Wyoming Department of Health
Care Management Entity Program
SFY 2020 External Quality Review
Technical Report

April 15, 2021

guidehouse.com/healthcare

Contents

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 Guidehouse to perform the EQR of Magellan for services delivered in State Fiscal Year (SFY) 2020 and produce this technical report.

Scope of EQR Activities Conducted

At the request of WDH, Guidehouse Inc. (Guidehouse) performed four mandatory EQR activities, one optional activity, 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
- **Protocol 6**: Administration or Validation of Quality of Care Surveys (optional)

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:

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

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

WDH will need to evaluate how these EQR findings impact the State's Medicaid Managed Care Quality Strategy and continue to incorporate elements of the Quality Strategy into program operations to better support quality, timeliness, and access to health care 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
CME Youth Served	328	431	494	402	402

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

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

Figure 1. CME Implementation Timeline

July 2006	CMS approves WDH's 1915(c) waiver application.
February 2010	Wyoming is awarded a grant under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to support creation of a CME program for Medicaid and CHIP-enrolled children with serious behavioral health challenges.
June 2013	WDH implements a seven-county CME pilot program.
July 2015	Magellan begins statewide expansion of CME program.
August 2015	CMS approves WDH's 1915(b) waiver application for the CME program.
July 2018	CME program shifts from capitated payment to FFS payment.

Special Considerations

As part of the State's response to the COVID-19 public health emergency, WDH filed a Section 1915(c) Emergency Preparedness and Response Appendix K waiver in March 2020 in conjunction with the Medicaid Agency's 1135 waiver for state plan services and eligibility.[1] The Appendix K waiver temporarily replaced all in-person services with services delivered via telehealth for the duration of the emergency. Required use of telehealth services within the CME program represented a large shift in program operations in SFY 2020.

Overview of the External Quality Review

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

The EQR consists of four mandatory and six optional activities, as listed in Table 2 on the following page.

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

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 external quality review organizations (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.

  The SFY 2020 compliance review focuses on new or changed federal requirements, as well as any requirements which were not 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.

- **EQR Protocol 6 (Optional): Administration or Validation of Quality of Care Surveys:** Surveys are a common method of measuring health care quality, especially consumer experience with care. Protocol 6 specifies procedures for conducting various types of surveys and validating those surveys.
- **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 five EQR activities in a manner consistent with the protocols established by CMS to evaluate Magellan's provision of health care services during SFY 2020 (July 1, 2019 to June 30, 2020). WDH had previously contracted Guidehouse to conduct the EQR to evaluate Magellan's activities during SFY 2018 (July 1, 2017 to June 30, 2018) and SFY 2019 (July 1, 2018 to June 30, 2019). This EQR relies on discussions with WDH and Magellan staff, documentation provided by WDH and Magellan, and Guidehouse's industry experience working with health and human services agencies in most states. This report summarizes the findings of the EQR and provides recommendations for Magellan and WDH to improve operational and program performance.

Results of SFY 2019 External Quality Review

Guidehouse's SFY 2019 review of Wyoming's CME program resulted in identification of six areas of strength, 16 areas of needed improvement, and 17 recommendations in relation to quality, timeliness, and access to services.

Of the 17 recommendations for WDH and/or Magellan:

- Ten recommendations have been fully addressed
- Six recommendations have been partially addressed
- One recommendation has not been addressed

Table 3 below provides the distribution of recommendations across EQR protocols. Please note that CMS released updated EQR protocols in March 2020; therefore, the updated protocol names and numbering used in this report are different from previous years' reports. Refer to Appendix B for more information regarding the extent to which previous recommendations have been addressed.

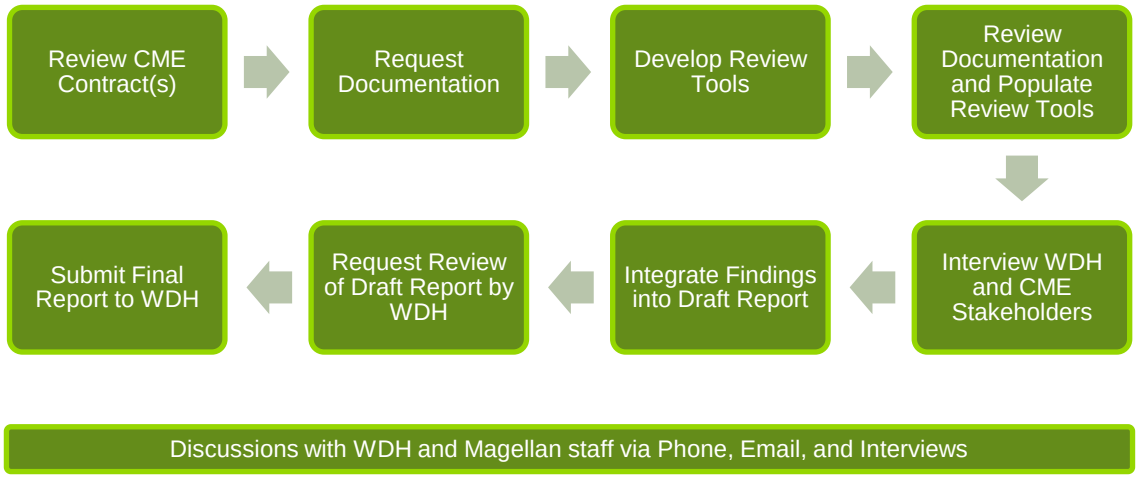
Table 3. SFY 2019 Recommendation Summary

EQR Protocol	Recommendations for:			Total
	Magellan	WDH	Both	
Protocol 1. Validation of Performance Improvement Projects	2	0	0	2
Protocol 2. Validation of Performance Measures	1	0	1	2
Protocol 3. Compliance with Medicaid Managed Care Regulations	4	3	0	7
Protocol 4. Validation of Network Adequacy	3	2	1	6

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 discussions with Magellan and WDH staff.

Figure 2. Key Assessment Steps



Review of Documentation

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

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

After identifying the elements of the SFY 2020 SOW which operationalized the relevant federal code requirements, Guidehouse requested and reviewed relevant documentation from Magellan and WDH including, but not limited to, the following:

- Magellan corporate policies and procedures (and, where different, Magellan of Wyoming policies and procedures) related to quality, timeliness, and access to service and care
- Enrollee and provider handbooks
- Outreach and marketing templates and materials
- Quarterly reports to WDH (including SFY 2020 Quarters 1 – 4, with the Quarter 4 report also serving as the annual report)
- Geographic information on enrollee residences and provider service areas
- Provider agreements, provider certification requirements, and training requirements
- Wyoming Administrative Rules

- Wyoming Medicaid Managed Care Quality Strategy

Discussions with WDH and Magellan

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

- Weekly telephone meetings between Guidehouse and WDH staff from December 2020 to March 2021
- Virtual interviews and review sessions with Magellan staff on February 1-5, 2021
- Ad-hoc emails and meetings

Validation of Data and Measures

Section IV, Validation of Performance Measures, details the methodology used to review and validate performance measures in accordance with the operational requirements under the SFY 2020 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 WDH's direction, Guidehouse reviewed the following three PIPs which were active during SFY 2020:

- Enrollment Initiative PIP that began during SFY 2019
- Minimum Contacts PIP that began during SFY 2018
- 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.

This section describes an overview of each PIP, including areas of strength and needed improvement. Appendix C includes the full EQR worksheets with additional details for each PIP.

Enrollment Initiative PIP

The Enrollment Initiative PIP seeks to educate potential enrollees about high fidelity wraparound while they are at a Psychiatric Residential Treatment Facility (PRTF). Magellan evaluates whether interventions to target youth are successful in decreasing readmissions to a higher level of care setting and shortening length of stay in PRTF settings. WDH and Magellan prioritized this PIP topic based on evidence of the limited effectiveness of treatment of target youth in inpatient or PRTF settings.

Table 4 evaluates the Enrollment Initiative PIP based on criteria specified in CMS protocol.

Table 4. Enrollment Initiative PIP Evaluation

Evaluation Category	Findings
Topic and PIP Selection	• While not specified in the QIA form, Magellan selected the Enrollment Initiative PIP after analyzing State and national research on treatment of youth at PRTFs. Magellan also held informal discussions with parents and youth enrolled in PRTFs to select this PIP topic. • The PIP topic directly aligned with national priority areas and goals, including U.S. Department of Health and Human Services (HHS) National Quality Strategy aims (*Healthy People / Healthy Communities*), CMS Quality Strategy priorities (*Promote Effective Communication and Coordination of Care, Work with Communities to Promote Best Practices of Healthy Living, Make Care Safer by Reducing Harm Caused in the Delivery of Care, Promote Effective Prevention and Treatment of Chronic Disease*), as well as numerous CME program goals.
Aim Statement	• Magellan developed the following aim statements for the PIP: 1. "Do the interventions implemented as part of the Enrollment Initiative demonstrate a change in the number of readmissions to a higher level of care (HLOC)?" 2. "Do the members included within the Enrollment Initiative have a different initial length of stay (LOS) compared to those members who opt-out of the program?" • The aim statements did not clearly specify the PIP's study population, time period, or improvement strategies as recommended by CMS. However, this information was included in different areas of the QIA. • The aim statements did not specify the change in performance measures that would constitute "improvement" (e.g., *fewer* readmissions to a higher level of care; *shorter* initial length of stay).

Evaluation Category	Findings
Population	• The population for this PIP included all Wyoming Medicaid enrollees (ages 4-20) that are enrolled in the PRTF level of care within the measurement timeframe (10/01/2019 – 09/30/2020). These are vulnerable youth who have SPMI / SED. • Magellan specified the PIP population by age, timeframe of enrollment, diagnoses, and other characteristics, including Medicaid enrollment status. • The PIP population did not encompass the entire CME program. Instead, Magellan specified comparison groups (e.g., Medicaid enrollees within PRTF that are included within the Enrollment Initiative; Medicaid enrollees within PRTF that opt-out of the Enrollment Initiative).
Sampling Method	• Magellan sampled the entire eligible population for this PIP and did not use any sampling methods.
Variables and Performance Measures	• Magellan outlined two performance measures for this PIP: 1. Measure #1: "Mean number of readmissions to a higher level of care (HLOC) (inpatient and/or PRTF) within 30/90/180 days after discharge from PRTF for Enrollment Initiative members and opt-out youth." 2. Measure #2: "Average length of stay (LOS) for members during the initial PRTF stay for members in the Enrollment Initiative compared to youth who opt-out of the Initiative." • Magellan specified objective, time-specific continuous variables for each performance measure: 1. Measure #1: "*Numerator:* The number of unduplicated members ages 4-20 who were readmitted to an inpatient psychiatric facility or PRTF within 30/90/180 days of the original discharge." *Denominator: "*The total number of unduplicated members ages 4-20 who were discharged from a PRTF during the measurement period." 2. Measure #2: *Numerator: "*Sum of days in PRTF (discharge date minus admission date) during measurement period." *Denominator: "*Number of discharges for participants in group." • Performance measures assessed mean number of readmissions and average length of stay within PRTF settings, which may impact enrollee health and functional status. Magellan analyzed claims data provided by WDH and stored in the iSeries claims database to calculate performance measures. • Magellan met all criteria for selected PIP variables and performance measures for this PIP.
Data Collection	• Magellan used Structured Query Language (SQL) to conduct a "programmed pull" of data for this PIP. • Magellan used the iSeries claims database as a data source for this PIP. While not specified in the QIA form, Magellan stated that this source is comprehensive and captures all PRTF discharges, assuming overnight data updates occurred successfully. • While not specified in the QIA form, Magellan collects and reports data to WDH quarterly. Magellan also includes a status update on this PIP within the annual report. • Magellan did not include information on the instruments used to collect data, including key data fields, and personnel collecting data for the PIP. • Magellan noted there is a lag in receipt of the full dataset for this PIP since CME providers have 12 months from the date of service to submit claims data, which may impact data consistency. However, as reported in OP-29 from the quarterly reports,

Evaluation Category	Findings
	over 98 percent of CME providers comply with Magellan's requirement to submit claims within 90 days of the date of service.
Data Analysis	• Magellan did not provide the full data analysis for this PIP. Magellan stated the full data analysis will be provided in May 2021.
Improvement Strategies	• The Enrollment Initiative was designed to address four barriers: 1. "Guardians/parents refusal to accept the program/opting out." 2. "Some guardian/parents may feel overwhelmed and stressed with youth being placed in PRTF in the early stages and not feel like deciding at that time." 3. "PRTF admissions seem to be cyclical with high and low times throughout the year." 4. "Limited knowledge and understanding of the HFWA Program." • Magellan selected six interventions / improvement strategies to address these barriers: 1. "Upon admission to PRTF, Magellan Family Support Specialist will reach out to the parents/ guardians within three days of auto-referral regarding the HFWA program to provide education and coordinate transfer to a network FSP [Family Support Partner]." 2. "FSP will work with the family during the youth's stay at the PRTF to educate about the benefits of HFWA." 3. "FSP will begin coordinating with a network Family Care Coordinator to ensure that supports are in place upon discharge from the PRTF." 4. "Initial training for providers on the Protocol for Service Coordination-education for how to work with PRTF and the treatment team." 5. "Website posting about the Enrollment Initiative on the provider website." 6. "Provider update sent out on the Enrollment Initiative." • Magellan selected interventions that were evidence-based and intended to address systemic issues (e.g., lack of enrollment; low awareness / lack of education on available programs; family stress). • Magellan stated that they followed the Institute for Healthcare Improvement (IHI) Plan Do Study Act (PDSA) rapid cycle approach to develop improvement strategies and ensured cultural and linguistic appropriateness within strategies.
Likelihood of Significant Improvement	• Guidehouse was unable to assess the likelihood of significant improvement for this PIP topic because Magellan did not provide the full data analysis. Magellan stated the full data analysis will be provided in May 2021.

Recommendations

To further align with guidance provided in CMS EQR Protocols, Magellan should:

- Document input directly obtained from enrolled youth, families, and providers to select the PIP topic within the QIA form.
- Specify the change in performance measures that would constitute "improvement" (e.g., fewer readmissions to a HLOC setting; shorter initial length of stay) within the aim statements.
- Specify the frequency of data collection within the QIA form.
- Include additional information in the QIA form regarding the instruments used to collect data, key data fields, and personnel responsible for collecting data.

- Align standards for claims submission across business practices and use consistent messaging when communicating required claims submission timeframes.
- Directly reference the PDSA cycle within the QIA form and describe the process of developing improvement strategies using the cycle.

Minimum Contacts PIP

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

Table 5 evaluates the Minimum Contacts PIP based on criteria specified in CMS protocol.

Table 5. Minimum Contacts PIP Evaluation

Evaluation Category	Findings
Topic and PIP Selection	• Magellan selected the Minimum Contacts PIP topic based on "ongoing concerns regarding providers' failure to achieve minimum contact requirements" since program inception. Magellan also solicited input via an informal survey of CME providers. • Magellan did not solicit input directly from enrollees or families to inform selection of this PIP topic. • The PIP topic directly aligned with national priority areas and goals, including HHS National Quality Strategy aims (*Better Care - Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe*), CMS Quality Strategy priorities (*Strengthen Person and Family Engagement as Partners in Their Care, Promote Effective Communication and Coordination of Care*), as well as numerous CME program goals.
Aim Statement	• While not specified in the QIA form, Magellan clarified the following aim statement for this PIP: ○ *Improve the frequency in which providers are in compliance with minimum contact requirements; meet goal of 100 percent compliance with minimum contact requirement.* • The aim statement did not specify the improvement strategy, population, or time period for the PIP. While the aim statement was measurable, the statement was not a concise and answerable statement as modeled by CMS protocol.
Population	• The population for this PIP varied slightly across performance measures (see *Variables and Performance Measures* below). For Measure #1, the population included the number of enrollees with a full week of enrollment within the measurement period (defined as Sunday – Saturday enrollment). For Measure #2, the population included the number of enrollees with a full month of enrollment within the measurement period. • While not specified in documentation, Magellan confirmed the following population characteristics via discussion: PIP population by age (4-20 years of age), timeframe of enrollment (full week / month of enrollment), and diagnoses (SPMI / SED diagnosis).
Sampling Method	• Magellan sampled the entire eligible population for this PIP and did not use any sampling methods.

Evaluation Category	Findings
Variables and Performance Measures	• Magellan outlined two performance measures for this PIP, which monitored Magellan's performance over time and compared across three measurement periods: 1. Measure #1: "Rate of members/caregivers contacted by telephone at least once a week." 2. Measure #2: "Rate of members/caregivers contacted in person at least twice a month." • Magellan specified objective, time-specific continuous variables for each performance measure: 1. Measure #1: *Numerator:* "Number of members contacted by phone at least once a week." *Denominator:* "Number of members enrolled with a full week within measurement period." 2. Measure #2: *Numerator:* "Number of members/caregivers contacted in person at least twice a month." *Denominator:* "Number of members/caregivers enrolled with a full month within measurement period." • Performance measures assessed the frequency of contacts between FCCs and enrollees, which is integral to ensuring enrollees obtain full benefit from the CME program and impacts enrollee health and functional status. • Magellan met all criteria for selected PIP variables and performance measures for this PIP.
Data Collection	• Magellan collected data for this PIP from progress notes submitted by providers to an online web portal. Magellan utilized SQL to pull data on contacts from progress notes. • Magellan confirmed in discussion that progress notes capture all potential contacts and include distinct checkbox fields for "Description of Support" (planned contact, CFT meeting, weekly phone contact, bi-monthly face-to-face). • Magellan specified that data is collected weekly and monthly for this PIP. To validate weekly data pulls, Magellan stated that results are "reviewed for follow-up with the providers as applicable." • Magellan did not use a formal data analysis plan for this PIP; rather, Magellan leveraged the Quality Improvement Committee (QIC) for planning discussions related to data analysis.
Data Analysis	• Magellan compared data for the performance measures across a baseline period, as well as two remeasurement periods: ○ Measure #1 (Rate of members/caregivers contacted by telephone at least once a week) ▪ Baseline (7/1/2017 – 6/30/2018): 28.42% ▪ Remeasurement 1 (7/1/2018 – 6/30/2019): 49.62% ▪ Remeasurement 2 (7/1/2019 – 6/30/2020): 71.63% ○ Measure #2 (Rate of members/caregivers contacted in person at least twice a month) ▪ Baseline (7/1/2017 – 6/30/2018): 72.71% ▪ Remeasurement 1 (7/1/2018 – 6/30/2019): 84.22% ▪ Remeasurement 2 (7/1/2019 – 6/30/2020): 90.53% • Both measures did not meet the goal of 100 percent compliance with minimum contact requirements. However, Magellan found statistically significant improvement across all periods for both measures through using Fisher's Exact Test.

Evaluation Category	Findings
	• Magellan did not address any factors that may threaten the internal or external validity of findings. • Magellan presented all calculations and findings in a concise and easily understood manner.
Improvement Strategies	• Magellan identified seven barriers to successful execution of this PIP: 1. "A lack of developed processes to address contact requirements if there is a planned sickness or emergency for the FCC." 2. "Lack of education on the minimum contact requirements." 3. "Providers do not have an awareness of how to resolve engagement issues they may encounter." 4. "Provider agencies do not have standard operating procedures outlining how to achieve minimum contacts with members/caregivers." 5. "Solo/individual providers do not have backup FCCs to provide services during an absence." 6. "Providers report confusion with how to properly fill out the progress note template on the provider portal to obtain credit for meeting requirements." 7. "Providers do not have an awareness of their overall rate of achievement of minimum contacts in relation to the Network of providers." • Magellan developed 11 interventions / improvement strategies to address barriers: 1. "Development of Minimum Contact Drilldown Report (OP10 Report) at the provider level for analysis and review with providers." 2. "Implementation of weekly Clinical Department review of OP10 Report to determine how to assist specific providers with meeting minimum contact requirements." 3. "Provided provider communications concerning: • The importance of selecting checkboxes on progress notes within the provider portal to ensure they are obtaining credit for their contacts with members/guardians. • Process changes and the importance of meeting minimum contact requirements." 4. "Development and utilization of the Provider Scorecard and review of the OP10 drilldown report with Network and provider 1:1s (claims-based report was utilized for provider education prior to the development of the OP10 drilldown report in 12/2018)." 5. "Development and roll-out of a training to provide education concerning minimum contact requirements and how to properly complete a progress note (sent out to Program Directors and Coaches and reviewed during the External QIC held 6/20/19)." 6. "Review overall network status on minimum contacts and reiterate minimum contact requirements during the Monthly Provider Calls." 7. "Magellan of Wyoming High Fidelity Wraparound Provider Requirements & Timelines posted to provider website as a reference for understanding minimum contact requirement timelines." 8. "Development and implementation of a Provider Education Desktop Procedure to identify providers consistently failing to meet minimum requirements and follow through the education process to the potential for escalation to a formal corrective action for failure to demonstrate improvement."

Evaluation Category	Findings
	9. "Developed an internal process where the Clinical Department in the CME will not process reauthorization requests unless providers are demonstrating that they are meeting the requirements of minimum contacts with the member/caregiver." 10. "Approved a back-up FCC when the primary FCC is unable to make the visits to the family." 11. (Added for Remeasurement 2): Magellan also approved "virtual contact through ZOOM/virtual platforms due to the COVID-19 restrictions on in-person contact." • Interventions included policy changes with substantial impact (e.g., allowing back-up FCCs, virtual contact, etc.) that will likely produce long-term change within the CME program. • While not specified in the QIA form, Magellan stated that they followed IHI's Plan Do Study Act (PDSA) rapid cycle approach to develop improvement strategies and ensured cultural and linguistic appropriateness within strategies.
Likelihood of Significant Improvement	• Magellan used the same methodology for calculating each performance measure across all measurement periods. • While Magellan did not meet goals of achieving 100 percent compliance with minimum contact requirements, there was significant quantitative evidence of improvement across the measurement period. • Magellan stated in the QIA form that the PIP workgroup "noted the successful impact of interventions," in reference to statistically significant improvement observed across measurement periods found using Fisher's Exact Test.

Recommendations

To further align with guidance provided in CMS EQR Protocols, Magellan should:

- Solicit input directly from enrolled youth and families to inform the selection of the PIP topic.
- Confirm the aim statement for the Minimum Contacts PIP topic. The aim statement should be a concise, answerable question that defines the improvement strategy, study population, and time period of the topic.
- Clearly define the identified PIP population within the QIA form.
- Formalize data collection and analysis processes in a written data analysis plan.
- Deploy strategies to assure reliability and validity of findings and describe these in the QIA form.
- Directly reference the PDSA cycle within the QIA form and describe the process of developing improvement strategies using the cycle.

Engagement and Implementation PIP

The Engagement and Implementation PIP seeks to engage additional youth in the CME program and promote 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 days of service) and fully implemented within the program (defined as greater than 180 days of service). WDH and Magellan prioritized this topic after the SFY 2017 annual report 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 6 evaluates the Engagement and Implementation PIP based on criteria specified in CMS protocol.

Table 6. Engagement and Implementation PIP Evaluation

Evaluation Category	Findings
Topic and PIP Selection	• Magellan selected the Engagement and Implementation PIP topic after completing a comprehensive analysis of opportunities for improvement, including gathering input from all stakeholders in the CME program. • Magellan held meetings with CME leadership, enrollees, caregivers, and providers to solicit feedback for this PIP topic. Magellan also used enrollee satisfaction surveys to inform the selection of this PIP topic. • Magellan selected this PIP topic based on opportunities for improvement related to face-to-face contacts, SNCD timeliness, and CANS severity identified in the SFY 2017 annual report. • The PIP topic directly aligned with national priority areas and goals, including HHS National Quality Strategy aims (*Better Care - Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe*), CMS Quality Strategy priorities (*Promote Effective Communication and Coordination of Care*), as well as numerous CME program goals.
Aim Statement	• Magellan developed the following aim statements for the PIP: 1. "Does the change in authorization process improve the percent of youth and families reaching engagement threshold (>60 days)?" 2. "Does the change in authorization process improve the percent of youth and families reaching implementation threshold (>180 days)?" • While the aim statements specified the improvement strategy and population, the statements did not specify the time periods for measurement / remeasurement.
Population	• The population for this PIP included Wyoming youth discharged from HFWA services within the review period reaching engagement or implementation thresholds. • While not specified in the QIA form, Magellan confirmed the PIP population by age (4-20 years of age), timeframe of enrollment (youth discharged during each measurement period), and diagnoses (SPMI / SED diagnosis).
Sampling Method	• Magellan sampled the entire eligible population for this PIP and did not use any sampling methods.
Variables and Performance Measures	• While not in the QIA form, Magellan outlined two performance measures for this PIP in the SFY 2020 Q4 Quarterly Report: 1. Measure #1: "Engagement: percent of youth and families not reaching engagement threshold (>60 days)" 2. Measure #2: "Implementation: percent of youth and families reaching implementation threshold (>180 days)" • While not in the QIA form, Magellan specified objective, time-specific continuous variables for each performance measure in the SFY 2020 Q4 Quarterly Report: 1. Measure #1: *Numerator:* "Count of youth <60 days of HFWA ("not engaged"). *Denominator:* Count of discharged youth HFWA." 2. Measure #2: *Numerator:* "Count of youth >180 days of HFWA ("implemented"). *Denominator:* Count of discharged youth HFWA." • Performance measures evaluated engagement and full implementation of program benefits and care plans, which impact enrollee health and functional status.

Evaluation Category	Findings
	• Both performance measures monitored performance at a point in time and over time. Each measure was a "rolling 12-month measure," encompassing data from the previous 12 months, and was recalculated quarterly.
Data Collection	• To collect data for this PIP, Magellan used a "programmed pull" from all claims / encounter files of all eligible enrollees. Based on discussions with Magellan, Magellan sourced data for this PIP from Magellan's authorization system, which is comprehensive and includes all discharges within the review period. • Magellan analyzed claims data within the Family Care Coordinator Average Length of Stay (FCC ALOS) engagement report for this PIP. • Magellan included a data analysis plan within the QIA form, outlining both quantitative and qualitative data analysis procedures.

Data Analysis	• Magellan compared data for the performance measures across a baseline period as well as two remeasurement periods:
	  ○ Measure #1 Engagement: Percent of youth and families not reaching engagement threshold (>60 days)
	  ▪ Baseline (5/2018 – 8/2018): 16%
	  ▪ Remeasurement 1 (7/1/2018-6/30/2019): 16%
	  ▪ Remeasurement 2 (7/1/2019-6/30/2020): 15%
	  ○ Measure #2 Implementation: Percent of youth and families reaching implementation threshold (>180 days)
	  ▪ Baseline (5/2018-8/2018): 59%
	  ▪ Remeasurement 1 (7/1/2018-6/30/2019): 62%
	  ▪ Remeasurement 2 (7/1/2019-6/30/2020): 61%
	• Magellan tested for statistical significance using Fisher's Exact Test for each measurement period. While improvement was observed, Magellan did not observe statistically significant improvement.
	• Magellan accounted for factors that impacted the comparability and validity of findings. To progress "towards a standard of excellence," Magellan adjusted the baseline for implementation once improvement was identified within Measure #2 after Remeasurement 1.
	• Magellan presented all calculations and findings in a concise and easily understood manner.

Improvement Strategies	• Magellan identified 10 barriers to successful execution of this PIP: 1. "Education on provider authorization and payment processes to stabilize the network and alignment of operationalizing engagement with wraparound process at 60 days." 2. "Providers leaving the network were not transitioning youth to other providers." 3. "Provider awareness of own performance compared to the WY CME and other providers." 4. "Provider education on measure and feedback from providers on barriers and solutions for measures." 5. "Provider awareness of measures" 6. "Provider direction talking with own staff." 7. "Transparency on measures for all stakeholders." 8. "1:1 assistance to providers on understanding and responding to measures."

Evaluation Category	Findings
	9. "No provider has had a letter of education directly for high disengagement or low implementation. Providers identified in the documentation measure at <95 percent for at least two months in a row have included providers with low engagement and implementation." 10. "Quality Improvement Committee accountability and feedback" • Magellan developed 10 improvement strategies / interventions to address barriers: 1. "Technical assistance given on the new authorization process related to move to FFS and providers leaving or considering leaving the network, causing disruption in youth engagement and implementation." 2. "Transition of Care process moved away from providers and to Magellan CME for connection to new providers." 3. "Engagement and Implementation measures added to Provider Scorecard." 4. "Scorecard review in all-providers meeting quarterly with talking points for staff, reference to manual, direction to talk with network in monthly 1:1s, and reminder that past and current materials on website." 5. "Provider newsletter included quarterly results." 6. "Talking points on measures quarterly." 7. "Posting on provider website in Scorecard." 8. "1:1 Provider review of scorecard scores with network monthly." 9. "Letter of education available if needed for high disengagement or low implementation." 10. "Scorecard quarter over quarter trending with QIC and EQIC quarterly." • Improvement strategies addressed systemic issues (e.g., providers not transitioning youth to other providers; lack of provider education; lack of transparency), which allowed interventions to have long-term impacts on the CME program and enrollee health and functional status. • While not specified in the QIA form, Magellan stated that they followed IHI's Plan Do Study Act (PDSA) rapid cycle approach to develop improvement strategies and ensured cultural and linguistic appropriateness within strategies.
Likelihood of Significant Improvement	• Magellan used the same methodology for calculating each performance measure across all measurement periods. • While showing evidence of improvement in meeting engagement and implementation thresholds, Magellan did not meet performance goals. Additionally, improvement across the review period was not statistically significant.

Recommendations

To further align with guidance provided in CMS EQR Protocols, Magellan should:

- Incorporate measurement timeframes, including baseline measurements and remeasurements, and the PIP study population within aim statements.
- Clearly define the PIP population within the QIA form by age, length of enrollment, diagnoses, procedures, and other characteristics as applicable.
- Outline numerators and denominators used for each performance measure within the QIA form.
- Directly reference the PDSA cycle within the QIA form and describe the process of developing improvement strategies using the cycle.

Areas of Strength and Needed Improvement

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

Strength: Magellan follows a continuous quality improvement process to identify barriers and develop improvement strategies for each PIP.

Magellan conducted multiple cycles of barrier identification and intervention development for each PIP. To facilitate this process, Magellan conducted extensive stakeholder engagement efforts including outreach to enrollees, families, and providers. Magellan linked each intervention with specific barriers, tracked performance across each remeasurement, and updated interventions based on measured performance.

- Across all PIPs, Magellan used a formal barrier analysis process to identify improvement strategies. This represents an advancement on needed improvements identified in the SFY 2019 EQR Report.
- For the Minimum Contacts PIP, Magellan continuously updated barriers and interventions based on documented progress. For example, after Remeasurement 2, Magellan identified that barriers #1, #2, and #6 "no longer appeared to be an issue in preventing improvement in the measures," noting the successful impact of intervention.
- Magellan also identified a new barrier for the Minimum Contacts PIP with the onset of COVID-19 and subsequent impacts on in-person meetings, which led to additional interventions permitting virtual meetings as in-person contacts.
- For the Engagement and Implementation PIP, Magellan adjusted the initial baseline implementation threshold to progress "towards a standard of excellence," after early interventions led to progress.

Needed Improvement: Magellan did not provide consistent and comprehensive documentation for each PIP within Quality Improvement Activity (QIA) forms.

QIA forms submitted by Magellan for each PIP provided inconsistent information and occasionally omitted key items.

- While clarified in discussion, Magellan did not directly reference IHI's Plan Do Study Act (PDSA) rapid cycle approach for identifying barriers and developing improvement strategies and did not address strategies for assuring cultural competence within documentation; both of which align with CMS EQR Protocol guidance for PIP documentation.
- While Magellan leveraged formal PIP documentation for the review period, Magellan did not always provide a written comprehensive data analysis plan to outline all processes (including qualitative and quantitative data analysis process) for each PIP. *(This is a continued needed improvement from SFY 2019 as this item was still outstanding during the review period.)*
- Magellan did not provide the full data analysis for the Enrollment Initiative PIP, citing a lag in claims submission due to federal (42 CFR § 447.45) and state guidelines requiring submission by the provider no later than 12 months from the date of service. However, Magellan appears to comply with more stringent internal timeframes for claims submission. According to OP-29 in the SFY 2020 Q4 Quarterly Report, over 98 percent of CME providers submitted claims within 90 days of service end date during the review period.
- Magellan did not report all information for the Engagement and Implementation PIP within the QIA forms. For example, Magellan outlined performance measures for the PIP within a separate document, the Q4 Quarterly Report for SFY 2020, but did not include performance measures within QIA documentation.
- For both the Enrollment Initiative and Minimum Contacts PIPs, Magellan did not clearly define aim statements within submitted QIA forms. Within CMS EQR Protocols (dated October 2019), CMS describes aim statements as "The PIP aim statement should define the improvement strategy,

population, and time period. It should be clear, concise, measurable, and answerable." Aim statements that were clarified verbally by Magellan leadership did not include all criteria to align with CMS' guidance (e.g., specified population, time periods, or improvement strategies).

Recommendation for Magellan: Update PIP documentation to include key elements and consistent information within a single document.

Guidehouse recommends that Magellan include the following items for all PIPs in QIA forms:

- A single concise, answerable aim statement that defines the improvement strategy, study population, and time period of the topic.
- A written comprehensive data analysis plan that defines the goals for data analysis and tracking, roles and responsibilities of staff, data collection instruments, and timing / methods for data collection. A data analysis plan is helpful for Magellan to confirm that the data analysis method follows the prescribed procedures, ensures reliability and consistency in the data, facilitates future replication of the data, and clarifies processes for external validation.
- Direct references to the PDSA rapid cycle approach and explanation for how Magellan leveraged the approach in barrier analysis and intervention development.
- Direct references to strategies for assuring cultural competence and linguistic appropriateness within services.

Additionally, PIP documentation should be comprehensive and include all relevant information within a single document. All sections of the PIP documentation should be fully completed once data analysis is finalized. Magellan should consult CMS EQR Protocols (dated October 2019) for additional guidance on comprehensive PIP documentation.

Recommendation for Magellan: Align standards pursued by Magellan across business practices.

Magellan appears to comply with 90-day internal timeframes for claims submission, but QIA forms for the Enrollment Initiative PIP imply that Magellan follows 12-month federal and state guidelines for claims submission. Magellan should align standards pursued across business practices and provide consistent messaging related to CME program operations. Since Magellan complies with 90-day requirements for claims submission, Magellan should communicate consistent timeframes for claims submission in QIA forms and other program documentation.

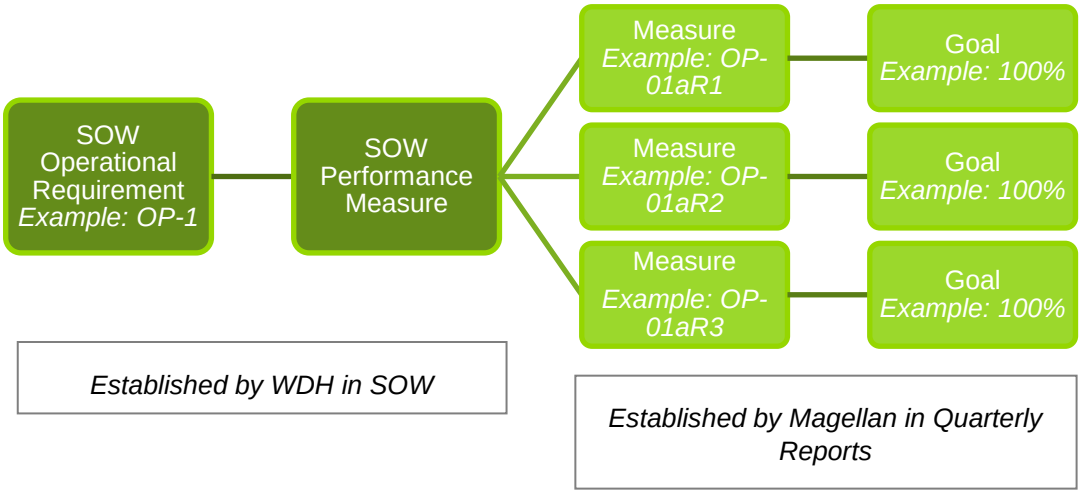
Section IV. Validation of Performance Measures

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 one of seven 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." Magellan also includes 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

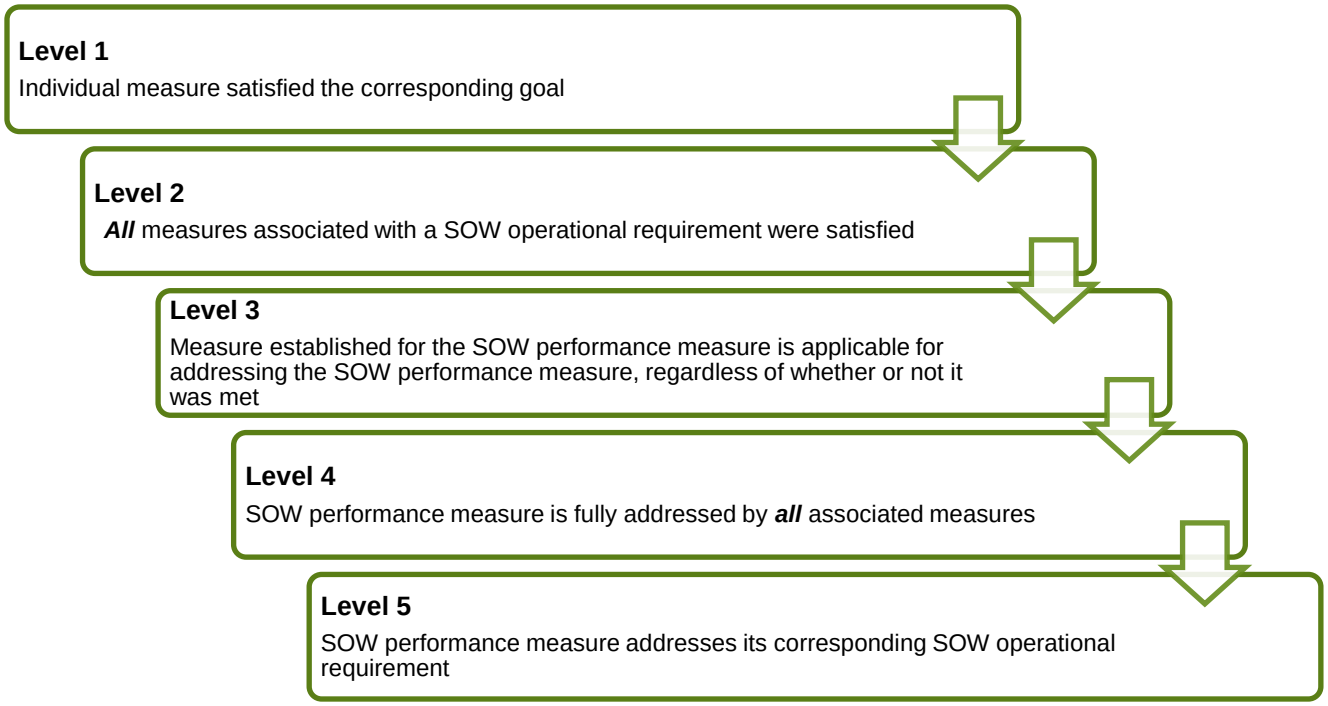


For SFY 2020, review and validation of reported data included 74 measures established by Magellan for 31 SOW operational requirements.

Levels of Analysis

Guidehouse conducted five levels of analysis for the measures and SOW operational requirements, displayed in Figure 4, on the following page. Refer to Appendix D 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 74 measures and 31 operational requirements. Table 7 provides the number of measures and SOW operational requirements by category. Appendix E includes Guidehouse's review tool for validating SOW operational requirements.

Table 7. Measures and Operational Requirements by Category

Contract Category	SFY 2020 SOW	
	# of Measures	# of OPs
High Fidelity Wraparound	37	15
Operations	15	8
Project Management	4	1
Provider Network	1	1
System of Care	10	3

Contract Category	SFY 2020 SOW	
	# of Measures	# of OPs
Technical	6	2
Financial	1	1
Total	**74**	**31**

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 74 measures. Table 8 below provides findings from Guidehouse's Level 1 analysis described previously, which assesses Magellan's performance on measures and the extent to which they satisfy their corresponding goals. Magellan met 48.6 percent of its total goals and did not meet 41.9 percent.[2]

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

Level 1 Evaluation	Percent of Measures *(n=74)*
Goal Met	48.6%
Goal Not Met	41.9%
Not Applicable	9.5%
Total	100%

Most unmet measures (26 of 31 unmet measures) fell under the HFWA category, which primarily focuses on the quality, access, and timeliness of care provided to enrollees.

[2] Throughout this section "Not Applicable" indicates there was no applicable data in SFY 2020 for this measure.

The following measures had goals of 100 percent yet reported results below 50 percent in one or more quarters:

- **OP-04R**: Rate of new referrals contacted by chosen FCC within three working days
- **OP-05R**: Rate of enrollments with POCs developed within 46 days of enrollment
- **OP-07R1**: Rate of enrollees enrolled with FSP
- **OP-07R2**: Rate of enrollees enrolled with YSP
- **OP-09aR2**: Rate of POCs completed during the last 30 days (two weeks prior to 7/1/2019) of the authorization period
- **OP-12R**: Rate of CFT meetings with invited formal supports
- **OP-19cR**: Rate of expedited auth decisions within timeframe

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

- **OP-04R**: Rate of new referrals contacted by chosen FCC within three working days
- **OP-05R**: Rate of enrollments with POCs developed within 46 days of enrollment
- **OP-09aR1**: Rate of CFT meetings held during the last 30 days (two weeks prior to 7/1/2019) of the authorization period)
- **OP-09aR2**: Rate of POCs completed during the last 30 days (two weeks prior to 7/1/2019) of the authorization period
- **OP-10bR**: Rate of enrollees contacted in person at least twice a month

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). Magellan met 41.9 percent and did not meet nearly half (48.4 percent) of all associated measures for the SOW performance measures.

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

Level 2 Evaluation	Percent of PMs *(n=31)*
Yes	41.9%
No	48.4%
Not Applicable	9.7%
Total	100%

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. Most of Magellan's measures (95.9 percent) address the SOW performance measure, 2.7 percent of measures partially addressed, and 1.4 percent does not address the 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=74)*
Yes	95.9%
Partially	2.7%
No	1.4%
Total	100%

There were three measures did not address or only partially addressed their SOW performance measure. These include:

- **OP-20aQ (Number of enrollees receiving flex funds)**: *(Did not address)* This measure includes the number of enrollees receiving flex funds, which is not specified in the associated SOW performance measure.
- **OP-28R (Rate of referral to C waiver within timeframe)**: *(Partially Addressed)* Although the reported measure does not indicate the timeframe, the quarterly reports listed the numerator as "Number of children and enrollees who qualify for the CME but do not have/ are not eligible for Medicaid who are referred to the C Waiver within timeframe (2 business days)." The SOW performance measure required referrals within two calendar days, whereas Magellan's reported measure is more lenient with two business days.
- **OP-29cR (Rate of claims submitted by providers within 90 days of service end date)**: *(Partially Addressed)* The SOW performance measure and Magellan's measure included slightly different timeframes. The SOW performance measure requires Magellan to report "percent of providers submitting claims within ninety (90) calendar days." However, Magellan's measure describes "rate of claims submitted...within 90 days of service end date."

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. Most (77.4 percent) of SOW performance measures were fully addressed by their measures, whereas 22.6 percent were not.

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

Level 4 Evaluation	Percent of PMs *(n=31)*
Yes	77.4%
No	22.6%
Total	100%

There were seven requirements where the listed measures did not fully address the SOW performance measures: OP-19, OP-20, OP-24, OP-27, OP-28, OP-29, and OP-30.

- **OP-19 (Authorizations)**: The measures outlined in this operational requirement addressed most components of the SOW performance measure. However, the measures did not address the following points from the SOW performance measure:
    - "If the Contractor's review results in an adverse action, the Contractor shall provide a thirty (30) calendar day advance notification to the enrollee and the enrollee's family care coordinator prior to implementing a change in program eligibility and/or service amount, duration or frequency."
    - "The Contractor must report quarterly on the status of the Contractor's relationship with the PA/UM vendor."
    - The SOW performance measure described giving enrollees notifications and written notices of authorization decisions, which was not addressed in the measures.
- **OP-20 (Flex Funds)**: The SOW performance measure indicated the report should include "the recipient, the amount, reason for the flex fund distribution, the date of distribution, and a brief description of the flex funds use/purpose." The measures did not describe the recipient, the amount of the funds, or the dates of distribution.
- **OP-24 (Critical Incidents)**: While the measures addressed the rate of critical incidents addressed according to State statute, the SOW performance measure required critical incidents to be addressed according to "processes defined in the 1915(b) and 1915(c) program waivers," in addition to State statute. This information was not included within Magellan's measures.
- **OP-27 (Relationships)**: The SOW performance measure indicated "all QIC and Advisory council meetings" but Magellan's measures do not address QIC meetings.
- **OP-28 (Waiver Referrals)**: Although the reported measure did not indicate the timeframe, the quarterly reports listed the numerator as "Number of children and enrollees who qualify for the CME but do not have/ are not eligible for Medicaid who are referred to the C Waiver within timeframe (2 business days)." The SOW performance measure required referrals within two calendar days, whereas Magellan's reported measure was more lenient with two business days.
- **OP-29 (Claims and Encounters)**: The SOW performance measure noted that "the Contractor must track utilization data at least monthly," which was not addressed in the measures.
- **OP-30 (Satisfaction Surveys)**: This SOW performance measure did not have associated measures but was instead based upon submission of satisfaction survey results. The Annual Fidelity Report did not ask youth / families specifically if they "would recommend HFWA to anyone else", which was required in the SOW performance measure.

Per Tables 10 and 11 above, most of Magellan's measures address their SOW performance measure (95.9 percent), and most SOW performance measures are addressed by their listed measures (77.4 percent). This indicates that the listed measures are sufficient in operationalizing the intent of the SOW performance 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. Most (61.3 percent) of SOW performance measures address the SOW operational requirement and 35.5 percent partially address 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=31)*
Yes	61.3%
Partially	35.5%
No	3.2%
Total	100%

There were 12 SOW performance measures that did not fully address the SOW operational requirements. Examples include, but are not limited to, the following:

- **OP-02 (Notification of Admission)**: The SOW operational requirement indicated that "All successful and attempted contacts should be documented by the Contractor", but the SOW performance measure does not address this.
- **OP-13 (OOH)**: The SOW operational requirement stated that "the Contractor must ensure FCCs communicate an out-of-home placement" and must also "work with children and youth who are in out-of-home placements to determine if services and supports can be safely, effectively, and appropriately provided in the community." However, the SOW performance measure addresses only the "number of enrollees in out-of-home placements" and "rate of enrollees disenrolled due to out-of-home placements."
- **OP-23 (Reporting Requirements)**: The SOW operational requirement indicated quarterly reporting should be submitted "accurate and timely" but the SOW performance measure does not address accuracy and timeliness of reports.

Validation of Selected Measures

Guidehouse conducted a detailed review of the data analysis and collection methods for six SOW operational requirements and their associated measures, as selected by WDH for validation. Four of the six SOW operational requirements were divided into multiple sub-parts that were also validated. Selected SOW operational requirements include the following:

- **OP-01:** Provider Network Certification
- **OP-04:** Family Care Coordinator (FCC) Family Engagement Timeliness
- **OP-07:** Family Support Partner (FSP) / Youth Support Partner (YSP) Inclusion
- **OP-08:** Provider Ratios
- **OP-10:** FCC Ongoing Contact
- **OP-25:** Medicaid Provider Coverage

Figure 5, on the following page, describes results of the measure validation and indicates that Magellan:

- Fully met four of the six SOW operational requirements (OP-04, OP-07, OP-08, OP-10).
- Did not meet two of the six SOW operational requirements (OP-01 and OP-25).

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 found issues, including, but not limited to:

- Lack of written step-by-step procedures for data access, calculation of numerator, denominator, and rate, as well as any scenarios which should be excluded from the measure.
- Lack of written measure validation steps.
- Inconsistencies in definition and/or calculation of the value "number of providers in network" between two different measures.
- Incomplete description in SOW describing, and allowing for, exclusion of contact occurring prior to the authorization application date.

Figure 5. Measure Accuracy[3]

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
OP-01: Provider Network Certification			
The measure owner has backup staff trained to use the available documentation to extract data from Mosaic and compare to Medicaid values. This measure process is entirely manual using Excel (no SQL code or other extract programming). The clinical team has a document describing the review process for measure results, and they provide the results to leadership for review on a weekly basis. The provider training leader and subject matter expert also provides oversight of the measure results. Overall Findings: • Based on the labels and measure intent, the numerator for OP-01a1 should equal the denominator for OP-25. • Denominator appears to be incorrect as value reported does not match value generated; for June 2020, the report indicates the denominator is 74, but upon re-calculation the value appears to be 83. The measure owner plans to create a document describing the provider count process. • Measure creation team is unable to re-create results from early months as source data (provider list) has changed, and the person who knew and calculated the measure in the earlier months is no longer with the team. • Manual de-duplication and counting process has potential for error. The measure creation team has corrected an issue with the input file which should resolve the Tier data and eliminate one step of the manual de-duplication. • While measure creator shared the process with backup staff via telephone, the process is not documented in a written form.	N/A	N/A	N/A
OP-01a1: Rate of providers in network meeting all requirements • **Numerator**: Number of providers in network meeting all requirements • **Denominator**: Number of providers enrolled in network			
See comments above for OP-01 regarding enrolled provider count reflected in the denominator. If the denominator is incorrect, and the numerator is a subset thereof, the numerator may also be incorrect. Magellan agreed that the numerator for OP-01a1 should equal the	No	No	Yes

[3] Guidehouse evaluated the individual components of performance measures, including each numerator and denominator. Larger performance measures (e.g., OP-01) did not receive ratings as indicated by "N/A."

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
denominator for OP-25, but different people complete each measure, and they may use different calculations.			
OP-01a2: Rate of providers in network not meeting all requirements • **Numerator**: Number of providers in network not meeting all requirements • **Denominator**: Number of providers enrolled in network			
This measure shares the denominator with OP-01a1, which appears to be incorrect. If the denominator is incorrect, and the numerator is a subset thereof, the numerator may also be incorrect. Magellan agreed that the numerator for OP-01a1 should equal the denominator for OP-25, and therefore the difference results in the numerator for OP-01a2, but different people complete each measure, and they may use different calculations.	No	No	Yes
OP-01a3: Rate of providers in network who received training on abuse, neglect, and exploitation (ANE) identification and reporting procedures annually as part of the recertification process • **Numerator**: Number of providers in network who received training on ANE identification and reporting procedures annually as part of the recertification process • **Denominator**: Number of providers enrolled in network			
This measure shares the denominator with OP-01a1, which appears to be incorrect. If the denominator is incorrect, and the numerator is a subset thereof, the numerator may also be incorrect. However, the process for creating the numerator follows the methodology, and no defect found.	Yes	No	Yes
OP-01b: Rate of providers completing annual recertification • **Numerator**: Number of providers completing annual recertification • **Denominator**: Number of providers with annual recertification expirations			
Following the previous year's EQR, Magellan created a quality assurance process to ensure the accuracy of this measure. The calculation method and numerator/denominator values reported are accurate for OP-01b based upon the available data.	Yes	Yes	Yes
OP-01c: Rate of new providers completing initial provider training • **Numerator**: Number of new providers completing initial provider training • **Denominator**: Number of new providers in network			
Magellan created a quality assurance process to ensure the accuracy of this measure. The calculation method and numerator/denominator values reported are accurate for OP-01c based upon the available data.	Yes	Yes	Yes

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
OP-04: Rate of new referrals contacted by chosen FCC within 3 working days • **Numerator**: Number of new referrals contacted by chosen FCC within 3 working days • **Denominator**: Number of new referrals who have chosen FCCs			
Magellan clearly demonstrated how providers enter data for this measure. • All new referrals are entered in the provider portal within one business day of awareness, and the FCC is notified of the referral via an authorization note. • It is the responsibility of the FCC to contact the child/family within three business days of the selection. The measure owner: • Explained the decrease of both numerator and denominator values during summer months and holidays, when families and children are less involved in school or other situations that typically result in referrals to the CME program or may be difficult to reach. • Clarified that an 'active referral' requires both a family agreement to participate in the program and a provider agreement to accept the family. Magellan created a quality assurance process to ensure the accuracy of this measure. The calculation method and numerator/denominator values reported are accurate for OP-04 based upon the available data. Magellan's analytics staff confirmed the accuracy of the numerator and denominator with a subject matter expert from the clinical team. Magellan's clinical measure expert agrees that the exclusion of progress note dated prior to authorization application date aligns with the intent of the measure as Magellan encourages providers to follow the process, but the SOW operational requirement does not support the exclusion. See *Areas of Strength and Needed Improvement* within Section IV.	Yes	Yes	Yes
OP-07: FSP/YSP Inclusion			
Magellan identified and trained backup staff for measure creation and developed appropriate and complete measurement plans / programming specifications including detailed instructions for both numerator and denominator. Magellan's clinical measure expert explained that OP-07b numerator is markedly lower than OP-07a numerator as a result of the COVID-19 pandemic reducing the number of young adults willing and able to serve as YSP.	N/A	N/A	N/A

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
OP-07a: Enrollees with FSP • **Numerator**: Number of enrollees with FSP • **Denominator**: Number of enrollees			
Magellan clarified that the OP-07a numerator is defined as the number of unique enrollment IDs with an FSP authorization that overlaps enrollment and time periods. The calculation method and numerator/denominator values reported are accurate for OP-07a based upon the available data.	Yes	Yes	Yes
OP-07b: Enrollees with YSP • **Numerator**: Number of enrollees with YSP • **Denominator**: Number of enrollees			
Magellan clarified that the OP-07b numerator is defined as the number of unique enrollment IDs with a YSP authorization that overlaps enrollment and time periods. The calculation method and numerator/denominator values reported are accurate for OP-07b based upon the available data.	Yes	Yes	Yes
OP-08: Provider Ratios			
The calculation method and numerator/denominator values reported are accurate for both OP-08a and OP-08b based upon the available data. Magellan created a quality assurance process to ensure the accuracy of this measure. Magellan's analytics staff confirm the accuracy of the OP-08a and OP-08b numerators and denominators with a subject matter expert from the clinical team. For both OP-08a and OP-08b, the calculation method and numerator/denominator values reported are accurate based upon the available data. • This measure is generated using SQL, and there are no manual calculations in the process. • The clinical team reviews the results of OP-08 during the monthly Quality Improvement Committee (QIC) meetings. Magellan identified and trained backup staff for measure creation and developed appropriate and complete measurement plans / programming specifications including detailed instructions for both numerator and denominator. Magellan explained that providers can be cross-trained resulting in an FCC simultaneously serving as an FSP. As the public health emergency began in March 2020, WDH approved the increase of ratios from the published 1:10 for FCC and 1:25 for FSP/YSP. Per the measure definition, when a provider has more than the allowable threshold, s/he is excluded from the denominator. Overall Findings:	N/A	N/A	N/A

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
• While measure creation and results appear to be accurate, Magellan is unable to adequately describe validation activities. The employee who specialized in the validation of OP-08 recently departed Magellan prior to documenting the steps; however, Magellan's Quality Committee produced notes from their QIC meetings during which the results are reviewed and approved.			
OP-08a: FCC Providers Supporting 10 or Fewer Enrolled Youth • **Numerator**: Number of FCC providers supporting 10 or fewer enrolled youth • **Denominator**: Number of FCC providers			
Measure creator demonstrated that the SQL executed to create the OP-08a result contains both the obsolete and current procedure code/modifier combinations giving Magellan the ability to calculate results from July 2015 to the present time. Measure creator made a recent code change to account for the 'HQ' procedure code modifier which indicates a service provided in a group rather than for an individual enrollee. Magellan presented the fee schedule details which matched the logic available in the SQL source code. The calculation method and numerator/denominator values reported are accurate for OP-08a based upon the available data.	Yes	Yes	Yes
OP-08b: FSP/YSP Providers Supporting 10 or Fewer Enrolled Youth Under FSP and 25 or Fewer Enrolled Youth Under YSP • **Numerator**: Number of enrollees with a full week within measurement period • **Denominator**: Number of FSP/YSP providers			
Magellan's clinical team clarified that measure OP-08b is not reporting the number of providers available but those who submit claims representing service. While the program may have additional providers available, the enrollees are not required to utilize the service. The calculation method and numerator/denominator values reported are accurate for OP-08b based upon the available data.	Yes	Yes	Yes
OP-10: FCC Ongoing Contact			
For both OP-10a and OP-10b, either the enrollee or the FCC may initiate contact. In either case, when the contact is properly documented, the count is included in the measure report. This measure is generated using SQL, and there are no manual calculations in the process. • Magellan's clinical team reviews the results of OP-10 on a weekly basis. • There are additional systems in place to verify that the progress note entries are representative of the service(s) provided. Magellan identified and trained backup staff for measure creation and developed appropriate and complete measurement plans / programming	N/A	N/A	N/A

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
specifications including detailed instructions for both numerator and denominator.			
OP-10a: Rate of enrollees contacted by phone at least once a week • **Numerator**: Number of enrollees contacted by phone at least once a week • **Denominator**: Number of enrollees with a full week within measurement period			
Magellan clarified: • Definition of "week" as minimum four days available coverage from Sunday-Saturday. • Face-to-face contact may count as a phone contact when face-to-face contact requirement is exceeded, but non-video phone contact is never to be counted as a face-to-face contact. For each statement above, the measure creator demonstrated proper accounting. The calculation method and numerator/denominator values reported are accurate for OP-10a based upon the available data.	Yes	Yes	Yes
OP-10b: Rate of enrollees contacted in-person at least twice a month • **Numerator**: Number of enrollees contacted in person at least twice a month • **Denominator**: Number of enrollees with a full month within measurement period			
Magellan clarified: • Definition of "month" as a true calendar month from the first day to the last day. • WDH approved counting video conference as face-to-face contact due to health concerns with in-person meetings resulting from the COVID pandemic. For each statement above, the measure creator demonstrated proper accounting. The calculation method and numerator/denominator values reported are accurate for OP-10b based upon the available data.	Yes	Yes	Yes
OP-25: Medicaid Provider Coverage • **Numerator**: Number of providers in network enrolled in Medicaid • **Denominator**: Number of providers in network			
The 50 percent decrease in numerator and denominator values from March to April is the result of a WDH-approved change in the calculation methodology whereby the provider count for both numerator and denominator includes only those actively enrolled in Medicaid, certified, and 100 percent engaged with CME enrollees. The new method properly reflects the count in a situation where provider(s) chose to no longer serve/engage the program but failed to formally disenroll. Rates for January through March may have included provider(s) with overdue certification, so the assessment focused on April forward. While the	Yes	No	Yes

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
numerator methodology changed during the measure year, the calculation appears to be correct under each definition. In September, Magellan also implemented a new verification method to guarantee accuracy of the certification numbers. This measure process is entirely manual using Excel (no SQL code or other extract programming). The measure creator and clinical team review the results of OP-25 on a weekly basis. The numbers posted to the quarterly and annual reports are those reported for the final week of each month. Overall Findings: • Magellan agreed that the denominator for OP-25 should equal the numerator for OP-01a1, but different people complete each measure, and they may use different calculations. Magellan did not report an accurate calculation of the numerator based on available data. • The numerator calculation method and values reported are accurate based upon the available data, but if the OP-25 denominator is incorrect, and the numerator is a subset thereof, the numerator may also be incorrect. However, the process for creating the numerator follows the methodology, and no defect found.			

Performance on Outcome Measures

Guidehouse assessed data provided by Magellan to evaluate compliance with 10 outcome measures. Table 13 below provides a summary of the outcome measure results based on performance throughout SFY 2020. 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 13. Status of Outcome Measures

Outcome Measure	Guidehouse Determination
OUT-1: Out-of-Home (OOH) Placements The Contractor shall report the number of OOH placements of Contractor youth. OOH=Out-of-Home (anything other than a family or adoptive placement)	Meets Requirement
OUT-2: Decreased Length of Stay (LOS) for Inpatient and Residential Treatment admissions The Contractor shall report the overall LOS for inpatient and residential treatment for youth enrolled in the CME.	Meets Requirement
OUT-3: Recidivism The Contractor shall decrease the recidivism of youth served by the Contractor moving from a lower level of care to a higher level of care.	Meets Requirement

Outcome Measure	Guidehouse Determination
OUT-4: Recidivism (LOC) at six (6) months post CME graduation The Contractor shall report recidivism of youth served by the Contractor and who graduated from the CME program who are moving from a lower LOC to a higher LOC within six (6) months of graduation from the CME.	Not Applicable *Per discussions with WDH, Magellan is not required to report this metric until July 2021 due to lagging data.*
OUT-5: Compliance with EPSDT The Contractor shall report the CME enrolled youth's compliance with EPSDT standards.	Meets Requirement
OUT-6: Appropriate Use of Psychiatric Medication The Contractor shall report on the number of CME enrolled youth not meeting the State standards for psychotropic medications (too much, too many, too young, polypharmacy) as reported by the Pharmacy Unit.	Meets Requirement
OUT-7: Cost Savings (Healthcare Costs) The Contractor shall report healthcare costs to Medicaid for the CME enrolled youth.	Meets Requirement
OUT-8: Fidelity to the high fidelity wraparound (HFWA) Model • The Contractor shall report fidelity to the HFWA model as measured by the Wraparound Fidelity Index (WFI-EZ) • The Contractor shall report the number of WFI-EZ surveys administered to capture a valid and representative sample of the experiences of enrollees served.	Meets Requirement
OUT-9: Family and Youth Participation at State-level Steering Committees The Contractor shall report family and youth participation on State-level Steering Committees.	Meets Requirement
OUT-10: Family and Youth Participation in Communities The Contractor shall report family and youth participation on the CME's community advisory boards, support groups and other stakeholder meetings facilitated by the Contractor.	Meets Requirement

Areas of Strength and Needed Improvement

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

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

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

(This is a continued strength from SFY 2019).

Strength: Documentation describing measure result creation has improved.

Magellan staff responsible for analytics and measure result creation have significantly enhanced both the quantity and quality of the documentation supporting acquisition of input data, calculation of numerator, denominator, and rate for the measures generated via SQL.

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 measure result creation 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.

Strength: Magellan implements proactive enhancement/issue identification and resolution.

The experience and knowledge among Magellan staff provide the ability for them to identify process improvement opportunities and ways to reduce potential for errors when generating measure results. Examples of process improvement efforts include:

- The documentation and coding for both obsolete and current procedure codes allowing the measure creator to generate accurate historic and current results such as OP-08.
- The current effort to filter the Tier data to eliminate potential for errors and save steps in finalizing input data such as OP-01.

By understanding the available data and the intent of the measure, staff are well-positioned to lead process improvement.

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

While the overall assessment found sufficient documentation for source code and measure result creation of automated (SQL) measures, the measures created manually using Excel to search, filter, and count could benefit from more detail describing the process from start to finish. Currently, Magellan has a limited number of staff who can perform manual measure creation, such as OP-01 and OP-25, in the event of an emergency or staff change.

> ***Recommendation for Magellan:*** Develop documentation describing the processes for manual (non-SQL) measure result creation.
>
> 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, calculation of numerator, denominator, and rate for the measures that are not generated via SQL. There may be an opportunity for Magellan to automate portions of this process using Excel “functions” capabilities.

Needed Improvement: Allowed exclusions were not consistently clarified in SOW.

In the specific case of OP-04, both the measure owner and the analytics staff responsible for measure result creation understand the goal of the program, and therefore the measure, for the provider to initiate the contact on or after the authorization application date, but not before.

> ***Recommendation for WDH:*** Specify the progress notes and dates for inclusion/exclusion in OP-04.
>
> Clarify the OP-04 numerator to count only those progress note records dated on or after the associated authorization application date. This will explicitly describe the exclusion of progress notes where an FCC may have a previous affiliation with an enrollee and essentially begins the contact process prior to the intended schedule as described by the measure.

Needed Improvement: Cross team reviews of shared measure content were not always conducted.

While measures often reported the same data elements, Magellan did not always ensure cross team review of results. This led to inconsistencies across measures – for example, OP-01 and OP-25 reported different values for total number of enrolled providers during the same month.

> ***Recommendation for Magellan:*** Document calculation steps and perform monthly reconciliation of shared measure content.
>
> For measures OP-01 (numerator a1) and OP-25 (denominator), the measure owners and measure result creation teams should meet to discuss and document the criteria and calculation of the value describing number of enrolled providers. If Magellan determines these two measures are using the same definition, Guidehouse recommends reconciling the measure results each month to ensure each measure is reporting the same value. If the measures intend to report differing values for number of enrolled providers, Guidehouse recommends clarifying the description for each measure, so it is evident to all report recipients what type of count is displayed.

Needed Improvement: Steps to validate measure results were not documented.

The overall assessment found sufficient staff, knowledge, and frequency of measure result validation, especially with the implementation of the QIC and weekly leadership review of data results. However, the program could benefit from documentation describing the reconciliation, balancing, and other topics necessary for measure result validation in the event of an emergency or staff change.

> ***Recommendation for Magellan:*** Document steps to validate provider ratio measure results.
>
> Following the recent departure of the subject matter expert for measure OP-08 regarding provider ratios, Guidehouse recommends documenting the validation process and highlighting any areas which may typically result in further review. Based on discussions with Magellan, the QIC reviews the results, so the documentation may focus on any information which may assist the measure creator in verifying initial results of the calculations and to assist the QIC in their final approval.

Needed Improvement: Multiple data inconsistencies were present in quarterly reports.

Guidehouse found several data inconsistencies in quarterly reports:

- Within OP-01, Magellan reported that 225 percent of new providers completed initial provider training during the fourth quarter of the review period. The maximum value for this type of measure should be 100 percent.
- There were inconsistencies reported for OP-20. Magellan reported there were two recipients of flex funds in August 2019. However, data for August 2019 showed only one reason for flex fund request ("Transportation") and one approved use of flex funds ("utility bills"). Number of enrollees receiving flex funds, reasons for requests, and use of flex funds did not align in August 2019.
- Magellan does not always update certain data elements as frequently as needed. For example, the SFY 2020 Q4 Quarterly Report included outdated SFY 2018 data related to Provider Satisfaction Surveys.
- Magellan did not appear to follow a consistent methodology for reporting null or no data. Magellan appeared to use "N/A" (OP-14, OP-17), "0" (OP-15, OP-19), and blank cells (OP-14) interchangeably to signify null data. If "N/A" or blank cells were used to signify no instances during the period, rates populated as "N/A" as opposed to zero percent. Conversely, if "0" was used to signify no data, rates populated as zero percent as opposed to "N/A." Unclear methodology for reporting null or no data poses a risk to accurate measure calculation and data interpretation.

Recommendation for Magellan: Design processes to remediate current inconsistencies in reported measure results.

Magellan should conduct additional rounds of data validation to align reported data. Guidehouse also recommends that Magellan utilize a consistent process to express measures for which there is no data.

Needed Improvement: Critical incident reporting processes require clarification.

Magellan's annual report indicates there were 73 critical incidents during SFY 2020. However, OP-24aR1 (Rate of critical incidents followed up on) was zero percent across all months, and OP-24aR2 "Rate of critical incidents that were addressed according to state statute" was 100 percent across all months.

The true intention of the "Rate of critical incidents followed up on" measure was unclear to reviewers. WDH described that critical incident follow-up is only required by Magellan if the incident meets federal classification as a critical incident, and the "Rate of critical incidents followed up on" is related to programmatic or system updates rather than individual incident follow up. Magellan described that "Rate of critical incidents followed up on" would only capture incidents which rise to the level of intervention needed by Magellan directly, beyond the FCC and CFT taking actions, including Magellan staff taking steps to make reports or further action required by the State.

This measure does not appear to encompass mandatory reporter requirements, which appear to be captured by the measure "Rate of critical incidents that were addressed according to state statute." Wyoming statutes 14-3-205 and 35-20-103 require any person who suspects child/vulnerable adult abuse, neglect, or exploitation to report immediately. In SFY 2020, 29 of the 73 incidents fell into the abuse, neglect, or exploitation categories. WDH indicated that FCCs and other responsible parties comply with mandatory reporter requirements.

Finally, there is one portion of the SOW relating to critical incidents which Magellan does not address in its quarterly reports. The SOW requires "The Contractor must report all critical incidents in accordance to Wyoming State Statute and *processes defined in the 1915(b) and 1915(c) program waivers*. Data showing compliance with this requirement shall be included in the quarterly data report." Although Magellan includes the rate of critical incidents addressed according to state statute, the quarterly report does not contain any information related to "processes defined in the 1915(b) and 1915(c) program waivers." For example, Wyoming's CMHW 1915(c) Medicaid waiver outlines specific processes for incident management which are not included in quarterly reports (e.g., "all waiver service providers and provider staff are required to submit critical incident reports….Reports must be filed immediately…").

Recommendation for WDH: Review and revise critical incident reporting processes.

WDH should clarify incident reporting requirements and Magellan's roles and responsibilities regarding incident management. WDH should evaluate the measures included in the quarterly report to determine whether they capture all information necessary for ensuring the health and welfare of enrollees, in accordance with CMS guidance.

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 44 elements applicable to the CME program.[4] The compliance review encompassed the following topics:

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

For the compliance evaluation, 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 14, on the following page, provides an overview of Magellan's compliance by topic. Magellan fully met 68 percent of applicable elements and partially met 32 percent in SFY 2020. No applicable elements were considered "not met" in SFY 2020.

When Guidehouse conducted the EQR for SFY 2019, Magellan fully met 81 percent of the applicable elements, partially met 16 percent, and did not meet 2 percent. However, it is important to note that the SFY 2019 and SFY 2020 reviews did not evaluate Magellan on identical criteria and, therefore, are not directly comparable. The SFY 2020 review approach differed for two reasons:

1. CMS released updated EQR protocols in March 2020 which introduced 51 new compliance review elements.
2. Full compliance reviews are required only once in a three-year period. Full compliance reviews had already been conducted in SFY 2018 and SFY 2019.

[4] 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

Therefore, the SFY 2020 compliance review evaluated Magellan on elements:

- Introduced by CMS within the updated protocol.
- Partially met or not met by Magellan during the SFY 2019 review period.

Since the full compliance review is required once every three years, Guidehouse did not evaluate 30 compliance review elements which had been fully met during the SFY 2019 review.

Additionally, there were 17 total elements of the compliance review worksheet that were not applicable to the CME program and were excluded from review, including elements regarding the following:

- 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 ages 4-20 years.
- Regulations and descriptions regarding advanced directives: Advanced directives do not apply to the CME program population; CME program does not deliver medical services.
- Identification of individuals with special health care needs: All CME program enrollees fall under this category.
- Standards regarding subcontractor monitoring: The CME program does not utilize subcontractors.
- Regulations regarding dual eligibles: Medicare does not apply to the CME program enrollee population.

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

Table 14. Extent of Compliance with EQR Protocol 3 Elements

Compliance Level	Enrollee Rights and Protections		Quality Assessment and Performance Improvement		Grievance System		TOTAL	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Fully Met	17	59%	4	100%	9	82%	**30**	**68%**
Partially Met	12	41%	0	0%	2	18%	**14**	**32%**
Not Met	0	0%	0	0%	0	0%	**0**	**0%**
Total Applicable	**29**	**100%**	**4**	**100%**	**11**	**100%**	**44**	**100%**
Review Not Required[5]	18	--	6	--	6	--	**30**	--
Not Applicable[6]	31	--	10	--	6	--	**47**	--

[5] "Review Not Required" indicates the requirement was fully met during the previous review period (SFY 2019) and does not require review during SFY 2020.
[6] "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 section "Objective" for further information.

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

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

Strength: Magellan has robust internal processes in place to ensure enrollee-facing materials are developed in an accessible and culturally competent manner.

Magellan has crafted internal process that aligns with the information requirements outlined in 42 CFR § 438.10. Specifically, Magellan makes all enrollee-facing materials, including the member handbook, marketing materials, and enrollee newsletters available in the enrollee's preferred language, such as Spanish, or in formats such as Braille, upon request. Magellan provides the phone number (toll-free and TDD/TTY) and website through which an enrollee can request written material in a preferred language / format.

Beyond the requirements set forth in 42 CFR § 438.10, Magellan ensures all enrollee-facing materials are written at a sixth-grade reading level and follows a comprehensive review process, engaging legal and marketing departments. If materials directly affect families and providers, Magellan may convene a small focus group to ensure content is accurate and helpful.

Last, Magellan publishes a provider directory that is available to enrollees. The directory is updated real-time, and available in machine-readable, downloadable format.

Needed Improvement: Magellan reported inconsistent data for key performance measures across reports.

Magellan calculated and reported inconsistently on select performance measures that were required for compliance with key Medicaid managed care regulations:

- The Q1 Executive Summary calculated OP-05 (POC Timeliness) using July – August 2019 (two months of data).

- The Q2 Executive Summary calculated OP-05 using September – November 2019 (three months of data).
- The Q3 Executive Summary carried over the same data reported in Q2. OP-05 would have been either 69 percent if using the two-month calculation, or 74 percent using the three-month calculation.
- The Q4 Executive Summary did not include data for OP-05.

Since accurate reporting of OP-05 is critical in Magellan's compliance with Medicaid managed care regulations related to coordination and continuity of care (42 CFR § 438.208), Magellan must correct inconsistencies across reports to reach full compliance. Additionally, inconsistencies pose a risk if WDH relies on the Executive Summary without verifying with the Committee Data File.

Recommendation for Magellan: Develop comprehensive quality assurance processes on committee data files and executive summaries.

In discussion, Magellan outlined quality assurance and validation processes that relied primarily on internal discussion with workgroups and the QIC. Magellan should develop comprehensive quality assurance processes specifically for the Committee Data Files and Executive Summaries reported to WDH. Quality assurance processes should be documented and tracked as internal Magellan policy.

Needed Improvement: The SOW did not document requirements for compliance with all federal and State requirements.

While Magellan clarified processes to meet certain federal and State Medicaid managed care requirements in discussion, materials submitted by Magellan or WDH did not always document compliance with requirements. This includes:

- **Information Sharing of Assessment Activities** (42 CFR § 438.208): Magellan did not provide evidence of information sharing with WDH to prevent duplication of assessment activities.
- **Definitions of Managed Care Terminology** (42 CFR § 438.100(b)(2)(i)): The SOW did not include definitions for all managed care terminology, or references to appropriate State administrative rule. Additionally, Magellan did not include State-developed definitions for managed care terminology in enrollee-facing materials.
- **Health Information Systems Reporting** (42 CFR § 438.242): Magellan did not include information on enrollee appeals or denials of referrals within quarterly reports.

Recommendation for WDH: Add language to the SOW to reflect above requirements.

Guidehouse recommends that WDH add and clarify language in the SOW regarding the following:

- **Information Sharing of Assessment Activities**: WDH should design formal processes for information sharing once assessment activities are completed. This may include State access to Magellan's web portal where completed assessment forms are housed.
- **Definitions of Managed Care Terminology**: WDH should include managed care definitions from Wyoming Administrative Rule in the SOW.
- **Health Information Systems Reporting***:* WDH should clarify requirements for reporting information on appeals and denials of referrals to the State on a quarterly basis.

Quality Assessment and Performance Improvement

Strength: Magellan maintains a well-structured Comprehensive Quality Assessment and Performance Improvement (QAPI) program for services furnished to enrollees.

Consistent with the requirements set forth in 42 CFR § 438.330(b), Magellan manages the WY CME Quality Program, which designs, measures, and evaluates the performance of clinical care and patient safety, disease management, preventive health services, and member services. Magellan's Quality Program includes:

- **Performance Improvement Projects (PIPs)**: Magellan provided documentation for three required PIPs during the review period: Enrollment Initiative PIP, Minimum Contacts Requirement PIP, and Engagement and Implementation PIP.
- **Mechanisms to Detect Over- and/or Under-Utilization of Services***:* As part of the Quality Program, Magellan reported number of enrollments, encounters, authorizations, and paid claims for FCCs, FSPs, YSPs, Youth and Family Training, and Respite Care.

Magellan also outlined an extensive organizing structure of the Quality Program, including a Corporate and Strategic Business Unit (SBU), which oversees individual Operating Units organized by topic (e.g., UM, SPD, PBM, Patient Management, Case Management).

Grievance System

Needed Improvement: There are discrepancies in tracking and reporting of enrollee grievances.

Following the SFY 2019 review, Magellan clarified use of the phrases "grievance" and "complaint" to describe the enrollee grievance process. In discussion, Magellan stated that "grievance" refers to enrollee grievances, and "complaint" refers to complaints filed by providers. This is consistent with language found in the member handbook, which uses "grievance" to describe the enrollee process.

However, reporting of OP-22 ("Complaints against Contractor") remains unclear. In discussion with WDH, Guidehouse confirmed that OP-22 covers enrollee grievances reported to WDH. This contradicts information obtained from Magellan, which stated that OP-22 refers to provider complaints obtained by Magellan and reported to WDH.

While Magellan has confirmed definitions of "grievance" and "complaint" internally and confirmed that enrollee grievances and provider complaints are all monitored and handled appropriately, the identified discrepancies with WDH may lead to confusion in tracking grievances and/or complaints, which poses a risk to program management and monitoring.

> ***Recommendation for WDH:*** Clarify the purpose of OP-22 ("Complaints against Contractor") with Magellan and update performance measures accordingly.
>
> WDH should clarify the purpose of OP-22 with Magellan. Currently, Magellan reports provider complaints quarterly to WDH, but does not report enrollee grievances. Guidehouse recommends WDH clarify requirements for performance measure reporting to include enrollee grievances as part of WDH's monitoring efforts.
>
> ***Recommendation for Magellan:*** Confirm updated definitions of "grievance" and "complaint."
>
> Magellan provided internal policies which clarify definitions of "grievance" and "complaint." If WDH and Magellan are in agreement with the definitions, all other policies and external materials (e.g., provider and member handbooks) should use the updated definitions. Magellan should also specify the source of information reported as part of OP-22 (e.g., providers or enrollees).

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 2020 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 2020 SOW.

Based on these federal and State standards, Guidehouse identified 30 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 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 normal operations, the community-based nature of the HFWA model involves providers traveling to the enrollees at a time and location that works best for enrollees, rather than enrollees traveling to a clinic or facility. Therefore, travel time and distance do not impact enrollee access.
- **Capacity of certain provider types:** The CME program provides care coordination services only and does not provide any clinical services. Providers must be certified in HFWA, but do not fall into typical clinical provider categories. Therefore, clinical provider categories (e.g., primary care, specialists, hospital, pharmacy, etc.) do not apply to the CME program.
- **Long-term services and supports (LTSS):** Requirements around LTSS do not apply to the CME program, which delivers care coordination services to children with complex behavioral needs.
- **Indian health care providers (IHCPs):** Although Magellan serves tribal enrollees, IHCPs are not involved because the program does not offer clinical services.
- **Exceptions process:** The provider-specific network adequacy standards do not apply to this program, and therefore there are not exceptions to the provider-specific network standards.

Table 15 provides an overview of Magellan's compliance levels with the applicable elements. Overall, Magellan and WDH met seven of the 11 applicable elements and did not meet four of the applicable elements.

Table 15. Network Adequacy Assessment

Category from 42 CFR § 438.68	# Elements Met	# Elements Not Met	Total # Applicable Elements
General Rule	0	1	**1**
Provider-Specific Network Adequacy Standards	0	1	**1**
Development of Network Adequacy Standards	7	2	**9**
Total	**7**	**4**	**11**

Areas of Strength and Needed Improvement

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

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

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

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

Strength: Magellan provides a robust program for provider training and development.

Magellan has a robust training program for new and existing providers. As providers enter the CME program's network, they must undergo two levels of training (Tier 1 and Tier 2) before becoming fully certified. Tier 1 training incorporates classroom-based learning and covers the phases of HFWA, required HFWA documentation (e.g., Plan of Care; Strengths, Needs, and Culture Discovery (SNCD); Child and Adolescent Needs and Strengths (CANS)), and other necessary topics.

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

- Orient the family, prepare the family, conduct a child and family team (CFT) meeting, and conduct a crisis plan meeting
- Complete HFWA documentation, including SNCD, crisis plan, progress notes, transition plan, etc.

In addition to initial trainings, providers demonstrate their skills as part of annual re-certifications. Providers also have access to twice monthly learning opportunities which serve as a method of keeping providers apprised of the latest trends and tools for working with CME youth.

(This is a continued strength from SFY 2019).

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

Magellan has historically used telehealth to allow continued care coordination when enrollees and providers are not in the same physical location. Magellan's enrollees and providers were able to exercise this option at any time and was especially useful during severe weather events. With the shift to full telehealth delivery in March 2020 due to COVID-19, Magellan was able to quickly pivot and extend its telehealth offerings to all providers, potentially with less growing pains than other programs experienced since telehealth was already a component of Magellan's offerings. Although enrollees and providers alike have experienced challenges with the longer-term full telehealth approach, especially given the relational nature of the program, Magellan has maintained steady enrollment. For example, based on Magellan's quarterly reports, CME program membership averaged 200 enrollees monthly from July 2019 to February 2020 and averaged 229 enrollees monthly from March 2020 to June 2020 (after the start of the public health emergency).

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

Magellan provided several documents describing the provider network, and there were some inconsistencies regarding the number of enrolled providers, as illustrated in Table 16 below. Both documents were intended to describe the status of the provider network at the end of SFY 2020. When asked about the inconsistent data, Magellan was unable to explain the data inconsistencies across documents since the employee who managed this information was no longer with the program. It appears that the previous employee's data management processes may not have been documented clearly.

Table 16. Provider Enrollment Count Comparison

	Document 1	Document 2
Category	**Provider List Clinical**	**Program Status Report (Annual Report) – Network Development/Scalability Report**
Provider Agencies	17	14
Other Certified Providers	83 (includes 61 providers within agencies and 22 solo providers)	73

Recommendation for Magellan: Develop improved record-keeping practices to ensure practices are easily transferable between staff.

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

Recommendation for WDH: Continue to regularly validate provider enrollment data.

WDH has implemented regularly scheduled validation checks of the data Magellan provides to confirm it aligns with information in WDH's system, with a small margin for differences in real time. It is especially critical for WDH to continue to review and critique any data inconsistencies to confirm accurate record-keeping and consistent provider enrollment reconciliation efforts. Per discussions with WDH, Magellan and WDH continue to work together to confirm shared understanding of provider network data reconciliation efforts.

Section VII. Administration or Validation of Quality of Care Surveys

Objective: EQR Protocol 6, Administration or Validation of Quality of Care Surveys evaluates the reliability and validity of quality of care surveys administered by Magellan to enrollees and providers.

Per WDH's direction, Guidehouse reviewed two surveys administered during SFY 2020:

- Provider Satisfaction Survey
- Wraparound Fidelity Index, Short Version (WFI-EZ) Survey

This section describes each survey, with additional detail included in Appendix I.

Provider Satisfaction Survey

Magellan administers an annual Provider Satisfaction Survey to assess providers' satisfaction with the services and programs provided by Magellan. Providers complete the survey online, and results are shared with providers and other stakeholders to discuss barriers and options to improve satisfaction where applicable.

Table 17 below evaluates the Provider Satisfaction Survey based on criteria specified in CMS EQR Protocols.

Table 17. Provider Satisfaction Survey Overview

Category	Findings
Survey Purpose, Objectives, and Audience	• Although a clear, written purpose statement was not found in reviewed documentation, Magellan clarified that the purpose of the survey is to "obtain feedback from providers on how things are going, see what needs providers have, and inform adjustments / improvements." • Magellan did not indicate a clear and measurable study objective. • The survey audience includes providers, members of the Wyoming Network Strategy Committee, and members of the Quality Improvement Committee.
Work Plan	• Magellan did not provide a work plan. Per discussions with Magellan, Magellan does not have a formal work plan but instead has internal, corporate policies which govern implementation of the provider satisfaction survey. However, corporate policies included general information about provider surveys and did not provide specific details about Wyoming CME's provider satisfaction survey. • **Data preparation plans:** Magellan obtains raw data from their internal provider listing and cleans data to remove duplicates. • **Data security protocols:** survey responses are assigned a randomly-generated ID, resulting in de-identified survey submissions. Additionally, surveys do not collect any protected health information (PHI). • **Project schedule:** Magellan distributes the survey annually. Providers have between two and four weeks to complete the survey.
Survey Instrument	• Magellan administers the survey via online questionnaire. Magellan developed the survey in-house based on "best practices related to customer experience."

Category	Findings
	• Magellan's corporate survey team indicated that it tests surveys for face validity[7], content validity[8], and a liability assessment.
Sampling Plan	• The survey is aimed at participating network providers, including all providers who received at least one authorization or submitted a claim for service within the State fiscal year. Magellan chose this threshold because submitting a claim/receiving service authorization demonstrates engagement with the program. Magellan offers a survey to all eligible providers.
Strategy to Maximize Response	• Magellan indicates the "cooperation rate" for SFY 2018 was 23 percent, for SFY 2019 it was 21 percent, and for SFY 2020 it was 42 percent. Magellan's method for calculating response rates was not clear in reviewed documentation. Per discussions with Magellan, Magellan's response rate includes all complete and partial responses (e.g., surveys with at least two questions answered) and removes any unreachable providers from the denominator. In reviewed documentation, Magellan lists a "cooperation rate" but did not describe this further in discussions. The American Association of Public Opinion Research defines "response rates" and "cooperation rates" differently and it is not clear which approach Magellan uses. • It is not clear whether Magellan currently has strategies in place to increase provider participation with the survey. For future surveys, Magellan described possible interventions to encourage responses including shorter surveys, text or call surveys, website popup surveys.
Quality Assurance Plan	• Magellan did not provide a quality assurance plan. Per discussions with Magellan, Magellan does not have a formal quality assurance plan but instead has internal, corporate policies which govern implementation of the provider satisfaction survey. However, corporate policies included general information about provider surveys and did not provide specific details about Wyoming CME's provider satisfaction survey.
Survey Implementation According to the Work Plan	• Magellan did not provide a work plan; therefore, it is unclear if the survey was implemented in accordance with the work plan.
Survey Data Analysis and Final Report	• Magellan includes an overview of the provider satisfaction survey results in multiple documents including the CME Quality Annual Program Evaluation, Network Development Plan, and the Annual Program Status Report submitted to WDH. • There is not a final, standalone report describing the survey purpose, implementation, and findings. Magellan indicated the intent to develop a standalone report in the future.

[7] Per CMS EQR Protocols, "Face validity refers to the degree to which the survey is measuring what was intended to be measured."
[8] Per CMS EQR Protocols, "Content validity refers to whether the survey questions accurately represent the concept or subject matter being measured."

Wraparound Fidelity Index, Short Version (WFI-EZ) Survey

Magellan administers the WFI-EZ survey to assess adherence to the primary activities of the wraparound process. The WFI-EZ was developed by the University of Washington / National Wraparound Initiative, and Magellan relies heavily on the existing national survey implementation practices.[9] The WFI-EZ incorporates input from several key stakeholders and is completed by up to four types of respondents for each family: parents or caregivers; youth 11 years of age or older; wraparound facilitators; other wraparound team members. The WFI-EZ collects information on the following topics, which may vary depending on the respondent type:

- Youth Information / Demographics
- Basic Information
- Experiences in Wraparound
- Satisfaction
- Outcomes

Table 18 below evaluates the WFI-EZ survey based on criteria specified in CMS EQR Protocols.

Table 17. WFI-EZ Survey Overview

Category	Findings
Survey Purpose, Objectives, and Audience	• Per Magellan, both the purpose and objectives are as follows: "The purpose of this evaluation is to determine the extent to which the services and supports that are being received by children, youth, and families enrolled in services adhere to those primary activities of the wraparound process on an individual youth or family basis, and explore caregiver and youth satisfaction as well as youth outcomes." The purpose statement addresses quality of care since the survey is intended to help determine how services adhere to wraparound principles and measure satisfaction. • **Survey audience:** WFI-EZ results are shared with providers, families, youth, and stakeholders for planning further community involvement, and to provide a baseline to measure improvement for the next annual measurement.
Work Plan	• Magellan did not provide a work plan and clarified that they do not develop a work plan since all processes are adopted from the existing tool/survey developed by the University of Washington. Although Magellan did not provide a specific work plan, several submitted documents from the University of Washington and Magellan included information regarding survey administration. • **Project timelines**: WFI-EZ surveys are administered on a rolling basis as enrollees become eligible for the survey after being enrolled in the CME program for 150 days (which indicates they are approaching the six-month interval). • **Data analysis and data security:** Magellan did not describe data analysis in detail. However, Magellan indicates that surveys do not include identifiable data, are submitted anonymously, and each youth receives a de-identified survey ID code.
Survey Instrument	• Magellan leverages an existing survey tool developed by the University of Washington and licensed by the National Wraparound Initiative. • Magellan administers the survey electronically or by paper copy if electronic completion is not feasible.

[9] National Wraparound Initiative. *Assessment and Fidelity in Wraparound.* https://nwi.pdx.edu/assessment-fidelity/

Category	Findings
	• The University of Washington has performed several analyses to confirm validity and reliability of the WFI-EZ surveys.

Sampling Plan	• Magellan clearly defines the study population, which includes:
	  ○ Parents or caregivers
	  ○ Youth 11 years of age or older
	  ○ Wraparound facilitators
	  ○ Other wraparound team members

Strategy to Maximize Response	• Magellan uses several strategies to maximize responses, including:
	  ○ Multiple methods for survey completion, as needed
	  ○ Multiple languages (English, Spanish)
	  ○ Early information via member handbook
	• For SFY 2020, there were 120 eligible youth and Magellan received survey responses representing 110 of the eligible youth (92 percent).

Quality Assurance Plan	• Magellan did not provide a quality assurance plan and clarified that all processes are adopted from the existing tool/survey developed by University of Washington.
Survey Implementation According to the Work Plan	• Magellan did not provide a work plan; therefore, it is unclear if the survey was implemented in accordance with the work plan.
Survey Data Analysis and Final Report	• Magellan creates an annual final report for submission to WDH which describes an overview of the survey, survey results/findings, respondent characteristics, etc. Magellan also distributes a press release which includes high-level information and discusses findings in more depth at QIC meetings.

Areas of Strength and Needed Improvement

Magellan's administration and implementation of quality of care surveys demonstrate several strengths and areas for improvement, described below.

Strength: The WFI-EZ survey relies on an existing, validated survey instrument.

As previously described, the WFI-EZ survey was developed by the University of Washington and is licensed by the National Wraparound Initiative. Magellan relies heavily on the existing national survey implementation practices with minimal modifications, which enhances the credibility of the survey tool and processes. The WFI-EZ has undergone extensive review and validation, including but not limited to testing for reliability and validity. Additionally, because other states also leverage the WFI-EZ survey, Magellan is able to compare Wyoming's CME program to national benchmarks on wraparound initiatives.

Needed Improvement: Magellan's survey documentation lacks certain elements regarding work plan and quality assurance processes.

CMS EQR protocols instruct the EQRO to review several survey documentation components, including but not limited to the following:

- Work plan, including project management plan, schedule, reporting requirements, data preparation plans, data analysis plans, and security protocols and procedures.
- Sampling plan, describing the study population, sampling frame, and sampling method.
- Quality assurance plan, describing quality checks, sampling and locating processes, and data collection efforts.

For the WFI-EZ survey, Magellan does not have specific work plans and quality assurance plans as described by CMS EQR protocols, but includes the majority of this information in related documentation (e.g., manuals, methodology summaries).

For the Provider Satisfaction Survey, Magellan maintains documentation which describes some, but not all, processes and procedures governing survey implementation and quality assurance described above. For instance, Magellan does not maintain specific work plans or quality assurance plans. Per discussions with Magellan, Magellan has internal, corporate policies which govern implementation of the Provider Satisfaction Survey. However, corporate policies included general information about provider surveys and did not provide specific details about Wyoming CME's provider satisfaction survey. Although Magellan's corporate policies address general survey development, survey administration, and survey analysis and reporting, Magellan's corporate policies do not address items specific to Wyoming's Provider Satisfaction Survey, including survey timeframes (e.g., length of time to complete survey, survey schedule) or details regarding project management (e.g., role of local Wyoming CME staff).

Recommendation for Magellan: Develop documentation to fully describe survey administration and implementation procedures for the Provider Satisfaction Survey.

Magellan would benefit from more clearly documenting survey administration and implementation procedures for the Provider Satisfaction Survey. Reviewed documentation describes corporate processes but does not adequately describe details relating to Wyoming's specific survey and processes. Documenting elements like project management details, survey timeframes, reporting requirements, and quality assurance procedures, for example, creates more structure and may improve Magellan's survey implementation processes.

Needed Improvement: Magellan continues to receive low response rates for the Provider Satisfaction Survey.

Magellan's Provider Satisfaction Survey response rates were 23 percent for SFY 2018, 21 percent for SFY 2019, and 42 percent for SFY 2020. Response rates decreased between SFY 2018 and SFY 2019, then showed significant improvement between SFY 2019 and SFY 2020. However, the survey still was not able to reach the majority or even half of the provider network, so this is an area where Magellan can continue to improve. Magellan does not have a documented strategy for increasing participation, and it is not clear whether Magellan is currently and actively pursuing strategies to increase participation. Per discussions with Magellan, the corporate survey team has discussed potential interventions to encourage increased responses in the future, including shorter surveys, text or call surveys, and website popup surveys. At the local Wyoming level, Magellan staff encourage participation during provider calls.

Recommendation for Magellan: Develop a robust, documented strategic plan for maximizing response rates.

Magellan indicates that "provider satisfaction surveys serve as the most direct measure of assessing the provider's satisfaction with the services and programs provided by Magellan." To best understand providers' perceptions and areas for improvement, increased participation is essential. The low response rates do not provide adequate representation of the provider network. Magellan should develop a robust, documented strategic plan for maximizing response rates. Magellan may choose to leverage existing communications, such as provider calls, to request feedback from providers regarding ease of access and barriers to completing the provider satisfaction survey. Magellan may also consider exploring provider incentives for survey completion as appropriate.

Section VIII. Information Systems Capabilities Assessment (ISCA)

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

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

Overview of Magellan's Information System

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

In previous years, Magellan's information system was not specific to the CME program and Magellan did not have sufficient IT staff to support the system; however, at the time of this review, Magellan has resolved these and other previously identified issues with additional recruitment and cross-training of staff, and systems demonstrate no areas for concern.

Staffing

Magellan's staffing level for those who support adjudication and reporting is appropriate for processing claims and generating measures. Measure owners reported obtaining support from team members who have access to instructions for measure generation. Additionally, claims processors and measure generation staff receive suitable training:

- Claims processors receive extensive classroom training during the first few weeks of employment which includes technical instruction, benefit information, and hands-on experience. Once claims processors begin processing claims, more senior staff audit all of a newer processor's claims until the staff member has demonstrated 98 percent accuracy on a 100 percent sampling for two consecutive weeks.
- Analytics and reporting staff are trained and experienced in SQL Server, Oracle SQL, Cognos, and Microsoft Office.

Processes and Technology

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

- **Technology:** Magellan processes claims on an AS400 mainframe then loads those claims into an EDW for reporting. Magellan also pulls data from Wyoming's Conduent system.
- **Claims adjudication, editing, and processing:** Providers submit all claims through Magellan's online provider web portal. All original claims are electronic; however, providers must submit any adjustments as paper claims. The electronic portal requires claims to contain all necessary elements prior to successful submission. Once Magellan staff process the claim, they send the claim to WDH for review and payment. WDH reviews the claim then sends Magellan a response indicating whether Magellan can pay the claim; if WDH approves the claim, it also sends payment. Generally, all claims are

processed within 30 calendar days unless there are issues with the enrollee's eligibility, which may cause a claim to be in suspended status at WDH until resolution.

- **Claims auditing process:** Magellan performs quality and adjudication accuracy audits on two percent of all completed claims (including both paid and denied claims). Magellan also conducts pre-disbursement audits on high dollar claims. During the audit process, Magellan confirms the claim paid or denied correctly, and, if the claim paid, that the claim priced correctly. Magellan clarified that is duplicate edits run against both paid and denied claims. They also provided a report showing 100 percent accuracy for both paid and denied fee-for-service (FFS) claims included in the two percent audit sample during the assessment review period.
- **Data flows through system:** Magellan uses several systems and programs to store and process data. Magellan loads all data into a data warehouse. The team provided process flow documentation and described the use of SQL Server Integration Services (SSIS) packages including encryption for data both at rest and in-transit.
- **Data reporting:** Magellan populates quarterly and annual report data based on claims data, authorizations data, and Wyoming Medicaid's Cognos system. Magellan does not use third-party reporting software to generate results for the measures included in the EQR Protocol 2 review.
- **Verification and approval of data:** Magellan validates performance measure data using their internal subject matter experts, whom Magellan calls "data owners." The team reviews some measure results on a weekly basis, while all are reviewed during monthly QICs. Data owners review the data for accuracy and completeness, including comparing data to previous quarters and identifying trends and / or anomalies.
- **Disaster recovery plan:** Magellan maintains a disaster recovery plan with strategies for confirming business continuity in case of catastrophic events. Magellan replicates data to a secure remote site and recovery teams can access the site remotely to restore business critical operations. Magellan performs "rehearsals" or tests to confirm the disaster recovery plan.

Section VIII. Conclusion

Guidehouse's review of Wyoming's CME program resulted in identification of 10 areas of strength, 13 areas of needed improvement, and 16 recommendations in relation to quality, timeliness, and access to services. Overall, major strengths of the CME program include, but are not limited to:

- The CME program incorporates cultural competency into nearly every aspect of its program and delivery of services to enrollees.
- Magellan staff are knowledgeable, engaged, and invested in the youth and providers of the CME program.
- Magellan provides ample opportunities for provider training and development.
- Magellan leverages existing, validated tools and surveys (e.g., WFI-EZ survey) which enhance credibility.

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

- Magellan has room for improved documentation and establishment of formal processes regarding program operations, including development of work plans. Magellan would also benefit from improved record-keeping to ensure practices are easily transferable between staff as needed.
- Magellan would benefit from improved data quality assurance to limit data inconsistencies across and within Magellan documentation.

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