2021).

Strength: Magellan now has access to extract the raw CME membership data from Izenda/Fidelity and import to its own data warehouse which is now the source for the denominator creation processes.

The technical staff has the knowledge and access to pull data directly from the EHR source tables and perform their own analysis rather than depending on use of the queries limited by the Izenda interface as experienced in the 2021 review.

Needed Improvement: Numerator and denominator alignment to guarantee accurate measure rate or average.

For measures where the denominator includes, for example, members in the CME Program for 6+ months, ensure the members or monetary amounts calculated in the numerator also include only those members in the CME Program for 6+ months to avoid over- or under-stating the rate or average.

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: Measure creation team is unable to recreate results as of a prior time period making it difficult to validate results.

Due to the possibility of retroactive enrollments and discharges up to 60-days after the effective date, CME membership and costs can fluctuate over time. Without saving the executed source code, timestamp, original source file, and the results at the point in time the measure is created each quarter, the team is unable to confidently prove the results as of a prior run date.

Recommendation for Magellan: Create and archive a run log with both code and results (roster, costs, etc.) for each output used from the CDF and each quarterly measure creation. Carefully document SAS and SQL scripts to reflect any logic changes that may result in one quarter being calculated differently than another for an individual measure.

Consider creating a secure folder structure where the team can store the final run used for each quarterly measure creation. If questions arise at any point in the future, both the clinical and technical teams will have access to see the input and output data exactly as it was processed as that time. Any future runs typically result in variances as membership may have changed due to retroactive updates.

Needed Improvement: Contract and business requirement documents (BRD) require more clarity.

To ensure the technical staff authors the extract and calculation scripts correctly, provide more clarity in the business requirements. This will also serve the reconciliation team and Quality Improvement Committee (QIC) as they validate the results.

Recommendation for WDH: Include more detail in the contract and subsequently the BRDs.

To avoid assumptions which may lead to under- or over-reporting of rates, cost, averages, etc., consider more specific documentation describing the exact inclusions and exclusions required for each measure. Rather than stating “number of CME members”, clearly state “CME members in the program as of the last day of the quarter”, “CME members with at least one day of membership at any point during the quarter”, “CME members for a minimum of six continuous months”, for example. Each of these statements may yield a different number for membership.

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.[6] 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 member materials and State laws on member 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 2022
	42 CFR § 438.207. Assurances of adequate capacity and services	SFY 2022
	42 CFR § 438.208. Coordination and continuity of care	SFY 2022
	42 CFR § 438.210. Coverage and authorization of services	SFY 2022
	42 CFR § 438.214. Provider selection	SFY 2021
	42 CFR § 438.224. Confidentiality	SFY 2022
	42 CFR § 438.230. Subcontractual relationships and delegation	SFY 2021
	42 CFR § 438.236. Practice guidelines	SFY 2021

[6] 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 § 438.242. Health information systems	SFY 2022
	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 members 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 2022
	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 98 percent of applicable elements and partially met two percent in SFY 2022. No applicable elements were considered "not met" in SFY 2022.

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. Due to the updated SOW between Magellan and WDH, Guidehouse reviewed all compliance elements in SFY 2021. In SFY 2022, Guidehouse only reviewed compliance element "Partially Met" or "Not Met" 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	4	7%	0	0%	1	6%	**5**	**6%**
Partially Met	2	4%	0	0%	0	0%	**2**	**2%**
Not Met	0	0%	0	0%	0	0%	**0**	**0%**
Not Reviewed in SFY 2022	49	89%	13	100%	16	94%	78	92%
Total Applicable	**55**	**100%**	**13**	**100%**	**17**	**100%**	**85**	**100%**
Not Applicable[7]	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.

[7] "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.

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
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 member rights and responsibilities and the member 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 member 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 demonstrate the ability to meet the State's network adequacy requirement for YSPs in five of the seven geographic regions in the State.

According to the SOW between Magellan and WDH, Magellan is required to certify that the MCP complied with the State's requirements for availability of services, including adequacy of the provider network. To satisfy the network adequacy requirement, Magellan must provide access to one YSP per 25 enrolled youth across all regions. However, Magellan does not demonstrate the ability to meet the requirement for YSPs. As of Q4 SFY 2022, there were zero YSPs in three of the State's geographic regions and 1 YSP in two of the State's geographic regions.

> ***Recommendation for Magellan:*** Identify and implement an updated recruitment process to expand YSP access across the State.
>
> Currently, recruiting is led by Magellan's Network Strategy Committee who works to develop and implement strategies to meet the needs for network expansion in each region. To address the lack of YSP access, Magellan should work with their Network Strategy committee to reevaluate their current recruiting process and identify steps to ensure the network adequacy requirement is met. Additionally, if the Network Development Team determines network adequacy requirements are unable to be met, Magellan should evaluate whether shifting network adequacy requirements can still meet member needs or whether the program has the capacity to continue providing YSPs as a service for members.

Needed Improvement: Magellan did not clarify in member-facing documents how members and their families provide authority to an evaluator to send external clinical assessment results directly to Magellan.

According to the 2022 SOW between Magellan and WDH, Magellan is required to share with the State, the results of any identification and assessment of that member's needs to prevent duplication of those activities. This includes informing each family or youth of their right to provide authority for an external evaluator determining a member's eligibility for the CME Program to send the assessment results directly to Magellan. However, member-facing documentation, including the Member Handbook, does not include explicit language communicating that by signing the "Choice of Provider" form during the onboarding process that members and their families are agreeing for the results of their external clinical assessments to be shared directly with Magellan. Without this information, there is increased risk of miscommunicating with a member about how their information is shared and with whom it is shared with.

> ***Recommendation for Magellan:*** Add additional information in member-facing documents to inform members and their families of the data sharing authorities they are agreeing to by onboarding with the CME Program.
>
> Magellan's "Choice of Provider" form allows the member to identify clinical eligibility assessors (e.g., independent assessor, qualified mental health professionals) to determine wither they are eligible for enrollment in the CME Program. However, the form does not provide detail to members how information is shared between the assessor and Magellan. To uphold Magellan's guiding principle of family voice and choice, Magellan should update member-facing documentation (i.e., Member Handbook and the Choice of Provider form) to include information that informs members and their families of how assessment results are shared between external evaluators and Magellan.

Grievance and Appeals System

Strength: Magellan "fully met" all compliance metrics for the Grievance and Appeals System.

During the SFY 2022 review, Magellan provided detailed documentation on the timely and adequate notice of adverse benefit discrimination and fully satisfied the remaining contract requirement attached to Grievances and Appeals. As a result, Magellan fully complied with all 17 requirements set forth in 42 CFR § 438.402 – 438.420 for the Grievance and Appeals System.

Magellan's Grievance and Appeals System allows for members to submit a grievance or complaint by phone, online, or in writing. Notably, accessibility services are offered for members who are deaf or hard of hearing and members who do not speak English.

Magellan manages a well thought-out, accessible, and organized grievance and appeal process for its members. Timelines are well defined in member and provider documentation to ensure all parties are well informed and held liable for maintaining reasonable response times.

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 2022 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 2022 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 member 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 related to 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 just over half of the 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	0	1	1	0
Provider-Specific Network Adequacy Standards	0	1	1	10
Development of Network Adequacy Standards	7	2	9	4
Network and Coverage Requirements	0	0	0	1
Exceptions Process	0	0	0	3
Publication of Network Adequacy Standards	0	1	1	0
Total	**7**	**5**	**12**	**18**

Areas of Strength and Needed Improvement

WDH and Magellan complied with only seven (58%) of the 12 federal and State-established network adequacy standards, a significant change from the prior year's EQR when Magellan demonstrated 100% compliance with the network adequacy standards. Strengths and areas for improvement are described below.

Strength: Magellan updated their geo-mapping methodology to more accurately demonstrate the number of providers available by region and their ability to meet provider-to-member ratios.

An area of needed improvement on the SFY 21 WY CME EQR was the accuracy of network adequacy documentation. Complications within the documentation included total provider counts on geo-mapping not conveying a clear representation of network adequacy with duplicative counts across service areas and cross-certified providers included. In response to recommendations included in the SFY 2021 EQR, Magellan implemented a new geo-mapping methodology in Q3 of SFY 2022 that included listing unique provider counts by region, effectively eliminating provider count duplication, and providing the total number of unique providers on the maps.

The effectiveness of the improved geo-mapping was immediately demonstrated when comparing provider counts from prior to and after the updated methodology was implemented. For example, in one region, the number of FCCs decreased significantly from 30 in Q1 to 10 by Q3. Following the WY CME virtual review, Magellan provided documentation showing that actually six providers exited that region and the significant perceived drop in providers was due primarily to the removal of duplicative provider counts.

Needed Improvement: Magellan and WDH do not have network adequacy standards for respite providers.

According to the Provider Handbook, Magellan and WDH have not established network adequacy standards for Respite Providers (e.g., regional provider-to-member ratios, or minimum number or providers per region). During the virtual review, Magellan confirmed that respite services are required to be provided to members on a one-on-one basis (i.e., providers cannot physically provide services to two members at the same time).

Additionally, the availability and utilization of respite services in the CME Program are very low. The quarterly provider and member geo-maps showed no respite providers as available in two of the seven geographic regions for all four quarters in SFY 2022. Magellan did not identify a formal process or methodology to provide respite services in the regions without providers or to educate FCCs and members in those regions on how to access services outside of their respective areas. During the virtual review, Magellan stated that FCCs will work directly with Magellan in cases where respite providers are not available to provide service within a member's region. Magellan is actively working to recruit more respite providers and to contract with agencies that provide respite services. Documentation shared by Magellan also revealed that there were no respite service authorizations during SFY 2022, which was stated to be “consistent with previous years”. Magellan has not conducted research to understand why members and their FCCs are not including respite services in their Plans of Care.

Four of the five (80%) network adequacy review elements determined as “Not Met” in SFY 2022 were due to the lack of respite provider network adequacy standards and utilization.

Recommendation for Magellan and WDH: Identify a measure of network adequacy for respite providers.

WDH and Magellan need to collaborate to determine a methodology to measure network adequacy for respite provider availability. Identifying network adequacy standards for the CME Program can help Magellan to develop an actionable plan to improve availability of providers for members, and to meet the requirements of the SOW. Potential measurements could include a provider-to-member ratio, of the total number of providers per region. Magellan and WDH should develop and document a rationale for the measurement methodology they select.

Recommendation for Magellan: Conduct research to understand why respite providers are not being utilized by CME members.

Documentation shared by Magellan revealed that Magellan has not received authorizations for respite service for many fiscal years. To date, Magellan has not investigated why respite services have not been requested by members, therefore, cannot accurately estimate future member need for the service. Magellan should collect feedback from, or distribute surveys to, CME members and their families as well as FCCs to better understand why respite services are not being requested. Data from these groups can help Magellan identify ways to increase CME utilization of respite services, or to determine that the program no longer needs to offer the services.

Needed Improvement: Magellan does not include established network adequacy standards on the program website.

According to CFR § 438.358 9(e), states must publish network adequacy standards on their program websites. Currently, network adequacy standards are only included in the Provider Handbook, which is not included on the website.

Recommendation for Magellan: Include network adequacy standards in the Member Handbook.

Magellan includes the WY CME Member Handbook on their website. However, the document does not include the network adequacy standards for network providers. Magellan should update their Member Handbook to include the network adequacy standards and continue to post the document on their website for easy access by current and potential CME members.

Section VII. Implementation and Effectiveness of State Quality Strategy

During SFY 2022, Magellan continued to implement the 2020 State Medicaid Managed Care Quality Strategy. The Quality Strategy covered topics pertaining to the CME Program operations, as required per 42 CFR § 438.340. Topics as applicable to the CME program that are 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
- Nonduplication of EQR activities
- Definition of "significant change"

Guidehouse reviewed whether Magellan met the goals and objectives outlined in the Quality Strategy by comparing their performance on the measures at baseline (i.e., SFY 2020) to their performance on the measures during SFY 2022. Findings from this review are detailed in Appendix I. Quality Strategy Findings and Recommendations.

Areas of Strength and Needed Improvement

Strength: Magellan improved their performance on half of the Quality Strategy Objectives from baseline in SFY 2020 to SFY 2022.

Magellan is taking active steps to address the goals and objectives outlined in the Quality Strategy. Magellan's documentation confirmed that performance on five of the ten (50%) Quality Strategy Objectives increased between SFY 2020 and SFY 2022. Magellan began measuring two of the ten objectives after the development of the Quality Strategy. Continued collaboration between Magellan and WDH will help to improve Magellan's performance on the Quality Objectives and to improve documentation of performance.

Needed Improvement: The Quality Strategy does not include Statewide Performance Targets for the Goals and Objectives.

While the Quality Strategy clearly outlines what the goals and objectives are, it does not identify performance goals for the different measures. Without identifying goals for the objectives, reviewers are unable to determine whether Magellan has met the quality standards outlined in the Quality Strategy.

> ***Recommendation for WDH and Magellan:*** Collaborate to identify performance targets for each of the Quality Strategy Objectives.
>
> WDH and Magellan should work together to identify targets for the objectives identified in the Quality Strategy. Targets should be realistic and attainable and will help Magellan to measure their progress year to year. WDH should also consider updating the SOW with the established performance targets to the accountability.

Section VIII. Conclusion

Guidehouse identified in its review of Wyoming's CME Program, 9 areas of strength, 10 areas of needed improvement, and 12 recommendations in relation to quality, timeliness, and access to services. Overall, major strengths of the CME Program include, but are not limited to:

- Continuous engagement with CME providers and stakeholders to identify methods to continuously improve the program;
- Continued improvement of program documentation to align with WDH and CMS requirements; and
- Updated Geo-Mapping methodology to more accurately measure compliance to Network Adequacy requirements.

The areas of needed improvement include but are not limited to the following:

- Minimal statistically significant impact across PIPs;
- Unclear data collection and validation processes that lead to discrepancies in data and reported measures; and
- Continuously not meeting Network Adequacy requirements for YSPs.

Appendix J 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.