Wyoming Department of Health
Care Management Entity Program
SFYs 2018 – 2020 Independent Assessment

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Executive Summary

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

As required by CMS and in accordance with guidance to states for Section 1915(b) Waiver Program Independent Assessments, this report conveys the findings of the Independent Assessment (IA) of the access to, and quality and cost effectiveness of the CME Program as determined by Guidehouse Inc. (Guidehouse). This IA review is for services Magellan delivered for the CME Program in State Fiscal Years (SFYs) 2018, 2019, and 2020.

Based on a comprehensive review of submitted reports and data from WDH and Magellan, as well as ongoing conversations and interviews with WDH and Magellan staff, and feedback collected from CME providers, Guidehouse identified multiple areas of strength in the CME Program. Strengths include a robust quality improvement process and running a cost-effective program during the measurement period.

Guidehouse also identified areas that needed improvement. To enhance program efficiency, Magellan should focus on identifying opportunities to automate processes that potentially impact enrollee access to services and quality of care. Transitioning manual activities to automatic processes can help to cut down on turnaround times and minimize the potential for human error. Examples of opportunities to automate processes include automated monitoring to process grievances and an automated process to activate the development of translated onboarding materials if an enrollee identifies a language other than English as their preferred language.

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 years old with serious emotional disturbance (SED) or serious and persistent mental illness (SPMI) who are high utilizers of behavioral health services. The CME Program serves Medicaid-enrolled children and youth who have an SED or SPMI and who meet criteria for Psychiatric Residential Treatment Facility (PRTF) or acute psychiatric stabilization hospital levels of care, as well as those who are enrolled in Wyoming's Children's Mental Health Waiver (CMHW) – a Section 1915(c) Medicaid waiver. Table 1 below quantifies the number of youths served in the CME Program since the program's inception.

Table 1. CME Enrollment[1]

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

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

Wyoming's Section 1915(b) and 1915(c) Waiver Programs

The CME Program operates via authority granted under concurrent federal waivers – Wyoming Medicaid's 1915(b) Youth Initiative waiver and the 1915(c) CMHW. 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 1915(c) CMHW was initially approved by the Centers for Medicare & Medicaid Services (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

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

evidence-based model at that time but had proven successful across a variety of settings in preventing admission to and decreasing the length of stay for children and youth with complex behavioral health needs who had traditionally been served in more restrictive, out of home settings. Currently, the 1915(c) waiver offers the Youth and Family Training and Support service, which is unique to youth enrolled through the 1915(c) waiver.

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

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

At the direction and approval of CMS, effective July 1, 2018 for SFY 2019, WDH amended the State's 1915(b) Medicaid waiver to shift from a capitated risk-based payment model to a non-risk fee-for-service (FFS) based payment model. This change was intended to alleviate challenges arising with a capitated risk-based payment to Magellan for a small population of members (approximately 200 members in a given month) with varying periodic changes in direct service uptake, utilization, and provider network development.

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

Figure 1. CME Implementation Timeline

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

Overview of the Independent Assessment

In accordance with federal regulations in 42 CFR § 431, subpart B, as explained in the State Medicaid Director letter titled "Independent Assessment Requirement for Section 1915(b) Waiver Programs: Guidance to States," states must choose an entity to conduct an independent assessment (IA) of its waiver program.[2] The IA focuses on three areas of a 1915(b) waiver program:

1. **Beneficiary access to services under the waiver:** A 1915(b) waiver program may not substantially impair a beneficiary's access to services as compared to accessibility of services prior to or without the waiver.
2. **Quality of waiver services:** The quality of services under a 1915(b) waiver program may not be less than the quality of services prior to or without the waiver.
3. **Cost-effectiveness of the waiver:** The total costs of the waiver, including program benefits and administrative costs, must not be greater than the cost of providing like services without a waiver.

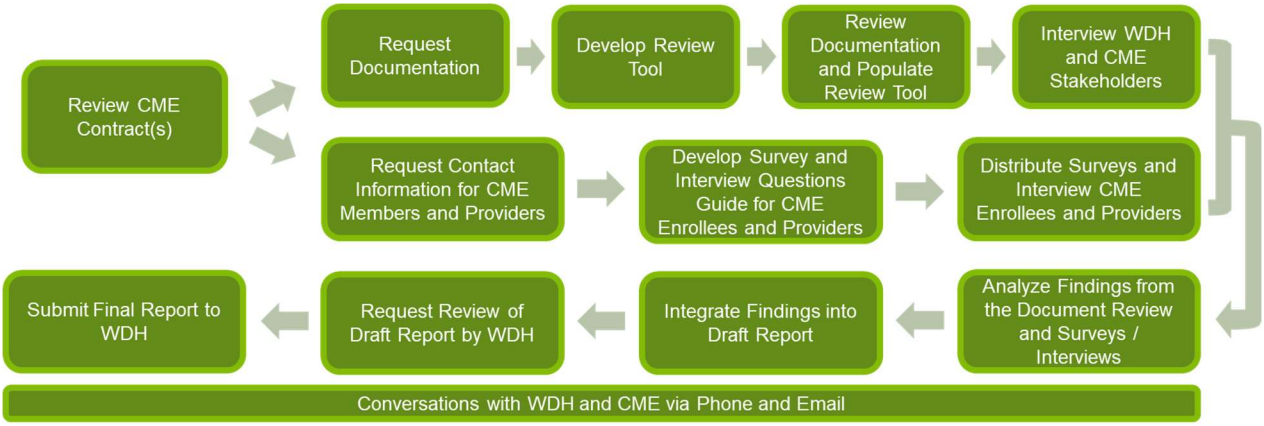
WDH contracted with Guidehouse Inc. (Guidehouse) as the entity to conduct the IA for SFY 2018 (July 1, 2017 to June 30, 2018), SFY 2019 (July 1, 2018 to June 30, 2019), and SFY 2020 (July 1, 2019 to June 30, 2020). The IA relies on discussions with WDH and Magellan staff, documentation provided by WDH and Magellan, and Guidehouse's industry experience working with health and human Services agencies in 49 states and Washington, D.C. This report summarizes findings of the IA and provides related recommendations to improve access to care, quality of care, and cost effectiveness of the CME Program.

[2] Department of Health & Human Services, Health Care Financing Administration, Center for Medicaid and State Operations. Section 1915(b) Waiver Program Independent Assessments: Guidance to States, December 1998. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd122298.pdf

Section II. Methodology

Guidehouse's methodology and associated review tools for the IA of the CME Program encompasses the following key steps, visualized in Figure 2.

Figure 2. Key Assessment Steps



CMS suggests states should incorporate the IA report and recommendations as tools to improve the waiver program. Determining areas applicable for the IA required mapping relevant language from the effective statement of work (SOW) between WDH and Magellan for SFYs 2018 - 2020 to the key elements for review designated by CMS guidance. Guidehouse identified the SOW sections which operationalized the relevant federal recommendations, then requested and reviewed relevant documentation effective in SFYs 2018 - 2020 including, but not limited to, the following:

- Magellan corporate policies and procedures (and, where different, Magellan policies and procedures) related to access to care, quality of care, and cost effectiveness
- Enrollee and provider handbooks
- Outreach and marketing templates and materials
- Quarterly reports to WDH
- Applications for enrollee and provider enrollment with the CME Program
- Geographic information on enrollee residences and provider service areas
- Provider agreements for individual and agency providers
- Training rosters and presentations for providers
- Wyoming Administrative Rules

Guidehouse reviewed all submitted documents in accordance with CMS's suggested elements. Guidehouse also reviewed findings from past External Quality Review (EQR) Technical Reports and communications from CMS for the assessment. However, given the non-clinical nature of

the CME Program, there were several assessment elements that are not applicable to this program and not included in this review because they are not covered benefits (see Appendix B). WDH verified all applicable elements prior to review of documents and completion of the review tool for each area of assessment included in Appendix B.

The evaluation criteria Guidehouse uses for each review area consisted of the following three-tier rating scale:

- **Fully Met –** All documentation listed under the protocol or requirement, 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 with protocol or requirement during interview(s) and/or discussion(s) with Guidehouse reviewers, but required documentation is unavailable, incomplete, or inconsistent with practice

- **Not Met –** Submitted documentation does not meet federal or State standards, or no documentation is present and Magellan staff have little to no knowledge of processes or issues that comply with the protocol or requirement

Guidehouse also collected feedback on program access and quality from CME Providers. Guidehouse solicited, but did not receive, feedback from CME enrollees and their families which is further discussed in Section V Interviews and Surveys of this report. Feedback was collected through telephonic interviews and anonymous online surveys. The questions asked during the telephonic interviews and through the survey can be found in Appendix C. After collecting the feedback, Guidehouse synthesized responses into key takeaways and areas for improvement. Findings based on the feedback received from CME providers can be found in Section V. Interviews and Surveys.

Section III. Access to Care

Guidehouse reviewed the CME Program and WDH's implementation of the 1915(b) waiver to assess the program's access standards and protocols, including Magellan's efforts to preserve and expand availability of and access to services. Federal guidance instructs the State to incorporate standards and protocols for access to care in its Request for Proposal (RFP) or contract(s) with a PAHP.

Review of the CME Program's access to care efforts focused on five topic areas recommended by CMS in the State Medicaid Director letter and affirmed by WDH as applicable and appropriate for review.[3] Table 2 summarizes the five topic areas and findings of each element in these areas.

Table 2. Elements for Evaluating Access

Topic	Summary of Findings	Evaluation
1. Evaluation of the State Program's Access Monitoring and Analysis		
Service Delivery in Amount, Duration, and Scope	The SOW, Member Handbook, and Provider Manual clearly describe the services provided by the CME Program. The documents also describe services available to enrollees when they need to access service after normal business hours.	Fully Met
2. Enrollment Information		
Materials	Distributed materials are understandable, regularly updated, and provided to enrollees in a timely manner. Prior to distribution, materials go through a rigorous review process by both Magellan and WDH to confirm enrollee accessibility and cultural appropriateness. Translation and accessibility services are available to all enrollees.	Fully Met
Enrollment	The CME Program enrollment process begins with client referrals and includes contacting a potential enrollee's guardian, provider selection, and completing a Plan of Care (POC). Despite changes in the enrollment process for new enrollees, Magellan does not meet the required standard for FCC provider contact i.e., OP-04.	Partially Met
Disenrollment and Transition of Care	The goal of the CME Program is to transition youth from the program to a lower level of care. Additionally, the CME Program operates under "Family Voice and Choice" allowing enrollees to disenroll from the program at any time for any	Fully Met

[3] Department of Health & Human Services, Health Care Financing Administration, Center for Medicaid and State Operations. Section 1915(b) Waiver Program Independent Assessments: Guidance to States, December 1998. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd122298.pdf.

Topic	Summary of Findings	Evaluation
	reason. The process to disenroll youth was clearly demonstrated via program policies and through interviews with Magellan.	
3. Education and Customer Service Information		
Outreach Plan	Magellan communicates with enrollees and providers via emailed newsletters, the CME Program website, and social media. Magellan regularly tracks engagement with the communication material through email open rates, site clicks, and social media reports.	Fully Met
Comprehension of Program	The Enrollee Handbook and Provider Manual contain clear descriptions of the CME Program. The document includes definitions of the services and providers available through the program, and a description of HFWA and what to expect from the program.	Fully Met
Beneficiary Hotline	Magellan operates a toll-free phone line that enrollees can call twenty-four (24) hours a day, seven (7) days a week. Magellan reports hotline data to the State on a quarterly basis.	Fully Met
4. Provider Capacity		
Provider Network and Provider-to-Beneficiary Ratios	Magellan maintained a constant number of FCC and FSP providers across the State and maintained the FCC and FSP provider-to-beneficiary ratios set by Wyoming in the SOW. Magellan, however, has very few YSPs, but is taking steps to recruit more providers. The CME Program does not include a provider-to-beneficiary ratio for respite providers.	Partially Met
5. Urgent / Emergent Care		
Availability of Care	CME Program enrollees have access to a telephonic hotline twenty-four (24) hours a day, seven (7) days a week. Enrollees are informed of their access to the hotline in the Enrollee Handbook.	Fully Met

Areas of Strength and Needed Improvement

No notable strengths were identified.

Enrollment Information

The enrollment information documents shared by Magellan included: recruitment and informational materials available to prospective youth, policies and procedures related to enrollment and disenrollment from the CME Program, provider directories, and transition of care

plans for youth leaving the program. Magellan also provided additional information and a systems demonstration on the program enrollment and disenrollment processes during the virtual onsite. The documents and information provided during the virtual onsite focused on Magellan's efforts to streamline the enrollment process for new enrollees.

Needed Improvement: Magellan does not meet FCC contact requirements for new referrals in the program.

Magellan did not meet the 100 percent adherence goal for contract requirement OP-04 (i.e., new referrals being contacted by their chosen FCC within three working days).

During the virtual onsite, Magellan described their efforts to meet OP-04 through implementing a revised enrollment process for new enrollees in the CME Program. Magellan determined through analysis and feedback from providers and an external Quality Improvement Committee (QIC) that the enrollment process was too complicated for enrollees to navigate resulting in too much time between an enrollee's application and becoming connected with a provider. To simplify the process, Magellan streamlined enrollment by assigning new enrollees to a single provider to help them navigate the enrollment process from the beginning to the end. Magellan initially paid providers out-of-pocket to manage the enrollment process for new enrollees. The streamlined process began in November 2017 (SFY 2018) and remains in use today. However, the provider payment is now included in the PMPM rate from Wyoming. Despite streamlining the enrollment process as well as establishing additional trainings for providers, Guidehouse's review of the Committee Data Files and Quarterly Reports submitted to WDH for the assessment period indicates whiles improved, Magellan's adherence rate for OP-04 remains non-compliant with the 100 percent adherence goal.

> ***Recommendation for Magellan:*** Reevaluate why FCCs are not contacting new referrals within the three working day timeframe and identify new methods to meet the requirement.
>
> The ongoing inability of FCCs to meet the new referral contact requirements highlights a need to reexamine possible reasons for the lag. Magellan should reevaluate why FCCs are not meeting the requirement and explore new options to increase adherence, including a new PIP or an additional provider incentive. Additionally, Magellan should explore with the State whether the three working day requirement is sufficient time for FCCs to contact new enrollees or whether a revised timeframe is needed.

Needed Improvement: Magellan's electronic health record (EHR) system does not require providers to collect enrollee language preference.

During the virtual onsite, Magellan clarified that the language preference of enrollees and parents / guardians is collected in the EHR. However, language preference is not a required field on the EHR. While a preferred language other than English triggers the availability of interpreter services during appointments, it does not trigger the development of written materials in the preferred language.

Recommendation for Magellan: Update the EHR system to make language preference a required field.

Language is a well-establish barrier to receiving health care. By requiring the identification of a language preference in the earliest stages of an enrollee joining the CME Program, Magellan can minimize delays in care related to language barriers and accessing translation services.

Recommendation for Magellan: Develop an internal process or alert that automatically triggers the development and distribution of translated materials if an enrollee's preferred language is a language other than English.

As part of the enrollment process, enrollees are given documents such as the Enrollee Handbook and Member Rights and Responsibilities. However, if these materials are inaccessible to enrollees and/or not fully understood by enrollees, they have little utility and can impact a youth's ability to maximize the benefits of the program. Magellan maintains a robust family of translation and interpretation services that can quickly translate documents into requested languages. Developing a clear process to initiate utilization of translation services can facilitate timely access to care.

Needed Improvement: Magellan's disenrollment data does not include analysis to identify changes or trends in enrollee disenrollment.

Magellan reports disenrollment rates to the State on a weekly and quarterly basis. However, Magellan does not analyze disenrollment data longitudinally (e.g., year over year) for internal purposes or in what it reports to the State. The lack of longitudinal analysis limits Magellan's ability to identify and address disenrollment trends.

Recommendation for Magellan: Develop an internal process to analyze disenrollment over longer periods of time to identify and address disenrollment trends.

The goal of the CME Program is disenrollment. Additionally, the program operates under "Family Voice and Choice", so if an enrollee / family decides no longer to participate in the program for any reason, Magellan will accept that choice. However, identifying program-related changes in disenrollment overtime can help Magellan proactively take action to identify any program changes that need to be made to best serve enrollees.

Provider Capacity

Provider capacity for the CME Program is measured by provider-to-beneficiary ratios established in the SOW between the State and Magellan. Provider ratios are regularly tracked by Magellan and reported to the State through quarterly reports and Provider Network Geomaps. Additional information on the provider network and capacity was provided to Guidehouse during the virtual onsite with Magellan and Wyoming. Magellan only partially met the provider access to care requirements for provider capacity. Additional information is below.

Needed Improvement: Magellan did not maintain enough YSP providers in their network to serve the enrollee population from SFY 2018 to SFY 2020.

The CME Program has a low number of YSPs. According to the Provider Network Geomaps, Magellan only had two YSP providers in the State from SFY 2018 to SFY 2020. This number is far below the amount needed to provide services to the over 400 youth in the program during that period.

During the virtual onsite, Magellan clarified that they are very aware of the low number of YSP providers available to CME Program enrollees and are familiar with the barriers the program faces to both recruit and retain YSPs. Barriers include: the large amount of training to become a YSP, the limited age range for the position (between the age of 18 and 26), and the lived experience required to qualify as a provider. The Magellan team highlighted the efforts they have taken to increase the number of YSPs available to their enrollees. Efforts include recruiting potential providers by running ads in local trade magazines, partnering with centers that have youth employed in roles similar to the YSP position, and building a pipeline of former program enrollees to become YSPs.

Recommendation for WDH and Magellan: Identify the impact of the low number of YSPs on the CME Program and evaluate whether YSPs should continue to be a service provided by the program.

Despite ongoing efforts, Magellan has not been able to secure a sufficient network of YSPs to fully serve program enrollees. It is unclear whether the lack of YSPs impacts the program's ability to provide services to enrolled youth. WDH and Magellan should collaborate and evaluate whether the lack of YSPs negatively impacts program enrollees, and identify whether the services provided by YSPs can be equally or better provided by another provider type or group.

Needed Improvement: Magellan and WDH currently do not have a set provider-to-beneficiary ratio for respite services.

The current SOW includes provider-to-beneficiary ratios for FCCs, FSPs, and YSPs. However, the SOW does not include a target provider-to-beneficiary ratio for respite providers. The lack of a target ratio makes it difficult to measure Magellan's ability to meet provider network requirements and sufficiency of respite providers to meet enrollee needs.

Recommendation for WDH: Establish a provider-to-beneficiary ratio and / or regional minimum for respite providers and include it in an updated SOW.

Current provider-to-beneficiary ratios for FCCs, FSPs, and YSPs, were set by the State in the SOW. The State should work with Magellan to identify a target provider-to-beneficiary ratio for respite providers and include it in the SOW. An alternative for WDH would be to set a respite provider minimum by region.

Section IV. Quality of Care

Federal guidance instructs the State to incorporate standards and protocols for quality of care in its RFP or contract(s) with a PAHP. Assessment of the CME Program's quality and impact on waiver services, including Magellan's methods for ensuring and improving quality of care, focuses on five topic areas recommended by CMS in the State Medicaid Director letter and affirmed by WDH as applicable and appropriate for review. Table 3 summarizes the five topic areas and evaluation of each element in these areas.

Table 3. Elements for Evaluating Quality

Topic	Summary of Findings	Evaluation
1. Evaluation of the State Program's Quality Monitoring Elements		
Standards of Care	Magellan's quality and appropriateness of care is measured by a set of quarterly-reported operational requirements and performance measures agreed upon by WDH and Magellan.	Fully Met
Sanctions	WDH may impose sanctions and penalties on Magellan per the SOW. Magellan demonstrated progress and met contractual obligations. WDH did not impose penalties or sanctions during this review timeframe.	Fully Met
Information Systems	Magellan conducted a virtual demonstration of its care management system for WDH and Guidehouse. Magellan's information system provides information on areas including denials of referrals, authorization requests; utilization; claims; enrollee and provider grievances, complaints, and appeals; and disenrollment for reasons other than loss of Medicaid eligibility including disenrollment requests made by an enrollee.	Fully Met
2. Clinical Review of Utilization Patterns		
Patterns for Select Beneficiaries	Magellan creates an annual Quality Assessment and Performance Improvement (QAPI) program for the services it furnishes to its enrollees and submits it for review to WDH annually. This includes reporting enrollee demographic data (including racial/ethnic data), outcomes measures, utilization, and special needs population (target population) data.	Fully Met
Improving Utilization Patterns	Magellan submits enrollment and utilization data to WDH as part of the State's ongoing monitoring and oversight efforts. WDH and Magellan have joint meetings to collaborate on improving issues and utilization	Fully Met

Topic	Summary of Findings	Evaluation
	trends and action items. Magellan and WDH maintain a process to review enrollee utilization and ensure enrollees utilize the full array of benefits available to them.	
3. Grievances and Appeals		
Grievance Process	Magellan policies outline compliance with 42 CFR 438.400 and 438.424, provides process for making grievances, tracking turnaround times, notices of grievances and dispositions, and enrollee rights grievance process. Although Magellan satisfies the minimum requirements for the grievance process, there's opportunity to further enhance the grievance system.	Fully Met
Comprehension of Grievance Process	Enrollee and provider handbooks describe Magellan's grievance process including enrollees' rights to file a grievance, what can be included and how to file, turnaround times, appeal information and rights, timing of appeals and timeframes for resolution, rights to fair hearing, and continuation of services during the process.	Fully Met
4. Beneficiary, Provider, and Subcontractor Satisfaction		
General Satisfaction	Magellan complies with the annual enrollee and provider surveys. Magellan submits the survey results to WHD, along with methodology and list of questions annually in Magellan's CME Quality Annual Program Evaluation report.	Fully Met
Involvement in Quality Activities	Magellan submits annual Quality Work Plans and evaluations to WDH. During the virtual onsite, Magellan provided information on additional quality improvement areas implemented based on feedback from annual EQRs.	Fully Met
5. State Quality Improvement Measures		
Quality Improvement Plan	Magellan submits annual CME Quality Program Evaluation reports and annual Quality Work Plans to WDH. Magellan solicits feedback from active youth and family, as well as other stakeholders. Magellan reports program metrics and analysis of the Quality Improvement (QI) system including oversight and monitoring. Magellan's annual Quality Work Plan describes a multi-year approach to incorporating quality improvement methodologies to improve performance. WDH and Magellan meet weekly to	Fully Met

Topic	Summary of Findings	Evaluation
	address quality and any concerns reported by providers.	

Areas of Strength and Needed Improvement

Evaluation of the State Program's Quality Monitoring Elements

Guidehouse conducted an initial desk review of documents including the EQR Technical Reports and all communications with CMS during the assessment period to generate a comprehensive list of questions and focus areas for the virtual interviews and systems demonstration. Several documents initially submitted by Magellan were for the incorrect assessment period and did not cover all the periods required. Guidehouse requested the outstanding documentation and Magellan submitted the documentation by the requested deadline (04/14/22).

During the virtual onsite, Magellan provided a system demonstration which showed a manual process for the entering of data and grievance tracking. When asked about the oversight and monitoring of the system and process in the manual environment, Magellan did not believe they required more than a manual process due to the low number of enrollees and grievances they track.

Strength: Magellan implemented Quality Improvement Projects to address areas of provider turnover.

During the virtual onsite, Magellan provided information on their quality improvement activities following the SFY 2019 EQR which included analyzing provider demographics, barriers, and creating a network development roadmap to address provider turnover. Interventions include shortening the length of training as well as implementing a provider exit survey in SFY 2020 to gather additional information.

Needed Improvement: Magellan does not appear to have a process for reviewing document requests which includes oversight and ensuring documentation is complete.

Magellan's document submissions did not cover the review timeframes and related topics required for review. Several documents were missing or did not cover the correct state fiscal years. These documents were requested pre- and post- onsite and were eventually received.

Magellan submitted enrollment files with member protected health information (PHI) that was neither required nor requested by Guidehouse to complete the review. Guidehouse, which has a business associate agreement (BAA) in place with WDH, notified Magellan and WDH of this and permanently deleted these files from its systems.

> ***Recommendation for Magellan:*** Magellan should create a process to manage document requests and review of all documentation prior to submission.
>
> Magellan should create an oversight process for managing documents including requests for documents. The process should first verify understanding of the full scope of the request to facilitate meeting the accuracy, completeness, and timeliness of requests. Additionally, PHI must be appropriately safeguarded, and only minimum necessary information is sent for reviews.

Needed Improvement: The grievance system is a fully manual and does not have a process for quality oversight and monitoring.

Magellan's virtual grievance system demonstration displayed a manual process without any system automated features such as notifications for timeframes or follow-up needed. Magellan's manual process leave room for errors such as an incorrect date grievance was received, missing information, meeting required turnaround time frames, member notices and ensuring timely resolution. The oversight and monitoring process for inputting information and follow-up is also manual process. When asked about the monitoring and oversight process Magellan said that they did not need a system with automated notifications due to the small volume of grievances in the program. The quality monitoring and oversight is a manual process that lacks efficiency and could leave room for key stroke errors, missing deadlines, and required follow-up activities. Although Magellan satisfies the minimum requirements for the grievance process, there's opportunity to further enhance the grievance system.

Recommendation for Magellan: Magellan should develop enhancements for grievance system to include a process for quality monitoring and oversight.

Magellan should review its current system and consider enhancing the data collection system to include automated monitoring features to process grievances. This includes automated oversight and monitoring functions to validate accuracy of data entry or expeditiously and consistently identify or flag items such as expiring turnaround times, sending letters to members and providers, etc.

Section V. Interviews and Surveys

To enhance the Access to Care and Quality of Care review, Guidehouse reached out to the eligible CME Program providers and enrollees via email to invite them to provide optional anonymous feedback on the CME Program through virtual interviews or web-based surveys. Providers and enrollees / caretakers were separately solicited via email in eight instances (four targeting providers and four targeting enrollees / care takers) from March - April 2022 with the opportunity to provide optional feedback through scheduling a virtual interview. A survey link was provided via email for providers and enrollees / caretakers who wished to leave anonymous feedback.

Guidehouse requested member experience feedback from enrollees / caretakers who participated with the CME Program for at least a six-month period during SFYs 2018 – 2020. Magellan provided Guidehouse with an enrollment file containing email addresses of eligible enrollees however, several of the emails were blank or returned as not valid. Despite Guidehouse's multiple outreach attempts to eligible enrollees / caretakers, none opted to participate in the virtual interviews or surveys.

Guidehouse requested provider feedback from both termed and active providers that provided CME Program services during SFYs 2018 - 2020. Magellan supplied Guidehouse with the rosters of eligible providers of which Guidehouse received feedback from eight providers through either virtual interviews or online survey. The key takeaways from the feedback received are listed below as an area of strength, or an area of needed improvement with recommendations to further enhance access to and quality of care.

Areas of Strength and Needed Improvement

Strength: The CME Program provides services that are beneficial to youth and families.

Providers cited many aspects of the CME Program as strengths including:

- Core principles of which the CME Program operates under help enrollees increase self-efficacy, coping skills, and confidence.
- Ongoing assessments indicate enrollees' growth and attainment/success with their respective care plans. This growth is recognized by the community, schools, and providers.
- Strong youth engagement with youth having an active voice in the program.
- Families can quickly learn to guide their own progress which facilitates their transition to other programs.
- Ability to provide services statewide including in rural areas.

Needed Improvement: Providers cited challenges with training, billing, and availability of other CME providers.

Providers identified areas that need improvement including:

- Difficulty with keeping track of required training, changes to processes, documentation, and templates.
- Challenging to get support timely when issues arise.
- Limited ability to collaborate across providers in the program due to time or provider constraints.

- Initiating services are constrained by the amount of documentation needed and turnaround time.
- Billing issues including tracking down authorizations and delays in receipt of payments.
- Lack of sufficient number of therapy providers and options in the community.

Recommendations for Magellan: Magellan should explicitly solicit provider feedback to resolve gaps in understanding program requirements and explore opportunities for continued program enhancement.

Providers expressed concerns with keeping track of ongoing changes in policies, documentation requirements and required trainings which makes it confusing for them to understand the latest requirements. Magellan can address these concerns through improved communication efforts with providers and ensuring the Magellan provider website clearly identifies the provider training requirements, including the latest changes, processes, and policies. Magellan should explicitly solicit providers for feedback on the CME Program including needs for additional trainings.

Section VI. Cost Effectiveness

Guidehouse's actuarial team reviewed WDH's 1915(b) waiver application and associated cost effectiveness submissions, financial reporting, quarterly cost effectiveness regional office submissions to CMS, and CMS-64 reporting to validate WDH's determination of cost effectiveness for its 1915(b) waiver program for SFYs 2018, 2019, and 2020. This technical review involved validating the base data used against CMS-64 reports and regional office submissions. Per CMS guidance, the total costs of the waiver, including program service costs and administrative costs, must not be greater than the cost of providing like services without a waiver.

At the direction of WDH, Guidehouse conducted a comparison of expenditures for services under the waiver, including administrative costs. By comparing actual costs by period and quarter against what was estimated in the waiver submissions for SFYs 2018 - 2020, Guidehouse determined that actual expenditures were less than what was initially projected, both in aggregate and in PMPM costs, as shown in Table 4. *Furthermore, the program was cost effective for every quarter for these three state fiscal years.* Please note that P1 represents SFY 2018, P2 represents SFY 2019, and P3 represents SFY 2020.

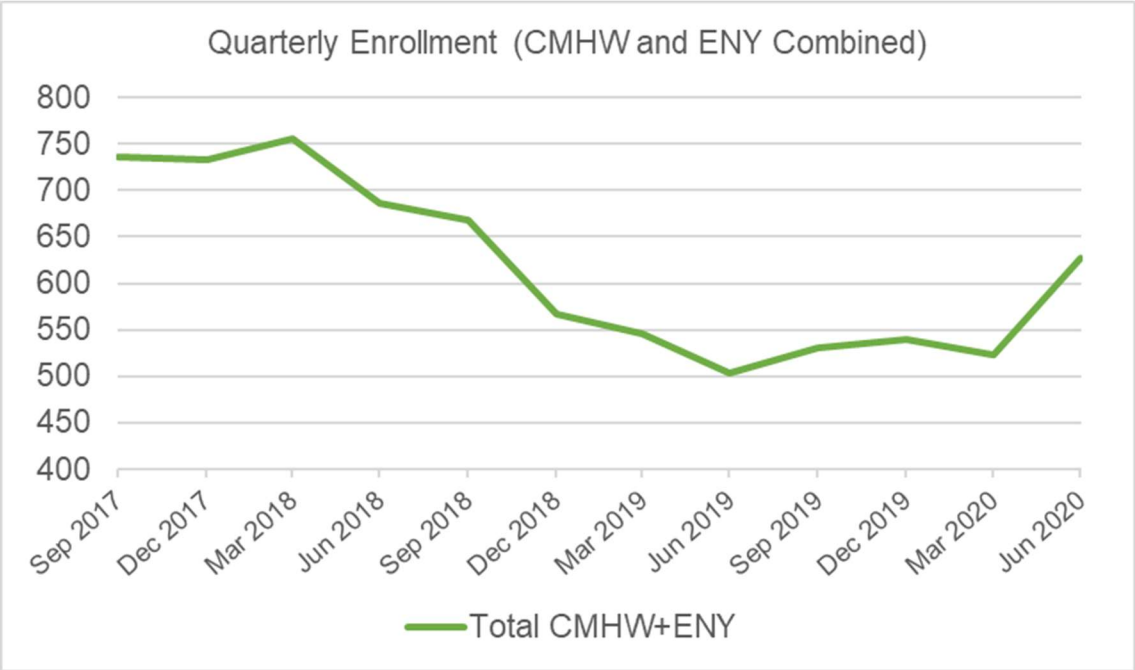
Table 4. Comparison of Projected Versus Actual Waiver Expenditures

	Projected			Actual			Difference		
	MMs (Member Months)	Total Cost	PMPM Costs	MMs	Total Cost	PMPM Costs	MMs	Total Cost	PMPM Costs
P1 Total	3,164	$14,484,793	$4,578.25	2,911	$10,845,734	$3,726.33	(253)	$(3,639,059)	$(851.92)
P2 Total	3,612	$16,651,389	$4,610.06	2,282	$5,952,205	$2,608.90	(1,330)	$(10,699,184)	$(2,001.26)
P3 Total	3,526	$13,906,535	$3,944.00	2,219	$7,115,574	$3,206.53	(1,307)	$(6,790,961)	$(737.47)

For the entire period for which actual costs were available (Q1 of P1 through Q4 of P3, or July 1, 2017, through June 30, 2020), the total costs amounted to $21.1 million less than originally estimated ($45.0 million). Notably, the lower actual costs are only partially attributable to the lower-than-expected membership. On a PMPM basis, expenditures are $852 lower in SFY 2018, $2,001 lower in SFY 2019, and $737 PMPM lower in SFY 2020.

Below, Guidehouse presents additional findings on the CME Program's cost effectiveness results. No areas were identified for needed improvement, and as stated previously, the program was cost effective for each state fiscal year of the three-year period.

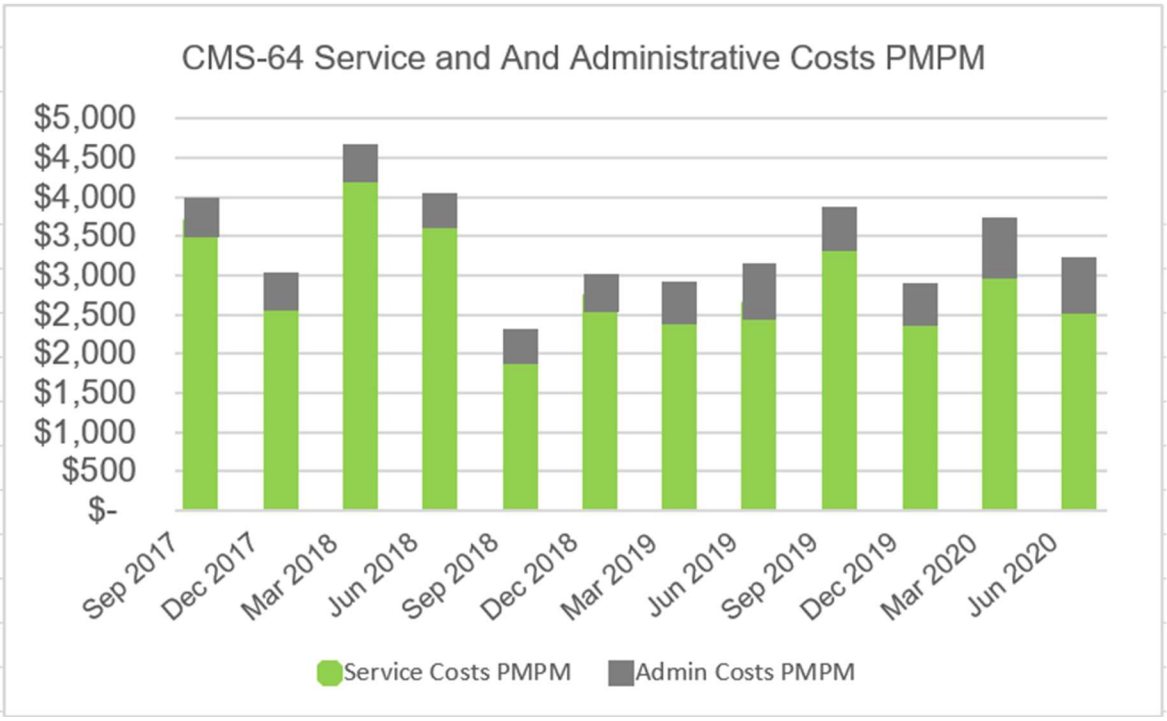
Figure 3. CMS-64 Quarterly Enrollment, Quarters Ending September 2017 – June 2020, CMHW and Enrolled Youth (ENY)



As illustrated in the above graph, enrollment was about 730-755 quarterly enrollees for July 2017 – March 2018, steadily declined to a trough of 503 quarterly enrollees for April – June 2019, and then enrollment resumed increasing from April to June 2020.

Figure 4. CMS-64 Quarterly Administrative Expenses and Service Costs, Quarters Ending September 2017 – June 2020

The below chart helps to illustrate that administrative expenses represent a small portion of total expenditures, or 3.9 percent on a total dollar basis, across SFYs 2018 - 2020. Administrative expenses PMPM did grow somewhat over the course of the program, likely at least partially due to program enrollment declines. The program PMPMs declined from $3,726 in SFY 2018, to $2,609 in SFY 2019, and slightly grew in SFY 2020 to $3,207. Due to the program's extremely small size and limited credibility, experience is quite volatile quarter to quarter.


CMS-64 Service and And Administrative Costs PMPM
$5,000
$4,500
$4,000
$3,500
$3,000
$2,500
$2,000
$1,500
$1,000
$500
$-
Sep 2017
Dec 2017
Mar 2018
Jun 2018
Sep 2018
Dec 2018
Mar 2019
Jun 2019
Sep 2019
Dec 2019
Mar 2020
Jun 2020
Service Costs PMPM
Admin Costs PMPM

Section VII. Conclusion

Guidehouse's assessment of Wyoming's 1915(b) waiver found that the CME Program provides services comparable to non-waiver services across access, quality, and cost effectiveness standards. The program did not limit enrollee access to services or lower the quality of care provided to enrollees. Additionally, the program provided services without incurring greater costs than non-waiver services. The review resulted in the identification of both areas of strength, and areas for improvement in relation to quality, timeliness, and access to services.

Overall, major strengths of the CME Program include, but are not limited to:

- Magellan successfully using feedback and quality improvement activities to implement new processes to increase both access to care and quality of care for enrollees.
- The CME Program maintaining cost effectiveness for every quarter of SFY 2018 to SFY 2020.

However, there is also potential for improvement, including but not limited to:

- Magellan identifying opportunities to automate processes related to access to services and quality of care.
- Magellan providing the correct documentation for the review process and ensuring documents do not have more PHI than is necessary for the review.
- The opportunity to create access standards for all provider types (e.g., respite providers) to better demonstrate enrollee ability to access all types of providers available through the program.

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 the CME Program and operation of the 1915(b) waiver.

Appendices

Appendix A: Abbreviations and Acronyms

CFT	Child and Family Team
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMHW	Wyoming's 1915(c) Children's Mental Health Waiver
CME	Care Management Entity
CMS	Centers for Medicare & Medicaid Services
DHCF	Division of Healthcare Financing
EHR	Electronic Health Record
ENY	Enrolled Youth
EQR	External Quality Review
FCC	Family Care Coordinator
FFS	Fee-For-Service
FSP	Family Support Partner
HFWA	High Fidelity Wraparound
IA	Independent Assessment
MM	Member Month
PHI	Protected Health Information
PIP	Performance Improvement Project
PMPM	Per-Member Per-Month
POC	Plan of Care
PRTF	Psychiatric Residential Treatment Facility
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
QIC	Quality Improvement Committee
RFP	Request for Proposal
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SFY	State Fiscal Year
SOW	Statement of Work
SPMI	Serious and Persistent Mental Illness
WDH	Wyoming Department of Health
YSP	Youth Support Partner

Appendix B: Independent Assessment Review Tool

See attached.

Appendix C: CME Enrollee and Provider Survey Questions

Table 5. Provider Questions

Topic	Question
Program Overview	1. Please tell us how long you have been a provider in the CME Program. 2. Are you a current or former provider? a. (For former providers) why did you decide to exit the program? b. What would incentivize you to rejoin the CME Program? 3. Are you an individual or group provider? 4. Please identify any challenges you have identified with being an individual or group provider. 5. Overall, how satisfied are you with the CME Program? a. Please provide specific examples of things you believe work well or should not be changed as well as areas that could be improved or are not working well.
Program Effectiveness (Quality of Care)	6. Please tell us about the changes in youth functional ability have you witnessed with members in the CME Program. a. What aspects of the program most impact youth functional ability? b. Are current evaluation tools (e.g., the CANS survey) effective in measuring members' functional ability? 7. Please tell us about any changes or recommendations you have to better foster improvement in youth functional ability.
Access to Service	8. Tell us about any barriers you face when trying to meet program requirements (e.g., minimum contact requirements). a. Please provide specific examples. 9. What are some of the barriers you face in accessing needed services / supports for your members? a. Please provide specific examples 10. How has the COVID-19 Pandemic impacted your ability to provide services to members in the CME Program?
CME Program Support	11. What is your comfort level for contacting the CME Program for support on a scale of 1-5 (5 being very comfortable and 1 being very uncomfortable)? 12. Have you contacted the CME Program and/or Wyoming for support? a. How would you rate the support that you received from a 1 to a 5 (5 being the best quality support and 1 being the lowest rating of support)? b. Please provide specific examples for the rating you provided.
Closing	13. How likely are you to recommend the CME Program to eligible youth on a scale of 1-5 (5 being very likely and 1 being not very likely)?

	a. Please provide details about why you selected this rating. 14. Describe the changes or recommendations would you make to improve the CME Program. a. Why do you support these changes? 15. Please share any information you would like to discuss with Wyoming CME that has not yet been addressed in this session.

Table 6. Enrollee / Family / Caretaker Questions

Topic	Question
Program Overview	1. Overall, how satisfied are you with the services provided by the CME Program on a scale of 1 to 5 (5 being very satisfied and 1 being not satisfied)? a. Please provide any specific examples of why you selected that rating.
Program Effectiveness	2. Since becoming a member of the CME Program, has the member's functional ability improved, maintained, or declined? a. Can you provide specific examples? 3. What can the CME Program offer to best improve the member's functional ability? What modifications to the Program would you recommend?
Access to Services	4. What are some of the barriers the member has faced in accessing needed services / supports? 5. How has the COVID-19 Pandemic impacted the member's ability to access services provided by the CME Program?
CME Program Support	6. What is your comfort level contacting the CME Program if you face barriers to care or need other types of support? Please answer on a scale of 1-5 (5 being very comfortable and 1 being very uncomfortable)? 7. If you have previously contacted the CME Program for support, were you satisfied with the support you received? Please provide details.
Closing	8. How likely are you to recommend the CME Program to others on a scale of 1-5 (5 being very likely and 1 being not very likely)? a. Please provide details on why you selected that number. 9. What changes or recommendations would you make to improve the CME Program? a. Why do you support these changes? 10. Please share any information you would like to discuss with Wyoming Medicaid that has not yet been addressed in this session.