Wyoming Department of Health
Care Management Entity Program
SFY 2023 External Quality Review
Technical Report

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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 concurrent 1915(b) and 1915(c) waivers by the Centers for Medicare & Medicaid Services (CMS). The Wyoming Department of Health (WDH) contracted with Magellan Healthcare, Inc. (Magellan) to serve as the single statewide prepaid ambulatory health plan (PAHP) for the CME Program.

Federal regulation mandates states to conduct an annual external quality review (EQR) of Medicaid services delivered through managed care entities including PAHPs. WDH contracted with Guidehouse Inc. (Guidehouse) as the external quality review organization (EQRO) to perform the EQR of Magellan for services delivered in State Fiscal Year (SFY) 2023 and produce this Technical Report as set forth in 42 CFR § 438.364.

Scope of EQR Activities Conducted

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

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

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

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

Unlike traditional managed care programs, the CME Program does not provide acute care services and only provides targeted case management. As a result, many aspects of the EQR are not applicable to the CME program.

Overall Review Findings

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

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

Section I. Introduction

Wyoming's Care Management Entity Program

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

Table 1. CME Enrollment

Year	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
CME Youth Served	328	431	494	402	402	385	366	307

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

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

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

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

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

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

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

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

Figure 1. CME Implementation Timeline

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

Overview of the External Quality Review

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

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

Table 2. EQR Activities and Protocols

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

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

- **EQR Protocol 1: Validation of Performance Improvement Projects**: MCOs, PIHPs, and PAHPs are required to implement performance improvement projects (PIPs) that focus on both clinical and non-clinical aspects of care. Protocol 1 specifies procedures for EQROs to use in assessing the validity and reliability of a PIP (42 CFR § 438.358(b)(i)).
- **EQR Protocol 2**: **Validation of Performance Measures**: Managed care plans (MCPs) must report standard performance measures as specified by the State. The State must provide to the EQRO and the MCP the performance measures to be calculated, the specifications for the measures, and the State reporting requirements. Protocol 2 tells the EQRO how to:
    - Evaluate the accuracy of the Medicaid/CHIP MCP reported performance measures based on the measure specifications and State reporting requirements; and
    - Evaluate if the MCP followed the rules outlined by the State agency for calculating the measures (42 CFR § 438.358(b)(ii)).
- **EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations**: The EQR is required to include a federal and State regulation compliance review of each MCP once in a three-year period. Protocol 3 specifies procedures to determine the extent to which MCPs comply with standards set forth at 42 CFR § 438.358(b)(iii), State standards, and MCP contract requirements.

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

  Due to the State program management changes, the SFY 2023 compliance review encompassed all federal requirements as requested by the State, including requirements which were fully met in the previous year's review.
- **EQR Protocol 4: Validation of Network Adequacy:** The EQR must validate MCO, PIHP, or PAHP network adequacy during the review period to comply with requirements set forth in 42 CFR § 438.68 which requires the State to develop and enforce network adequacy standards.

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

WDH contracted with Guidehouse Inc. (Guidehouse) as the EQRO to conduct the four mandatory EQR activities in a manner consistent with the protocols established by CMS to evaluate Magellan's provision of health care services during SFY 2023 (July 1, 2022 to June 30, 2023). WDH had previously contracted with Guidehouse to conduct the EQR to evaluate Magellan's activities during SFY 2018 (July 1, 2017 to June 30, 2018), SFY 2019 (July 1, 2018 to June 30, 2019), SFY 2020 (July 1, 2019 to June 30, 2020), SFY 2021 (July 1, 2020 to June 30, 2021), and SFY 2022 (July 1, 2021 to June 30, 2022). This EQR relies on interviews with WDH and Magellan staff, documentation provided by WDH and Magellan, and Guidehouse's industry experience working with CMS and health and human services agencies across the country. This report summarizes the findings of the EQR and provides recommendations for Magellan and WDH to improve operational and program performance.

CMS released updated EQR protocols in February 2023. The new protocols were utilized for Protocols 1, 2, and 3, but as directed by CMS, the new protocols for Protocol 4: Validation of Network Adequacy was not utilized. The EQR process was initiated in October 2023 and the new Network Adequacy Protocol will be utilized next year. Guidehouse will be working with the State and Magellan during this year to finalize the Network Adequacy Standards in preparation for evaluating against the new protocol.

Results of SFY 2022 External Quality Review

Guidehouse's SFY 2022 review of Wyoming's CME Program resulted in identification of 9 areas of strength, 10 areas of needed improvement, and 12 recommendations in relation to quality, timeliness, and access to services.

Of the 12 recommendations for WDH and/or Magellan:

- 4 – recommendations have been fully addressed;
- 2 – recommendations have been partially addressed;
- 5 – recommendations have not been addressed; and
- 1 – recommendation was not applicable and WDH will be addressing with the implementation of the new Network Adequacy standards.

Table 3 below provides the distribution of recommendations across EQR protocols, as well as the number of recommendations by status as of SFY 2023 ("Fully Addressed", "Partially Addressed", "Not Addressed", or "Not Applicable"). Please refer to Appendix B for more information regarding details on specific recommendations from the SFY 2022 review period.

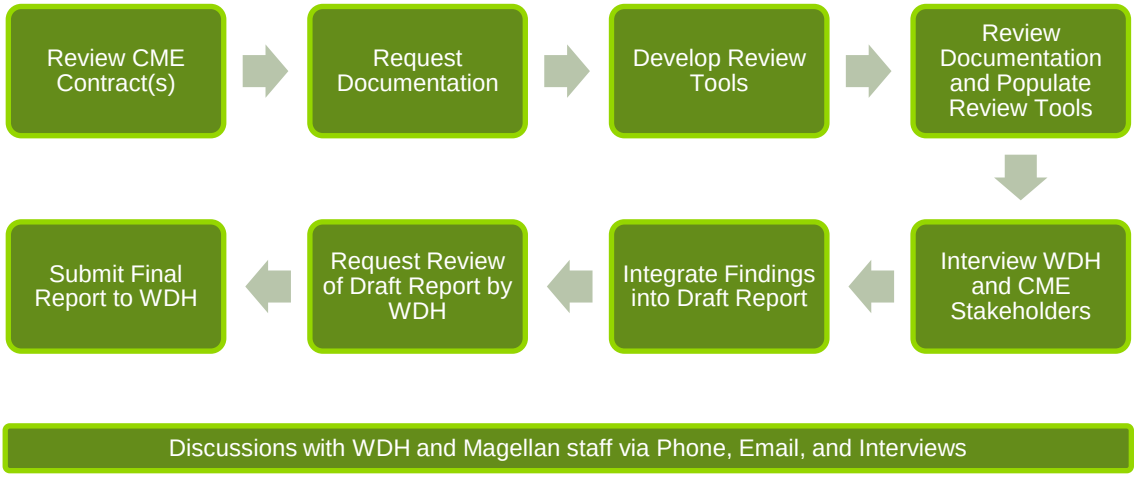
Table 3. Status of SFY 2023 Recommendations

EQR Protocol	SFY 2022 Recommendations for:		Total	Total # of Recommendations, by SFY 2023 Status			
	Magellan	WDH		Fully Addressed	Partially Addressed	Not Addressed	N/A
Protocol 1. Validation of Performance Improvement Projects	3	0	**3**	0	1	2	0
Protocol 2. Validation of Performance Measures	2	1	**3**	2	0	1	0
Protocol 3. Compliance with Medicaid Managed Care Regulations	2	0	**2**	2	0	0	0
Protocol 4. Validation of Network Adequacy	3	0	**3**	0	1	2	0
TOTAL	10	2	**12**	4	2	5	1

Section II. Methodology

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

Figure 2. Key Assessment Steps



Review of Documentation

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

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

After identifying the elements of the SFY 2022 Amendment 1 SOW which operationalized the relevant federal code requirements, Guidehouse requested and reviewed relevant documentation from Magellan and WDH including, but not limited to, the following:

- Magellan corporate policies and procedures (and, where different, Magellan of Wyoming policies and procedures) related to quality, timeliness, and access to service and care
- Member and provider handbooks
- Outreach and marketing templates and materials
- Quarterly reports to WDH (including SFY 2023 Quarters 1 – 4, with the Quarter 4 report also serving as the annual report)
- Geographic information on member residences and provider service areas
- Provider agreements, provider certification requirements, and training requirements
- Wyoming Administrative Rules

- Wyoming Medicaid Managed Care Quality Strategy

Interviews with WDH and Magellan

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

- Weekly telephone meetings between Guidehouse and WDH staff from November 2023 to February 2024
- Virtual interviews and review sessions with Magellan staff on February 12 - 20, 2024
- 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 2023 SOW. Section IV also reviews designated "outcome" measures consistent with EQR Protocol 2.

Section III. Validation of Performance Improvement Projects

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

Per WDH's direction, Guidehouse reviewed the following three PIPs which were active during SFY 2023:

- Improving the Prior Authorization Process PIP ("Prior Authorization Process PIP") that began during SFY 2023 as its baseline year.
- PIP focused on increasing the number of Family Care Coordinators and Respite providers in the Wyoming Care Management Entity network ("Network PIP") that began during SFY 2023 as its baseline year.
- Engagement and Implementation (Provider Scorecard) PIP that began during SFY 2018

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

Methodology

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

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

Appendix C includes the complete EQR worksheets with additional details for each PIP. The worksheets also provide the validation rating assigned by Guidehouse for the overall design, methodology, and impact of each PIP. Validation ratings for SFY 2023 are summarized in Table 4. Possible validation ratings include:

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

Table 4. SFY 2023 PIP Validation Ratings

Performance Improvement Project (PIP)	Intervention	Validation Rating
Prior Authorization Process PIP	Evaluated the impact of educational initiatives for providers related to Plan of Care development and Child and Adolescent Needs and Strengths (CANS) assessments on key CANS score outcomes. Also evaluated the impact of changes in the HFWA Plan of Care review process on successful continuous authorizations.	Low Confidence
Network PIP	Evaluated the impact of targeted recruitment, training, and support initiatives for providers on the number of active Family Care Coordinators and Respite providers in Magellan's HFWA network.	Low Confidence
Engagement and Implementation (Provider Scorecard) PIP	Evaluated the impact of improvement strategies on discharged youth fully engaged in the CME Program and fully implemented within the program.	Moderate Confidence

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

Prior Authorization Process PIP

The Prior Authorization Process PIP tracks HFWA participants' outcomes through the Child and Adolescent Needs and Strengths (CANS) assessment scores over time, linking initial CANS assessments and CANS-driven plans of care to improvement in CANS scores. It aims to evaluate how education on CANS as it relates to care planning and related procedural redesign can improve participant outcomes. It also looks to evaluate the direct impact of altering the HFWA plan of care review process on the frequency of non-authorizations for services. The Plan of Care is a central part of the HFWA program, and providers and participants face significant challenges building data-driven Plans of Care and gaining timely service and Plan of Care. WDH and Magellan prioritized this PIP as an opportunity to standardize the care planning process, mitigate undue non-authorizations, and drive improved participant outcomes through improvement in the Prior Authorization Process.

Table 5 evaluates the Prior Authorization PIP based on criteria specified in CMS protocol.

Table 5. Prior Authorization Process PIP

Evaluation Category	Findings
Topic and PIP Selection	• The Prior Authorization Process PIP was selected by Magellan based on recorded concerns brought forth by participants and their families, provider satisfaction surveys, and program restructuring goals. • The PIP was constructed as an opportunity to improve Plan of Care development, closely aligning it with CANS assessments, and avoid delays in Plan of Care creation and authorization. • The target population is the entire population served by Wyoming's youth behavioral health HFWA program. • The PIP aligns with CMS priority areas such as *Alignment, Outcomes, and Resiliency.*
Aim Statement	• Magellan developed the following aim statements for the PIP: 1) "Will education to the High Fidelity Wraparound providers concerning the utilization of the completed Child and Adolescent Needs and Strength (CANS) assessment when developing Plans of Care with the youth and their family improve the positive change percentage (CANS) score for items in the Child Strengths domain (specifically Resilience) for Wyoming Care Management Entity youth ages 4-20 years old with a Serious Emotional Disturbance (SED) Diagnosis enrolled during Standard Fiscal Year (SFY) 2024 with an approved Plan of Care?" 2) "Will education to the High Fidelity Wraparound providers concerning the utilization of the completed Child and Adolescent Needs and Strength (CANS) assessment when developing Plans of Care with the youth and their family improve the positive change percentage (CANS) score for items in the (CANS) Child Strengths domain (specifically Resourcefulness) for Wyoming Care Management Entity youth ages 4-20 years old with a Serious Emotional Disturbance (SED) Diagnosis enrolled during Standard Fiscal Year (SFY) 2024 with an approved Plan of Care?" 3) "Will the introduction of changes in the High Fidelity Wraparound Plan of Care review process (documents required for the prior authorization at the initial submission versus documents that can be submitted after the authorization and the Prior Authorization feedback form) result in members receiving continuous authorizations for Wyoming Care Management Entity youth (ages 4-20 years old with Serious Emotional Disturbance (SED) Diagnosis) enrolled during Standard Fiscal Year (SFY) 2024?" • The aim statements met all requirements identified by CMS in the PIP Review Worksheet, including requirements for statement specificity, measurability, answerability, conciseness, and time restrictions. • While the aim statements meet the criteria regarding the construction of the siloed aim statements themselves, the content of each does not fully link together the overall goal of the PIP, guiding narrative, and various areas for improvement discussed.
Population	• Magellan lists the population for the Prior Authorization Process PIP as "All WY CME enrolled youth, ages 4-20 with a Serious Emotional Disturbance (SED) diagnosis." • The population description statement met all requirements identified by CMS in the PIP Review Worksheet.
Sampling Method	• The entire eligible population was included in the Prior Authorization Process PIP. • The QIA form clearly identified that sampling was not used for the PIP.

Evaluation Category	Findings
Variables and Performance Measures	• Magellan outlined three (3) performance measures for the baseline data collection period for this PIP: 1) **Numerator:** Number of CANS responses in the Resilience domain scored as a 2 or less in the participant's discharge CANS assessment. **Denominator:** Number of CANS assessments completed. 2) **Numerator:** Number of CANS responses in the Resourcefulness domain scored as a 2 or less in the participant's discharge CANS assessment. **Denominator:** Number of CANS assessments completed. 3) **Numerator:** Number of non-authorizations. **Denominator:** Number of Plans of Care. • Magellan's PIP variables clearly define evaluation periods as quarterly and annually but do not clarify if the data used for the variables will be pulled from standard periodic assessments or limited to only assessments from program discharge. • Magellan specified objective, time-specific continuous variables for the performance measure: ○ **Numerator:** "Number of enrollees contacted in format of youth/caregiver's choice minimum of two times a month" ○ **Denominator:** "Number of WY CME enrollees, aged 4-20 years old, with a full month of enrollment during the measurement period." • Magellan plans to implement CANS assessor trainings and evaluations to standardize assessment approaches and promote inter-rater reliability, but the efforts to do so are not documented in the PIP and inter-rater reliability is otherwise not addressed. • The variables and performance measures do not clearly link to each other and the overall focus of the PIP. During the virtual on-site, Magellan clarified that the PIP is looking to also improve Plan of Care development and evidence-based care planning based on the CANS assessment, expanding the PIPs scope beyond the prior authorization process. • There are also no clinical guidelines or evidence from relevant literature cited that provides empirical or agreed-upon evidence behind improvement in CANS scores and providers' documentation and assessment practices.
Data Collection	• In the Prior Authorization Process PIP form, Magellan stated that data is collected from medical/treatment records (FidelityEHR). • Magellan noted that the data they plan to collect includes member ID, name, gender, date of birth, race, ethnicity, enrollment date, discharge date, length of stay, reason for discharge, survey date prior to enrollment, survey gap prior to enrollment, survey date following enrollment, survey gap following enrollment, all CANS modules, and Aces scores. • Magellan's documentation did not include links between the data being collected and an analysis plan, • Data will be pulled quarterly and annually for evaluation.
Data Analysis	• Magellan was in the baseline data collection period for the Prior Authorization Process PIP (SFY 2023) and did not yet have a detailed analysis plan constructed. • Magellan did not have any analyses completed to share the baseline values of the PIP.

Evaluation Category	Findings
	• Magellan did not include a list of the qualifications required for each role in the PIP's data analysis or an intended staffing plan. • Magellan confirmed during the virtual on-site that they have not yet developed documentation of medical record review processes.

Improvement Strategies	• Magellan conducted a provider survey to identify satisfaction with the prior authorization and care planning processes. The Magellan Prior Authorization Process PIP workgroup then met on several instances to identify the following barriers to meeting Prior Authorization Process goals:
	  ○ Providers may not fully understand documentation needs.
	  ○ Providers may not use CANS results when developing Plans of Care.
	  ○ Providers may feel burdened and do not want documentation requirements.
	  ○ Providers may not clearly understand how to develop Plans of Care using CANS results.
	  ○ Families may lack engagement and commitment to the High-Fidelity Wraparound process.
	  ○ Providers may be reluctant to change.
	  ○ Providers may have varied philosophical approaches to High-Fidelity Wraparound.
	  ○ Providers may be hesitant to bring up sensitive areas with participants and their families.
	• Based on the barriers, the Magellan identified the following interventions aimed at improving provider documentation and Plan of Care development.
	  ○ Developing a prior authorization review form to be completed by reviewers during the Plan of Care review period.
	  ▪ Any items the provider misses will be captured on the form.
	  ▪ The form will be automatically sent to the agency for feedback on incomplete or missing items for a Plan of Care review and returned to the provider.
	  ○ Implementing minimum documentation requirements for providers to receive a full 90-day authorization for service delivery.
	  ▪ Providers will receive a partial authorization if any documentation is missing to ensure no lapse in services to participants.
	  ▪ Providers will be required to correct Plans of Care for missing items within a set time frame.
	  ○ Shaping behaviors of providers to use CANS results when developing Plans of Care.
	  ○ Providing learning opportunities on the use of CANS in care planning.
	  ○ Providing trainings to CANS assessors that include an inter-rater reliability testing.
	  ○ Surveying providers on the state of the prior authorization process in late SFY 2024 for feedback on prior authorization process changes.
	  ○ Soliciting feedback from providers during monthly provider conference calls and the quarterly EQIC meetings.

Evaluation Category	Findings
	○ Rolling out new trainings materials that connect with the CANS Child Strengths domains. ○ Sending reminders to providers on due Plan of Care reviews 30 days prior to their due date. • Magellan identified in the QIA form that they followed IHI's PDSA rapid cycle approach to develop improvement strategies and ensured cultural and linguistic appropriateness within strategies. • Magellan did not cite any evidence-based studies to support their choice of improvement strategies to address identified prior authorization process challenges. • The development process and appropriateness review were conducted by a workgroup of Wyoming CME employees that included the Quality Improvement Director, Account Operations Manager, Clinical Contract Advisor, Trainer, Quality Clinical Reviewer, and Network Manager.
Likelihood of Significant Improvement	• The PIP documentation does not effectively connect the many topics and goals that it contains. While the improvement strategies are meaningful and likely to lead to improved documentation and care planning, the evaluation of the improvement is not closely tied to the narrative aims to effectively demonstrate the intended improvement. As such, the PIP activities are likely to lead to improvements, but the improvements are less likely to be fully targeted to the prior authorization process like the PIP's topic suggests.

Recommendations

Since this was the baseline year for the Prior Authorization Process PIP, Magellan did not have the remeasurement plans and analyses designed and documented. The narrative of the PIP, however, did show some opportunities for Magellan to further align their documentation and plans with guidance provided in CMS EQR Protocols and improve design and implementation of the PIP. These largely focus on clarifying the goals of the PIP, providing more evidence to support the improvement activities, and considering alternative measures for PIP evaluation. The recommendations to improve the Prior Authorization Process PIP include:

- Clarifying the measurable goals of the PIP in the narrative or PIP name to avoid the disconnect between the title of "Improving the Prior Authorization Process" and the focus on improving CANS scores, CANS-based Plans of Care, and Plan of Care documentation.
    - Magellan can consider several methods to develop a more cohesive PIP with logic that follows from the PIP name at the start of the document through the PIP rationale, evidence supporting the PIP design, aim statements, evaluation, and improvement strategies. Examples of improvement methods include:
        - Creating a separate PIP for CANS-driven Plan of Care development that separates the documentation elements focused on improving the prior authorization process from the training and care planning elements that drive improved Plans of Care and direct links to CANS results.
        - Adding content that flows to create a more robust and cohesive narrative linking together CANS assessments, Plan of Care development, Plan of Care documentation, Plan of Care review and the resulting prior authorization with evidence supporting how all pieces inform the aim statements and measures used. In this case, the PIP would also benefit with a name change from

"Improving the Prior Authorization Process" to something broader that encapsulates the many elements addressed in the PIP.

  - Adjusting the aim statements to better reflect the improvement in the administrative processes the PIP targets instead of the downstream clinical outcomes impacted by administrative processes as well as other confounding variables.

- Providing evidence and/or literature to draw clear lines between the PIP narrative, aim statements, and measures.
- Including a discussion of confounding variables that may impact the outcomes measured to demonstrate a sound link between improvement strategies and improved outcomes.
- Outlining and detailing the data analysis process for the PIP.
- Providing clear qualifications required for the data analysis and collection staff working on the PIP.
- Including a discussion of inter- and intra- rater reliability in the assessment of the PIP instead of only as it relates to the CANS assessors and Plans of Care development based on CANS results.

Network PIP

The Network PIP employs recruitment, training, and support initiatives for the HFWA program for stakeholders across Wyoming. It aims to increase the program's volume of enrolled Family Care Coordinators and Respite providers through increased exposure to the program for individuals that may not have been aware of its existence, how to enroll in it, or without the adequate support to feel comfortable delivering the program's services. WDH and Magellan prioritized this PIP as an opportunity to address the network adequacy and provider access challenges present in Wyoming's HFWA program.

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

Table 6. Network PIP Evaluation

Evaluation Category	Findings
Topic and PIP Selection	• A Network Adequacy assessment is required in the 2023 SOW between Magellan and WDH. • The population includes active Family Care Coordinators and Respite providers in the HFWA program network as well as potential HFWA providers delivering services in Wyoming. • The Minimum Contact goals align with CMS Priority Areas such as: *Engage individuals and communities to become partners in their care* and *enable a responsive and resilient health care system to improve quality.*
Aim Statement	• Magellan developed the following aim statements for the PIP: 1) "Will targeted recruitment, training, and support by the CME concerning the HFWA program and provider roles with stakeholders throughout the state of Wyoming increase the number of Family Care Coordinators active in the Network for SFY 2024?" 2) "Will targeted recruitment, training, and support by the CME concerning the HFWA program and provider roles with stakeholders throughout the state of Wyoming increase the number of Respite Providers active in the Network for SFY 2024?"

Evaluation Category	Findings
	• The aim statements did not clearly define specific improvement strategies or key terms such as “targeted recruitment,” “training and support,” and “stakeholders.” • The aim statement met all CMS-identified requirements for measurability, answerability, conciseness, and time restrictions.
Population	• Magellan’s documentation for the Network PIP does not explicitly define the target population, but the narrative describes a PIP targeting providers in the WY HFWA network as well as unenrolled stakeholders throughout the State. • The population description statement met all requirements identified by CMS in the PIP Review Worksheet.
Sampling Method	• The QIA form clearly identified that sampling was not used for the PIP.
Variables and Performance Measures	• Magellan outlined two (2) performance measures to evaluate the success of the PIP: 1) Number of Family Care Coordinators in Network. 2) Number of Respite Providers in Network. • Magellan set goals for each performance measure of: 1) Increasing Family Care Coordinators by two (2) providers each quarter; and 2) Increasing network to eight (8) total respite providers by the end of SFY 2024 • Baseline evaluations were collected from SFY 2023. • SFY 2024 will be the PIP’s first remeasurement period.
Data Collection	• The Network PIP documentation included a description of the data collection procedure used to review the network provider roster, but it did not describe the data sources used for collection beyond the procedure for processing applications for network providers and reviewing the current provider roster. • The PIP noted that data collection cadences as annually, quarterly, and weekly, but did not clarify which data would be collected in each cadence.
Data Analysis	• The Network PIP documentation did not include a description of a data analysis plan. • The PIP included baseline measurements and a brief description of the reanalysis to be conducted at the end of SFY 2023, but the results were not submitted for review and the steps of the analysis plan were not detailed.
Improvement Strategies	• Magellan convened a CME Workgroup to identify strategies for improving the HFWA program’s provider network. Based the Workgroup discussions, Magellan identified the following barriers to meeting network goals: ○ Frontier nature of Wyoming. ○ Limited number of qualified individuals to recruit as providers. ○ Lack of awareness and knowledge of Magellan CME and the HFWA program. ○ Small target population in certain counties. ○ In-person training/live coaching limitations due to geographical challenges. ○ Community awareness of the program. • Based on the barriers, the Workgroup identified and executed on the following interventions to encourage network growth: ○ Gather current prevalence data for Wyoming’s counties.

Evaluation Category	Findings
	○ Review SED report to aid in the determination of youth need throughout the counties of Wyoming. ○ Hold a "Summit" call with current Wyoming providers and stakeholders throughout the state (held in Laramie and Natrona counties). ○ Education and raising awareness of the Wyoming CME throughout the counties of Wyoming. ○ Leverage current provider contacts throughout the state to recruit new providers. ○ Contact pediatricians and doctors' offices, pharmacies, and school districts. ○ Distribute promotional brochures for the HFWA program throughout the State. ○ Publish CME newsletter articles recruiting Respite providers. ○ Include in Family Care Coordinator exit process an exit survey sent to the Program Director of the Family Care Coordinator's affiliate agency. • Intervention 1 (Development of Minimum Contact Report through the EHR for 2021) and Intervention 3 (Provider communications concerning minimum contact expectations) were implemented in 2021. All other interventions were implemented prior to SFY 2021. • Magellan identified on the QIA form that they followed IHI's PDSA rapid cycle approach to develop improvement strategies and ensured cultural and linguistic appropriateness within strategies. The development process and appropriateness review were conducted by a workgroup of Wyoming CME employees that included the General Manager, the Senior Director of Operations, the Director of Program Innovation and Outcomes, the Quality Improvement Director, the HFWA trainer and the Clinical Contract Advisor.
Likelihood of Significant Improvement	• The Network PIP does not include detailed approaches to the strategies driving the PIP. It also does not leverage data to evaluate barriers to care or outcomes that directly measure improvement activities. The PIP provides an outline of how challenges identified will be addressed, but it does not back up specific strategies with best practices, data, and targeted activities to address the identified challenges.

Recommendations

As the Network PIP moves into the conclusion of its first remeasurement year, there are several opportunities for Magellan to further align with guidance provided in CMS EQR Protocols and improve design and implementation of the PIP. Mainly, these improvements center on documentation of PIP rationale, supporting evidence, and measurement techniques. The suggested improvements include:

- Utilize the data currently available to empirically evaluate barriers to care or strategies to improve participant outcomes.
    - The PIP lacks evidence-based research and standard of practice guidelines that would be helpful in establishing appropriate performance improvement strategies.
- Clearly delineate recruitment, education, and support elements of targeted interventions.
- Ensure that data elements collected as outcome measures are directly measuring improvement activities and closely linked to improvement interventions.

- Include the timing of data collection, the frequency of measurements, the means of data collection, and strategies for data analysis in the PIP's data collection methodology documentation with clear descriptions of each process and links to selected interventions.
- Continue collaborating with WDH on PIP development to align the PIP and measured outcomes with State priorities to ensure the long-term success of the program.

Engagement and Implementation PIP

The Engagement and Implementation PIP engages additional youth in the CME Program and promotes full implementation of program benefits. The PIP evaluates the impact of improvement strategies on the share of discharged youth fully engaged in the CME Program (defined as greater than 60 calendar days of service) and fully implemented within the program (defined as greater than 180 calendar days of service). WDH and Magellan prioritized this topic after reviewing numerous SFY 2017 reports, including the Committee Data File, Quarterly Reports, and internal management reports, and identified several opportunities for improvement in areas of face-to-face contacts, Strengths, Needs, and Culture Discovery (SNCD) completion timeliness, Plan of Care (POC) development timeliness, and Child and Adolescent Needs and Strengths (CANS) severity, as well as low rates of full implementation of program benefits for enrolled youth. The Engagement and Implementation PIP held its final evaluation year during SFY 2023.

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

Table 7. Engagement and Implementation PIP Evaluation

Evaluation Category	Findings
Topic and PIP Selection	• The Engagement and Implementation PIP is required in the 2022 Statement of Work between Magellan and WDH. • Engaging family and youth in their care decisions and care planning is critical to successful outcomes. Best practice research shows family and youth are most successful when youth are staying out of a higher level of care. When this happens, the youth are less likely to escalate to the point where they need to go to a crisis center. • According to the QIA form, the strategy was developed to address areas of improvement for providers identified in various reports generated for SFY 2017 including the Committee Data File, Quarterly Reports, and internal management reports. Measures identified for improvement were engagement (>60 calendar days), and implementation (>180 calendar days). Magellan included specific input and feedback from both members and providers in selecting this PIP topic. • The Engagement and Implementation PIP aligns with CMS Aims and Priorities (i.e., *Strengthen Person and Family Engagement as Partners in their Care*, and *Promote Effective Communication and Coordination of Care*).

Aim Statement	• Magellan developed the following aim statements for the PIP:
	  ○ "Does the change in authorization process improve the percent of Wyoming CME youth (aged 4-20 years old who were discharged during the measurement period), and their families reach engagement threshold (>60 calendar days) for SFY 2023?"
	  ○ "Does the change in authorization process improve the percent of Wyoming CME youth (aged 4-20 years old who were discharged during the measurement period), and their families reach implementation threshold (>180 calendar days) for SFY 2023?"
	• The aim statements met all requirements identified by CMS in the PIP Review Worksheet, including requirements for statement specificity, measurability, answerability, conciseness, and time restrictions.

Evaluation Category	Findings
Population	• Magellan lists the population for the Minimum Contacts PIP as "All Wyoming CME youths aged 4-20 years old discharged during the measurement period (SFY 2023)." • The population description statement met all requirements identified by CMS in the PIP Review Worksheet.
Sampling Method	• The entire eligible population was included in the Engagement and Implementation PIP. • The QIA form clearly identified that sampling was not used for this PIP.

Variables and Performance Measures	• Magellan outlined two performance measures for this PIP:
	  ○ **Measure #1:** "Engagement: percent of youth and families not reaching engagement threshold (>60 calendar days)"
	  ○ **Measure #2:** "Implementation: percent of youth and families reaching implementation threshold (>180 calendar days)"
	• Magellan specified objective, time-specific continuous variables for each performance measure in the SFY 2022 QIA form:
	  ○ **Measure #1: *Numerator*:** "Count of youth >60 calendar days of HFWA ("not engaged")." ***Denominator*:** "Count of discharged youth HFWA."
	  ○ **Measure #2: *Numerator:*** "Count of youth >180 calendar days of HFWA ("implemented"). ***Denominator:*** Count of discharged youth HFWA."
	• Magellan noted that both engagement and implementation are key principles of HFWA and need to be met for members to obtain full benefits of the CME Program. In previous EQR years, Guidehouse recommended adding an additional performance measure that evaluates the participants' benefits of care. This performance measure was not included.

Data Collection	• Data was pulled from the Fidelity EHR for SFY 2023. • To collect data for this PIP in SFY 2023, Magellan used a "programmed pull" from all claims / encounter files of all eligible members. Based on discussions with Magellan, Magellan sourced data for this PIP from the Fidelity EHR system for all included discharges during the review period. • The data collection process includes data set reviews by the Director of Quality to determine the accuracy of the data or flag any opportunities for further review. • Data collected for the PIP include member data, enrollment status and discharge data, and Plan of Care data, including provider name. • Data was collected monthly and quarterly for review.

Data Analysis	• Magellan compared data for the performance measures across a baseline period as well as four remeasurement periods:
	  ○ **Measure #1 Engagement:** "Percent of youth and families not reaching engagement threshold (>60 calendar days)"
	  ▪ Baseline (May 2018 – August 2018): 16%
	  ▪ Remeasurement 1 (SFY 2019, July 2018 – June 2019): 16%
	  ▪ Remeasurement 2 (SFY 2020, July 2019 – June 2020): 15%
	  ▪ Remeasurement 3 (SFY 2021, July 2020 – June 2021): 15%
	  ▪ Remeasurement 4 (SFY 2022, July 2021 – June 2022): 13%
	  ▪ Remeasurement 5 (SFY 2023, July 2022 – June 2023): 13%
	  ○ **Measure #2 Implementation:** "Percent of youth and families reaching implementation threshold (>180 calendar days)"

Evaluation Category	Findings
	▪ Baseline (May 2018 – August 2018): 59% ▪ Remeasurement 1 (SFY 2019, July 2018 – June 2019): 62% ▪ Remeasurement 2 (SFY 2020, July 2019 – June 2020): 61% ▪ Remeasurement 3 (SFY 2021, July 2020 – June 2021): 64% ▪ Remeasurement 4 (SFY 2022, July 2021 – June 2022): 70% ▪ Remeasurement 5 (SFY 2023, July 2022 – June 2023): 59% • Magellan tested for statistical significance using Fisher's Exact Test for each measurement period. Out of the two measures, neither result was statistically significant from last year's to this year's performance. • Magellan increased the comparison goal of 10% for measure one (1) to less than 16%, citing the goal change as reflecting initial baseline results. • Magellan increased the comparison goal of 80% for measure two (2) to 70%, citing the goal change as a reflection of the Provider Scorecard baseline goal since the start of the Provider Scorecard Process.
Improvement Strategies	• The CME Workgroup identified barriers to PIP goals as: o Provider awareness of their performance. o Lack of understanding of the importance of engagement and implementation with the youth and their families. o New providers may not be educated on measures and understand the impact of the measures. o Providers may not view feedback in a positive manner. o A few providers can have a negative impact on the overall engagement and implementation process. • PIP performance and potential improvement strategies were identified by a Magellan workgroup on an ongoing basis and documented by fiscal year in the QIA form. Magellan identified the following improvements and strategies for Remeasurement 5 (SFY 2023): o Sharing of quarterly Provider Scorecard. o Discussing performance measures in Monthly Provider Calls. o Sending provider communication emails. o Updating website information. o Conducting RISE trainings concerning requirements and processes of HFWA. o Encouraging engagement through the FEHR since providers can easily access records and the FEHR Plan of Care tracks the participant and family level of engagement. o Prompting Family Care Coordinators to complete radio buttons with the level of family engagement in the FEHR. o Encouraging providers to become familiar with the Provider Dashboard in the FEHR and to complete the dashboard consistently. o Providing feedback to providers on performance based on consistently completed Provider Dashboard. o Providing coaching and training support to providers. • Magellan included a comprehensive table in the QIA form that included all interventions implemented from SFY 2018 to SFY 2023 and the identified barrier that each intervention addressed.

Evaluation Category	Findings
Likelihood of Significant Improvement	• Magellan has not observed sustained improvement with the Engagement and Implementation PIP. Neither engagement nor implementation measures have met the stated target, even after the benchmark was lowered. As stated in past years, the EQRO suggests reviewing the format and design of other PIP documents to improve the documentation of the process and work achieved by Magellan over the past five years of the implementation of this PIP.

Recommendations

The submitted PIP documentation was consistent with federal requirements, but the PIP continues to fail to reach its goals despite lowering the goal measures and the program being administered since SFY 2017. As in previous years, Magellan has opportunities for performance improvement including:

- Consider incorporating feedback from previous review years.
- Add a discussion on the evidence supporting the implementation of the PIP and data validation.
- Evaluate the benefits of the PIP to program participants.
- Provide targeted progress or expected performance to aim statements and the justification for the targets.
- Document in detail how EHR data is validated for performance measures.
- Document a thorough discussion of data validation practices that ensure accuracy or completeness of submitted documentation.
- Provide language addressing comparability and internal/external validity concerns with the analyses conducted.
- Add validity checks of the analysis in PIP documentation.
- Discuss why measurement goals were lowered and the justification for changes to the goal, in detail.

Areas of Strength and Needed Improvement

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

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

The QIA forms provided for the SFY 2023 EQR continued to include clearly labeled items and sections, comprehensive data tables, and identification of the IHI's PDSA process used to develop performance improvement project development. The strengths in documentation exhibited during the SFY 2022 EQR continues to be seen in the SFY 2023 EQR.

Strength: Magellan's team demonstrates commendable institutional knowledge and a strong desire to improve services and general welfare for the population the Wyoming HFWA program serves.

Magellan's CME Workgroup has amassed considerable expertise in the state of services and health in Wyoming as well as the functional barriers and successful techniques to improving care services in the State. The Workgroup's institutional knowledge continues to provide meaningful insights for the continued development and improvement of the HFWA program and evolving goals. The close attention the Workgroup provides for the program also allows for a hands-on approach to program improvement that considers the nuances and idiosyncrasies of the population served and the State agency overseeing the program.

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

As recommended in the previous year's review, Magellan maintains a detailed written data analysis plan as described in the submitted QIA forms but lacks a standardized validation plan. Documentation notes

that validation does occur through initial staff reviews for reasonableness and random spot checks against case notes to determine validity. While these steps are commendable, a standardized validation process should be developed and documented to ensure continuity of data processing.

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

Needed Improvement: Magellan's PIPs do not contain sufficient evidence-based research to support their claims and targeted interventions.

While documented effectively and according to federal standards, none of the PIPs executed by Magellan during the SFY 2023 period contain clinical documentation, proof of best practices, or evidence-based research to support PIP elements or narratives. The PIP documentation relies heavily on commendable institutional knowledge but lack a scientific foundation for improvement efforts.

> ***Recommendation for Magellan:*** Provide additional research and best practice documentation to support PIP elements and conclusions that are woven into the PIP narrative and description.
>
> All Magellan's PIPs would benefit from a stronger foundation in clinical and public health evidence established as best practice. Current documentation and improvement strategies are explained as though they hinge on internal discussions. Supporting these strategies with national evidence and industry-supported approaches would greatly strengthen PIP narratives and interventions.

Needed Improvement: Despite previous PIPs showing limited sustained improvement, current PIPs do not appear to evaluate improvement activities from the previous year.

Evaluations of the PIPs' effectiveness does not fully build in alterations to improvement strategies based on what has been found to work or not work in previous years of the PIPs. These evaluations would provide opportunities to pivot interventions when needed, if a strategy is found to be ineffective. Current practices do not appear to have such an approach formulaically built in.

> ***Recommendation for Magellan:*** Incorporate consistent evaluation of PIP impacts and create pre-determined checkpoints to consider if improvement strategies would best be amended.
>
> As the HFWA program evolves, the PIPs pushing it forward should evolve along with it. While previous PIPs have been shown to struggle when providing sustained improvement, the PIPs were not structured to encourage intervention evaluation and adjustment throughout the life of the PIP. Each year, Magellan would benefit from creating set evaluations with well described measures that highlight opportunities for adjustment and improvement of developed PIPs.

Needed Improvement: Performance measures used to evaluate the PIPs' impacts do not clearly align with PIP narratives and, sometimes, with each other.

The performance measures used in the Network and Prior Authorization Process PIPs do not provide strong goals or values to directly evaluate the impact of the improvement strategies developed and, in the case of the Prior Authorization Process PIP, the overarching PIP goal.

- In the Network PIP, the various elements included in the intervention strategies do not directly align with any performance measures. For example, a statewide SED report to evaluate need in particular areas is a powerful tool in setting network goals, but the success and documentation of these goals is not best evaluated by performance measures that simply look at the general number of providers in the program.

- In the Prior Authorization Process PIP, the initial goal of the program is to reduce non-authorizations and gaps in care. The narrative, however, delves into effective Plan of Care development and linking those Plans of Care with CANS results. The aim statements look at direct CANS score improvement at discharge before non-authorizations are evaluated. The PIP looks to address several topics at once while providing an unclear framing that, at first glance, looks like it would focus on a smooth prior authorization process instead of addressing challenges in that process, provider documentation practices, evidence-based care planning, CANS assessment reliability, and CANS outcome improvement.

  Recommendation for Magellan: Clarify how performance measures align with the goals of the PIP and adjust PIP framing to fully encapsulate and provide sufficient attention to the scope of the PIP.

  The Network PIP and Prior Authorization Process PIP would both benefit from closer connected narrative framing, goals, and performance evaluation. Magellan has several avenues to address these concerns such as:

  - Cross-walking interventions and performance measures.
  - Tailoring the narrative and/or PIP titles to the full aims of the PIP.
  - Fine tuning specific measurements to empirically assess PIP impact.
  - Grounding quantitative performance goals in evidence-based determinations and actualizable outcomes.
  - Addressing potential confounding in the relationship between performance measures and improvement strategies.

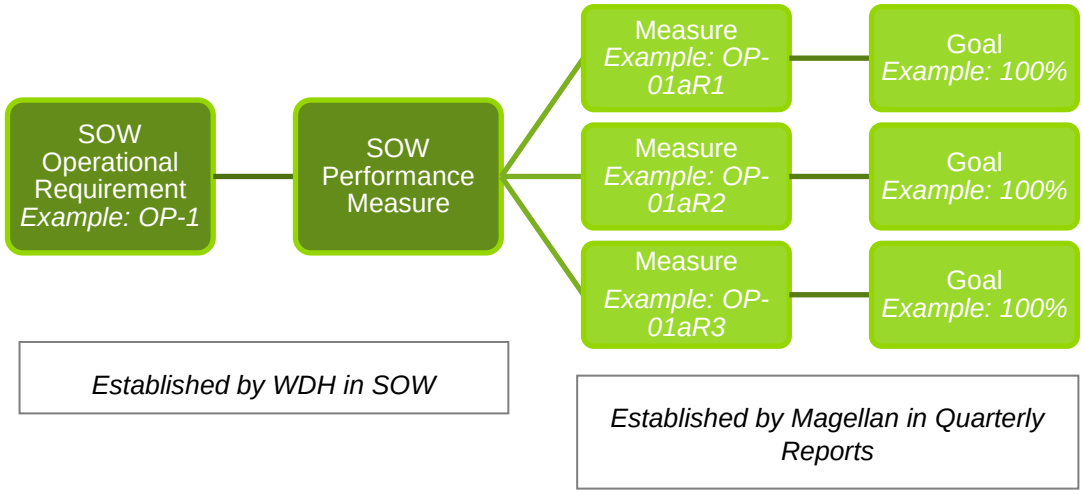
Section IV. Validation of Performance Measures

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

Methodology

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

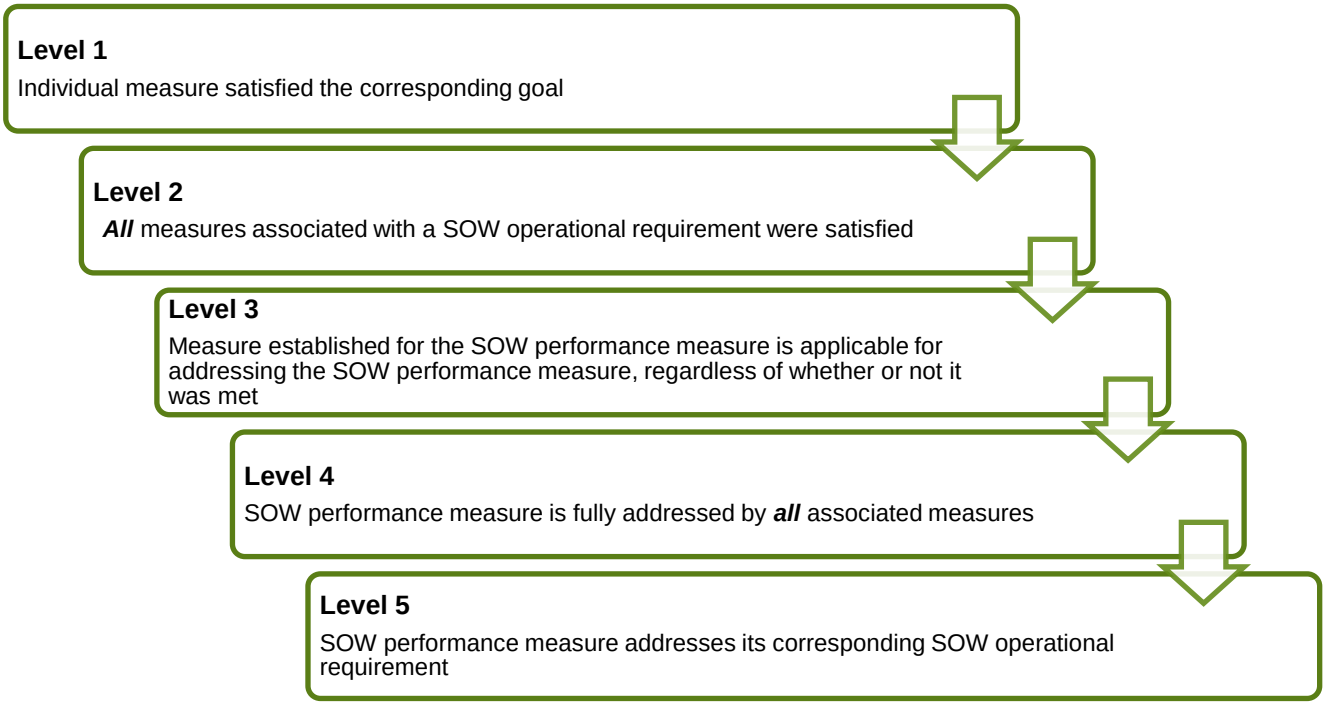
Figure 3. SOW Requirements, Performance Measures and Goals



Levels of Analysis

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

Figure 4. Levels of Analysis



Overview of Reporting Requirements

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

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

   For SFY 2023, review and validation of reported data included 26 unique measures (goals) established by Magellan for 23 SOW operational requirements.

Table 8. Operational Requirements and Associated Measures

Operational Requirement	Performance Measure Description	Measure / Goal
OPS 8-17	Authorization decisions within additional timeframe (Standard)	OPS 8-17A
	Authorization decisions within additional timeframe (Extended Standard)	OPS 8-17B
	Authorization decisions within additional timeframe (Expedited)	OPS 8-17C
	Authorization decisions within additional timeframe (Extended Expedited)	OPS 8-17D
OPS 8-19	Notify the Agency within two (2) business days of any critical incident event	OPS 8-19
OPS 8-25	Resolve enrollee grievances and provide notice according to the enrollee's health condition, no more than ninety (90) calendar days from grievance receipt	OPS 8-25
OPS 8-28	Make a decision and send written notification to the requestor of the appeal review (an enrollee of their authorized representative such as the ordering and/or rendering provider) within seventy-two (72) hours of receipt of the initial verbal or written request for appeal review	OPS 8-28
OPS 8-29	Handling expedited resolution of appeals	OPS 8-29
OPS 8-30	If services were not furnished during the appeal, the Contractor must authorize or provide the services as expeditiously as the enrollee's health condition requires, but no later than seventy-two hours from the date that the State fair hearing officer reverses a decision to deny, limit or delay services	OPS 8-30
OPS 8-31	Send enrollee grievances, received about the Contractor, to the Agency. Data showing compliance with this requirement shall be included in the Quarterly Report	OPS 8-31
EM 9-3	Process all referrals received by the Contractor	EM 9-3
EM 9-4	Assist families with the application or admission process for children and youth	EM 9-4
EM 9-5	Process all applications	EM 9-5
EM 9-6	Completed applications for the Children's Mental Health Waiver (CMHW)	EM 9-6
EM 9-7	Youth and/or the families of admission to the CME	EM 9-7
EM 9-9	Client disenrollment if the enrollee meets criteria	EM 9-9
EM 9-12	Review all evaluations, including the CASII and ECSII, for completeness	EM 9-12
EM 9-15	Member Handbook to all new enrollees and their guardians	EM 9-15
EM 9-16	FCC & Plan of Care (POC) Measure is on a Quarter Lag for data purposes	EM 9-16
EM 9-17	Authorize POCs	EM 9-17
EM 9-20	FCC & Contact with Parent and Youth twice a month in a quarter	EM 9-20
EM 9-22	Routine readiness assessments based on the pre-approved Transition Readiness Scale	EM 9-22
EM 9-23	FCC holds regularly scheduled CFTs and updates to the POC	EM 9-23
EM 9-24	Respite shall only be authorized for one enrollee per respite provider per instance at a time unless the CME reviews and approves additional youth. Exception may be made for sibling groups	EM 9-24
EM 9-29	Prompt and oversee that families complete the Agency's WFI-EZ and prepare families to submit six months after enrollment	EM 9-29
PM 10-4	Conduct initial provider training and certification as an FCC, FSP, YSP, or respite provider prior to being activated to provide CME service	PM 10-4

Performance on Operational Requirements

Magellan's Performance on Measures

Guidehouse assessed data from Magellan's quarterly reports to evaluate Magellan's performance on 35 measures for 10 operational (OPS) requirements, as stipulated in the SOW active during the review period. Table 9 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.[1, 2]

Table 9. Level 1 – Assess whether Magellan satisfied individual goals as set in the annual report.

Level 1 Evaluation	Percent of Goals *(n=26)*
Goal Met	46.2%
Goal Not Met	23.1%
Not Applicable	30.8%
Insufficient Data	0.0%
Total	**100.0%**

Table 10 below provides findings from Guidehouse's Level 2 analysis described previously, which assesses Magellan's performance satisfying *all measures associated with a SOW performance measure* (i.e., Magellan's performance meeting the SOW performance measures themselves).

Table 10. Level 2 – Assess whether Magellan fully met all measures associated with a performance measure.

Level 2 Evaluation	Percent of PMs *(n=23)*
Yes	52.2%
No	26.1%
Not Applicable	21.7%
Insufficient Data	0.0%
Total	**100.0%**

[1] Throughout this section "Not Applicable" indicates there was no applicable data in SFY 2023 for this measure.

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

Relationship Between Goals and Performance Measures

Table 11 provides findings from Guidehouse's Level 3 analysis described previously, which assesses whether a particular measure is applicable for addressing the associated SOW performance measure.

Table 11. Level 3 – Assess whether a particular measure addresses its SOW performance measure, regardless of whether or not it was met.

Level 3 Evaluation	Percent of Measures *(n=26)*
Yes	100.0%
Partially[3]	0.0%
No	0.0%
Total	**100.0%**

Table 12 provides findings from Guidehouse's Level 4 analysis described previously, which assesses whether the listed measures fully address their associated SOW performance measure.

Table 12. Level 4 – Assess whether the SOW performance measure is fully addressed by all associated measures.

Level 4 Evaluation	Percent of PMs *(n=23)*
Yes	100.0%
No	0.0%
Total	**100.0%**

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

Relationship Between SOW Performance Measures and SOW Operational Requirements

Guidehouse assessed the appropriateness of the SOW performance measures in relation to the SOW operational requirements. WDH developed both the SOW operational requirements and the associated SOW performance measures. Table 13 provides findings from Guidehouse's Level 5 analysis, which assesses the adequacy of SOW performance measures in addressing and operationalizing the intention of the SOW operational requirement.

Table 13. Level 5 – Assess whether a particular SOW performance measure addresses its SOW operational requirement.

Level 5 Evaluation	Percent of PMs *(n=23)*
Yes	95.7%
Partially[4]	0.0%
No	4.3%
Total	**100.0%**

Validation of Selected Measures

Guidehouse conducted a detailed review of the data analysis and collection methods for three SOW operational requirements and their associated measures, as selected by WDH for validation. One of the three SOW operational requirements was divided into multiple sub-parts for further validation. Selected SOW operational requirements include the following:

- **OUT 13-5**: Primary Care Practitioner Access (EPSDT)
    - OPS 8-36S: Primary Care Practitioner Access (EPSDT) by First Plan of Care (POC) Authorization
- **OUT 13-7:** Fidelity to the high-fidelity wraparound (HFWA) Model (Score)
- **OUT 13-8**: Fidelity to the high-fidelity wraparound (HFWA) Model (Receipts)

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

Table 14. Validation of Protocol 2 Selected Performance Measures

Selected Performance Measure	Measure Steward	Data Collection Method	Findings				Confidence Rating
			N	D	S	Total	
OUT 13-5: Primary Care Practitioner Access (EPSDT)	WY Custom	EHR	5	5	5	15	High
OPS 8-36S: Primary Care Practitioner Access (EPSDT) by First Plan of Care (POC) Authorization	WY Custom	EHR	3	5	5	13	Moderate
OUT 13-7: Fidelity to the high-fidelity wraparound (HFWA) Model (Score)	WY Custom	EHR	4	N/A	5	9	High*
OUT 13-8: Fidelity to the high-fidelity wraparound (HFWA) Model (Receipts)	WY Custom	EHR	5	4	5	14	High

**OUT 13-7 rated as "High" as N and S scored 9 out of 10, since there was no Denominator for review.*

Guidehouse evaluated the information provided throughout the review, including virtual interviews in which both the technical and clinical measure creation experts responded to questions and provided reviews of logic and documentation required for measure creation. For each measure, Guidehouse provided a score for each of three elements: Numerator (N), Denominator (D), and Source (S) Data as described in Table 15 below.

Table 15. Scoring Scheme for Protocol 2 Performance Measures

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

Table 16 describes results of the measure validation and indicates that Magellan:

- Fully met two of the four SOW operational requirements (OUT 13-7 and OUT 13-8).

A SOW operational requirement's measure was considered "fully met" if Magellan was able to demonstrate valid creation methods and accurate source data, according to the following three areas:

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

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

- Inconsistencies in definition and/or calculation of the value "number of youth enrolled in network" between the SOW, which indicates *newly* enrolled youth, and measure creation documentation and logic, which indicate *all* enrolled youth.

Table 16. Protocol 2 Measures and Findings

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
OUT 13-5: Primary Care Practitioner Access (EPSDT) • **Numerator**: Number of participants who have identified a Primary Care Provider • **Denominator**: Number of youth enrolled in CME Program			
The measure owner has backup staff trained to use the available documentation to import data, execute the SQL code, and complete calculation(s) reported in the Committee Data File (CDF). **Numerator**: • To reduce potential errors with PCP matching, we recommend using a TRIM () function to eliminate spaces on the PCP name searches. **Denominator**: • The denominator is described in the CDF as "Number of youth enrolled in CME program", but the query counts Number of youth *newly* enrolled during the measured quarter. EQR participants agreed the source code is an accurate representation of the measure intent and the description shall be clarified. • The measure documentation for OUT 13-5 describes the denominator as "# of CME enrolled youth for the Fiscal Quarter (youth with referral and a crisis plan)". If this is the intent of the measure, we recommend including this along with the addition of "newly" as noted above. **Overall Findings**: • While the quarterly averages appear to be accurate, the annual average reported in the CDF is likely understated. The current CDF method of using an Excel formula to calculate an annual average as an average of the four quarterly averages does not account for the weight of each numerator and denominator over the course of the year. If the team re-runs the measure for the full year at year-end, any PCPs identified after the enrollee's first quarter will be counted. This will be especially helpful for those cases where youth join the program near the end of the quarter as they would be counted in the denominator, but a PCP assignment in the next quarter would never be counted unless the team re-runs the measure at year end. Additionally, an annual calculation will not assign equal weighting to a quarter with a lower average and a quarter with a higher average thereby giving a true average for the year. The measure creator demonstrated the data extraction and measure calculation processes in SQLServer. Each person on the technical team can perform the steps and has written documentation on the process.	Yes	Yes	Yes

Table 16. Protocol 2 Measures and Findings

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
OPS 8-36S: Primary Care Practitioner Access (EPSDT) by First Plan of Care Authorization • **Numerator**: Number of participants who have identified a PCP by first Plan of Care Authorization • **Denominator**: Number of youth enrolled in CME Program			
The measure owner has backup staff trained to use the available documentation to import data, execute the SQL code, and complete calculation(s) reported in the CDF. Measure is similar to 13-5 above, but specifically defines the PCP assignment by the time of the first POC authorization. **Numerator**: • The numerator is likely overstated as the description states 'number of participants who have identified a PCP at the first Plan of Care authorization', but the measure logic appears to be checking for both a PCP assignment and POC authorization at the time of the measure run. This could mean a PCP is identified well after the first POC authorization (first 46 days). • Update measure logic to count only newly enrolled youth *whose PCP identification date <= their first POC authorization* (and POC authorization date is not null); otherwise, we could count a youth in the program for just two days who does not have a PCP yet; this will also prevent a different response for re-runs where the PCP was not present at the time of the POC authorization (where the PCP is identified by the measure run date). • To reduce potential errors with PCP criteria, we recommend using a TRIM() function to eliminate spaces on the PCP name searches. **Denominator**: • The denominator is described in the CDF as "Number of youth enrolled in CME program", but the query counts number of youth *newly* enrolled *during the measured quarter*. EQR participants agreed the source code is an accurate representation of the measure intent. • Consider updating denominator description to count only youth newly enrolled in the CME program during the quarter and who have had their first POC authorization. This will reduce the denominator but allow the overall rate to include only those who are eligible for consideration in the measure which counts an event required to occur at a 46-day mark. This would prevent counting a youth who joins the program at the very end of a quarter and for whom the first POC has not occurred. This will also prevent a different response for re-runs. • Consider adding start date to the join where team retrieves Crisis Plan data based on Youth ID.	No	Yes	Yes

Table 16. Protocol 2 Measures and Findings

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
OPS 8-36S: Primary Care Practitioner Access (EPSDT) by First Plan of Care Authorization • **Numerator**: Number of participants who have identified a PCP by first Plan of Care Authorization • **Denominator**: Number of youth enrolled in CME Program			
Overall Findings: • While the quarterly averages appear to be accurate, the annual average reported in the CDF is likely understated. The current CDF method of using an Excel formula to calculate an annual average as an average of the four quarterly averages does not account for the weight of each numerator and denominator over the course of the year. If the team re-runs the measure for the full year at year-end, any PCPs identified by the first POC authorization, but after the enrollee's first quarter, will be counted. This will be especially helpful for those cases where youth join the program near the end of the quarter as they would be counted in the denominator, but a PCP assignment in the next quarter would never be counted unless the team re-runs the measure at year end. Additionally, an annual calculation will not assign equal weighting to a quarter with a lower average and a quarter with a higher average thereby giving a true average for the year. • The measure creator demonstrated the data extraction and measure calculation processes in SQLServer. Each person on the technical team can perform the steps following written documentation.			

Table 16. Protocol 2 Measures and Findings

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
OUT 13-7 Fidelity to the high-fidelity wraparound (HFWA) Model (Score) • **Numerator**: The contractor shall report fidelity to the HFWA model as measured by the Wraparound Fidelity Index (WFI-EZ)			
The measure owner has backup staff trained to use the WFI-EZ portal to create the survey average and to update the CDF. **Numerator:** The numerator is calculated inside the WFI-EZ portal, but it can be mis-reported if the requestor makes an error with either the report request, such as selecting the wrong date span or choosing more than 'Caregiver', or if the requestor mistakenly enters the wrong value in the CDF. **Overall Findings:** • While the quarterly averages appear to be accurate based upon the surveys available to the query, the annual average reported in the CDF is likely understated. The current CDF method of using an Excel formula to calculate an annual average as an average of the four quarterly averages does not account for the weight of each individual survey over the course of the year. If the team re-runs the measure for the full year at year-end, any caregiver scores should be equally weighted. This will be especially helpful for those cases where a single caregiver provided various scores for multiple youth. Additionally, an annual calculation will not assign equal weighting to a quarter with a lower average and a quarter with a higher average thereby giving a true average for the year. • While not a reflection on Magellan and understandable in terms of data and security, the WFI-EZ software's removal of Disabled Provider accounts results in the measure creator's inability to accurately calculate the current quarter scores, recreate prior quarter measure results, or rely upon the year-end average including the same providers/surveys previously measured. Consider a method of using scores for disabled providers in the measure creation while making these providers otherwise unavailable for youth interaction, billing, etc. • The measure creator demonstrated the measure generation processes in the WFI-EZ portal. Each person on the quality team can perform the steps and has written documentation on the manual portion of the process. **Magellan has already opened a ticket with the WFI-EZ developer to discuss removal of the disabled provider accounts.*	Yes	N/A	Yes*

Table 16. Protocol 2 Measures and Findings

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
OUT 13-8 Fidelity to the high-fidelity wraparound (HFWA) Model (Score) **Numerator**: Number of WFI-EZ surveys received during this quarter **Denominator**: Number of WFI-EZ surveys received during the same quarter in the previous year			
The measure owner has backup staff trained to use the WFI-EZ portal to create the survey average and to update the CDF. **Numerator:** The numerator is calculated inside the WFI-EZ portal, but it can be mis-reported if the requestor makes an error with either the report request, such as selecting the wrong date span or choosing 'Care Coordinator' rather than 'Caregiver', accidentally excluding 'Youth', or if the requestor mistakenly enters the wrong value in the CDF. The team verified the measure creation document accurately describes the process. **Denominator:** The denominator is copied from the previous year's CDF per the instructions in the measure documentation. If the measure owner fails to copy or mistakenly the wrong value, this could result in errors. **Overall Findings:** • While not a reflection of Magellan performance, as currently documented, Measure 13-8 compares the number of surveys received this quarter/year compared to the same quarter in the prior year. It seems the more useful measure would be the percentage of surveys returned as a subset of those requested. A year having fewer CME youth may result in fewer survey submissions, but this could actually be a higher percentage of the total requested. • While not a reflection on Magellan and understandable in terms of data and security, **the removal of Disabled Provider accounts results in the measure creator's inability to accurately calculate the current quarter survey receipts, recreate prior quarter measure results, or rely upon the year-end average**. Consider a method of counting surveys for disabled providers in the measure creation while making these providers otherwise unavailable for youth interaction, billing, etc. • The measure creator demonstrated the measure generation processes in the WFI-EZ portal. Each person on the quality team can perform the steps and has written documentation on the manual portion of the process. **Magellan has already opened a ticket with the WFI-EZ developer to discuss removal of the disabled provider accounts.*	Yes	Yes	Yes*

Performance on Outcome Measures

Guidehouse assessed data provided by Magellan to evaluate compliance with 10 outcome measures. Table 17 provides a summary of the outcome measure results based on performance throughout SFY 2023. 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 17. Status of Outcome Measures

Outcome Measure	Guidehouse Determination
OUT 13-1: Out-of-Home (OOH) Placements The Contractor shall report the number of OOH placements of Contractor youth. OOH = Out-of-Home (anything other than a family or adoptive placement)	Meets Requirements
OUT 13-2: Decreased Length of Stay (LOS) for Inpatient and Residential Treatment admissions The Contractor shall report the overall LOS for inpatient and residential treatment for youth enrolled in the CME.	Meets Requirements
OUT 13-3: Recidivism The Contractor shall decrease the recidivism of youth served by the Contractor moving from a lower level of care to a higher level of care.	Meets Requirements
OUT 13-4: Recidivism Level of Care (LOC) at six (6) months post CME graduation The Contractor shall report recidivism of youth served by the Contractor and who graduated from the CME Program who are moving from a lower LOC to a higher LOC within six (6) months of graduation from the CME.	Meets Requirement
OUT 13-5: Primary Care Practitioner Access (EPSDT) The Contractor must report the number of CME enrolled youth who have an identified Primary Care Practitioner.	Meets Requirement
OUT 13-6: Cost Savings (Healthcare Costs) The Contractor shall report healthcare costs to Medicaid for the CME enrolled youth.	Meets Requirement
OUT 13-7, 13-8: Fidelity to the high-fidelity wraparound (HFWA) Model • The Contractor shall report fidelity to the HFWA model as measured by the Wraparound Fidelity Index (WFI-EZ) • The Contractor shall report the number of WFI-EZ surveys administered to capture a valid and representative sample of the experiences of members served.	Meets Requirement
OUT 13-9: Family and Youth Participation at State-level Steering Committees The Contractor shall report family and youth participation on State-level Steering Committees.	Meet Requirements
OUT 13-10: Family and Youth Participation in Communities The Contractor shall report family and youth participation on the CME's community advisory boards, support groups and other stakeholder meetings facilitated by the Contractor.	Meet Requirements

Areas of Strength and Needed Improvement

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

Strength: Clinical and technical teams are knowledgeable, engaged, and invested.

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

(This is a strength continued from SFY 2021 and 2022).

Strength: Documentation describing measure result creation.

Magellan provided detailed measure creation documentation for each measure performance review. The documentation includes specific references to both internal and external file names as well as the SQL source code, criteria selection, and screenshots where appropriate. Additionally, the documentation describes detailed references to input files and each manual calculation required to determine numerators and denominators.

Strength: Documentation describing measure run logs.

Magellan provided a review of the run logs detailing the date timestamp and values originally recorded for each SQL-related Measure. WFI-EZ staff also provided a review of shared drive storage for their survey-related Measures. Since it is impossible to run a Measure "as of" a particular date, these run logs are critical to the EQR process.

Strength: Measure creation staff are cross-trained.

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

(This is a continued strength from SFY 2021 and 2022).

Strength: WFI-EZ measure owners are familiar with system.

With the concerns over disabled provider removal, Magellan has already opened a ticket and is actively engaged with the portal designers to better understand how this impacts the values throughout the year.

Needed Improvement: Contract and business requirement documents (BRD) require more clarity to adequately inform calculations.

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

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

Consider updating the criteria for Measure OUT 13-8 to track the number of surveys returned this timeframe over the number of possible surveys (youth in program at least 6 months) also in this timeframe. The current measure of receipts this timeframe over the receipts in the same timeframe of the previous year provides no indication of improvement.

Recommendation for Magellan: Clarify with the clinical the intent of each measure and ensure logic/process is accurate.

For Measure OUT 13-5, for example, the CDF states the denominator is "Number of youth enrolled in the waiver program', but measure logic is coded to count *newly* enrolled youth to waiver program at some point in the quarter. All agree that this is the intent, but this is not reflected in the value descriptions.

For Measure OP 8-36S, for example, the CDF states the numerator is "number of participants who have identified a Primary Care Provider at the first Plan of Care authorization", but the coding logic appears to be counting "number of participants who have identified a Primary Care Provider as of the query run date". Consider moving the process documentation comment on the referral and crisis plan up to describe the numerator, not the denominator.

(This is a continued recommendation from SFY 2021 and 2022).

Needed Improvement: Annual measure calculations may require final calculation rather than sum, or average, of prior quarters.

For measures where the annual value is an average, and currently calculated as either the sum of the four quarters or in some cases the average of the prior four quarter averages, consider re-calculating following the close of the fourth quarter. Note that running an annual calculation would not reduce for any values manually removed by clinical quality staff throughout the month/quarterly runs.

Recommendation for WDH: Review each measure where the final annual amount is simply a sum of the four quarters, or in some cases an average of the four quarters and consider calculating a final annual amount.

WDH clinical experts and measure authors should review each measure and determine if the annual report value displayed in the CDF should be the result of a simple total or average of the four quarters or if the measure should be run for the full fiscal year. Re-running the measure would result in the true total or true weighted average, but recipients of the CDF would have to understand that the annual value may not appear as a perfect sum or average of the monthly or quarterly values. Occurrences such as disabled providers, retroactive enrollment, or other factors may result in an annual value being higher or lower than the values calculated on the inclusive months or quarters. WDH should have clear documentation regarding the decision for each Measure.

Recommendation for Magellan: Discuss with WDH any measure(s) where the year-end value displayed in the Committee Data File requires a separate annual calculation encompassing all dates within the SFY.

Magellan staff are currently responsible for monthly/quarterly measure calculations, and in most cases, it appears the team uses Excel formulas to sum or average the months or quarters in the fiscal year yielding the annual value displayed in the CDF. In many cases, this annual calculation is an understated or overstated value. For some measures, such as OUT 13-5, OPS 8-36S, and OUT 13-7, WDH is currently calculating the annual value as the average of the quarterly averages, and this does not allow for proper weighting.

Section V. Compliance with Medicaid Managed Care Regulations

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

Guidehouse followed CMS' *EQR Protocol 3 Compliance Review Worksheet* to collect information from WDH, establish compliance thresholds, and perform review of Magellan's compliance across 85 elements applicable to the CME Program.[5] The compliance review encompassed the standards listed in Table 18.

Table 18. Compliance Standards Reviewed by the EQRO

Standard Reviewed by the EQRO	Subpart D and QAPI Standard	Last Reviewed
MCP Standards, including Enrollee Rights and Protections: Includes standards for content and distribution of member materials and State laws on member rights.	**42 CFR § 438.56.** Disenrollment: Requirements and limitations	SFY 2021
	42 CFR § 438.100. General compliance, including enrollee rights and protections; information requirements for all enrollees	SFY 2021
	42 CFR § 438.102. Provider-enrollee communications	SFY 2021
	42 CFR § 438.114. Emergency and post-stabilization services	SFY 2021
	42 CFR § 438.206. Availability of services; Access and cultural considerations; Furnishing of services and timely access	SFY 2022
	42 CFR § 438.207. Assurances of adequate capacity and services	SFY 2022
	42 CFR § 438.208. Coordination and continuity of care	SFY 2022
	42 CFR § 438.210. Coverage and authorization of services	SFY 2022
	42 CFR § 438.214. Provider selection	SFY 2021
	42 CFR § 438.230. Subcontractual relationships and delegation	SFY 2021
	42 CFR § 438.236. Practice guidelines	SFY 2021

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

Standard Reviewed by the EQRO	Subpart D and QAPI Standard	Last Reviewed
	42 CFR § 438.242. Health information systems	SFY 2022
	42 CFR § 440.230. Sufficiency of amount, duration, and scope	SFY 2021
Quality Assessment and Performance Improvement: Includes standards for network adequacy, timely access to services, delivery of services in a culturally competent manner, coordination and continuity of care, service authorization, provider selection, enrollment and disenrollment, performance measurement and improvement, and health information systems.	**42 CFR § 438.330**. Quality Assessment and Performance Improvement; Performance improvement projects	SFY 2021
Grievance and Appeals System: Includes standards for resolution and notification of grievances and appeals and communication to providers and members regarding the grievance system.	**42 CFR § 438.228.** Grievance and appeal systems	SFY 2021
	42 CFR § 438.402. General requirements	SFY 2021
	42 CFR § 438.404. Timely and adequate notice of adverse benefit determination	SFY 2022
	42 CFR § 438.406. Handling of grievances and appeals	SFY 2021
	42 C.F.R. §438.408. Resolution and notification, Grievances and appeals	SFY 2021
	42 CFR § 438.410. Expedited resolution of appeals	SFY 2021
	42 CFR § 438.414. Information about the grievance and appeal system to providers and subcontractors	SFY 2021
	42 CFR § 438.416. Recordkeeping requirements	SFY 2021
	42 CFR § 438.420. Continuation of benefits while the MCO, PIHP, or PAHP appeal and the state fair hearing are pending	SFY 2021
	42 CFR § 438.424. Effectuation of reversed appeal resolutions	SFY 2021

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

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

Table 19 provides an overview of Magellan's compliance by topic. Magellan fully met 87 percent of applicable elements and partially met 12 percent in SFY 2023. One percent of applicable elements were considered "not met" in SFY 2023.

Full compliance reviews are only required once every three years. Guidehouse conducted a full review in 2019, and a follow-up review to accommodate updated CMS EQR Protocols in SFY 2020. Due to the updated SOW between Magellan and WDH, Guidehouse reviewed all compliance elements in SFY 2021. In SFY 2022, Guidehouse only reviewed compliance element "Partially Met" or "Not Met" in SFY 2021. Due to program needs and evolving CMS standards, Guidehouse conducted a full review in SFY 2023. The results of that review are detailed below:

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

Table 19. Extent of Compliance with EQR Protocol 3 Elements, by MCP Requirement Section

Compliance Level	Enrollee Rights and Protections *(438.56 – 438.230)*		Quality Assessment and Performance Improvement *(438.330)*		Grievance and Appeals System *(438.402 – 438.420)*		TOTAL	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Fully Met	48	91%	7	54%	17	100%	**72**	**87%**
Partially Met	5	9%	5	38%	0	0%	**10**	**12%**
Not Met	0	0%	1	8%	0	0%	**1**	**1%**
Not Reviewed in SFY 2023	0	0%	0	0%	0	0%	0	0%
Total Applicable	**52**	**100%**	**13**	**100%**	**17**	**100%**	**82**	**100%**
Not Applicable[6]	7	--	1	--	0	--	8	--

[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 "Objective" section for further information.

Additionally, there are eight (8) total elements of the compliance review worksheet that are not applicable to the CME Program and were excluded from review. The excluded compliance elements are summarized in Table 20.

Table 20. Compliance Review Elements Not Applicable to the CME Program

Elements Not Applicable to the CME Program	Subpart D and QAPI Standard
Regulations and descriptions regarding long-term services and supports (LTSS): LTSS does not apply to the CME Program population; CME Program delivers care coordination to children aged 4-20 years old.	**42 CFR § 438.208.** Coordination and continuity of care (2 elements)
Identification of individuals with special health care needs: All CME Program members fall under this category.	**42 CFR § 438.208.** Coordination and continuity of care (3 elements)
Regulations regarding the dual eligible population*:* The CME Program member population does not qualify for Medicare.	**42 CFR § 438.208.** Coordination and continuity of care (1 element) **42 CFR 438.330.** Performance Improvement Projects (1 element)
Including in enrollee handbooks any additional coverage requirements beyond those in Federal regulations*:* There were no additional state requirements found or documented.	**42 CFR § 438.210.** Coverage and Authorization of Services (1 element)

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

- MCP Standards, including Enrollee Rights and Protections
    - Standards for information made available through the Magellan Wyoming Care Management Entity Family and Youth Guide to High Fidelity Wraparound (herein referred to as the member handbook), including information on member rights and responsibilities and the member grievances, appeals, and State fair hearing processes.
    - Standards for culturally competent promotion of services.
    - Quality assurance and utilization review standards, including definition of medical necessity.
    - Standards for maintaining member health records.
    - Standards for disenrollment policy.
- Quality Assessment and Performance Improvement
    - Standards for the choice and description of performance measures.
    - Standards for performance measure calculation.
- Grievance and Appeals System
    - Standards for handling of grievances and appeals, including compliance with State-established timeframes for request and disposition of grievances, appeals, and State fair hearings.

- Requirements for continuation of benefits while pending appeal and State fair hearings.
- Standards and contractual requirements for the timeframes and content of notices of adverse benefit determination.

Areas of Strength and Needed Improvement

MCP Standards, including Enrollee Rights and Protections

Strength: Magellan's team is closely in touch with the operations of Wyoming's youth behavioral health High Fidelity Wraparound program.

Magellan's team plays a very hands-on role in the administration of the HFWA program, with weekly committee meetings that review provider caseload, participant needs, and match participants in need of services with providers shown to have capacity for more participants. The team is comprised of individuals from a variety of backgrounds in the health care space, creating a rich and collaborative environment supported by a wealth of varied experience. The nature and makeup of Magellan's team allows for a deeply knowledgeable set of administrators that leverage their experiences to support and improve the HFWA program. While the effective and well-reasoned approaches to program improvement Magellan employs are not thoroughly described in their documentation, the Magellan team demonstrates a clear understanding of their program and the manner through which it can be improved.

Strength: Magellan is in the process of overhauling and improving their approach to network adequacy standards and definitions based on their experience with the unique characteristics of Wyoming's program.

Magellan has demonstrated efforts to better define and assess network adequacy to meet CMS documentation standards, Magellan's SOW with WDH, and their own access and network goals. They are incorporating telehealth widely across the HFWA program, creating less rigidity in geographic network standards and addressing the widespread nature of Wyoming's population. Magellan is working to move away from static ratio standards for providers and participants in each region to allow providers to serve participants across Wyoming, evaluating provider capacity through weekly reports examining provider caseload and directing participants in need of a provider able to take on more participants. They are also working to promote proximity to provider that vary based on a participant's residence being local in an urban or rural location.

Needed Improvement: Magellan did not demonstrate the development or use of clear network adequacy standards beyond citing increased use of telehealth services to provide improved access for individuals in remote and hard-to-reach locations.

According to the SOW between Magellan and WDH, Magellan is not obligated to contract with more providers than necessary to meet the needs of enrollees. The SOW states that the number of providers required to meet enrollees' needs is to be determined based on the number of enrollees and expected utilization of services as well as the number of providers that have "met ratio requirements." complied with the State's requirements for availability of services, including adequacy of the provider network. However, Magellan's documentation shows differing adequacy standards that are currently in development but have not been fully implemented.

> ***Recommendation for Magellan:*** Improve reporting materials to include narrative around provider ratios and access differences across regions.
>
> Magellan reported that the organization is turning to standards of at least one (1) provider being present within a ten (10) mile radius from a program participant in urban regions and within a fifty (50) mile radius from a participant in a rural region. Magellan staff noted that the organization is currently in the process of defining new adequacy standards that account for the unique nature of Wyoming's geography and distribution of participants as well as telehealth's emergence as a viable service delivery method. While these standards and initiatives are meaningful and hold

promise, current documentation does not describe this system or these standards thoroughly. Magellan would benefit from finalizing adequacy standards to clearly measure access beyond what appear to be meaningful access for all participants from a qualitative assessment. The organization's process of leveraging committees to weekly discuss provider caseloads and participants' access to providers is meaningful. Providing further documentation that outlines these reviews and the measures the committee uses will improve Magellan's compliance with contract requirements and better position the organization for initiatives to improve access and its provider network where most needed.

Needed Improvement: Magellan did not clearly measure network adequacy through defined metrics and standards.

According to the SOW between Magellan and WDH, Magellan is required to generate geographic maps that demonstrate access to providers across the state in line with a formal analysis of access to meet State access and provider capacity requirements. CMS Protocol 3 standards require that Magellan provide information on the documentation and measures used to assess access to care requirements. Magellan does submit maps that show provider and enrollee location as well as participant volume for each provider. However, Magellan's maps and summary tables consolidates every provider that serves a region via telehealth without accounting for how many participants providers deliver services to. For example, Magellan's documentation shows that its network contains sixty-two (62) unique providers delivering Family Care Coordination services, while, when added together, the number of providers serving each region totals two hundred and twenty-five (225). There is no differentiation between a provider serving one region and four (4) participants and a provider that may be serving 4 participants in each of the six (6) regions in the reports submitted to WDH, and no description of provider-to-participant ratios.

Magellan also does not have clear measures to report how often individuals seeking a service are actually receiving the service. Instead, Magellan reported that they currently rely on close relationships with families and providers and a small participant pool that ensures that the Magellan team is aware that all participants are receiving the services they desire. This process does not allow for clear reporting or performance evaluation by WDH or Magellan.

Recommendation for Magellan: Develop and standardize thorough network adequacy measures for WDH reporting and proof of compliance with network adequacy standards.

Magellan's internal committees that govern provider assignment and recruitment have a very clear idea of the needs of and on-the-ground services delivered to participants. Its teams do exemplary work communicating closely with participants and providers to ensure adequate delivery of services. The organization reported that they are currently reworking their network adequacy framework and measures to better add data-driven context to their qualitative practices and understanding. Magellan would benefit from expediting this measure development process and incorporating any new measures into the reports submitted to WDH. Possible measures include the number of plans of care requesting a particular service relative to the number of individuals actually receiving a service or surveys for all enrollees delivered by Family Care Coordinators that inform participants of services available to them where they can indicate an unmet need for a service.

Further, Magellan must delineate between providers serving several regions when assessing provider-to-participant ratios for a true assessment of how provider capacity in its geographic maps of providers and participants.

Needed Improvement: Magellan does not provide a full description of the scope of benefits available to enrollees in its enrollee handbook or direction to a more detailed policy outlining the full scope of benefits.

According to the SOW between Magellan and WDH, Magellan is required to include information on the amount duration, and scope of benefits available to enrollees through their plan. It requires that the

information is described in adequate detail for enrollees to fully understand their benefits and the procedures for receiving their benefits. While the procedure for receiving services is described in Magellan's processes and procedures regarding care coordination and service authorization, the scope, duration, and amount of benefits is not explicitly stated in the enrollee manual. Magellan noted that they are focused on including minimal, consumer-friendly language on benefits in the manual, but do not include the full scope of benefits.

Recommendation for Magellan: Add additional information in enrollee-facing documents to inform enrollees and their families of the full scope, amount, and duration of benefits to which they are entitled in the CME Program.

Magellan's enrollee handbook details how enrollees receive services and service authorizations, but it does not outline the scope and maximum amount of those authorized services. It is important that enrollees have easy access to information regarding their maximum benefits to inform their cadence of service receipt and promote transparency in the service authorization and care plan process. Magellan can refrain from including all such information in the enrollee manual if there is language in the manual clearly directing enrollees to easily found online documents that further detail their scope of benefits in plain language.

Quality Assessment and Performance Improvement

Strength: Magellan's team is developing new standards, benchmarks, and measures to evaluate access to services.

To apply quantitative value to meaningful access to services, Magellan is determining new measures that objectively assess if participants can receive all services that they request or need. They are engaging providers in trainings to promote universal understanding of all services offered through Wyoming HFWA for inclusion in the care plans of participants each service may benefit. This is intended to ensure that care coordinators are not excluding services that would benefit a participant from their care plan due to knowledge that the network in their area cannot support access to these services. In doing so, Magellan will be able to collect additional data on what it means for a participant to be accessing the services they need and target areas for improvement.

Needed Improvement: Magellan did not submit a Quality Assurance and Performance Improvement (QAPI) Plan with strong quantitative components and robust methods for stakeholder engagement, surveys, and auditing.

According to the SOW between Magellan and WDH, Magellan must specify in their QAPI how they will demonstrate improvement through objective quality indicators and thorough evaluations of the interventions based on performance measures. In order to meet these requirements, Magellan must include clear quantitative analyses and targets in their QAPI to demonstrate performance and the effectiveness of the QAPI. While Magellan's QAPI states high-quality outcomes and performance improvement, it does not provide clear quantitative assessments of those objectives.

Recommendation for Magellan: In the QAPI, provide clear quantitative objectives and components.

Magellan can improve their QAPI by tying objective, quantitative measures to performance, thus improving the validity of their QAPI and evaluation and proving performance improvement. These quantitative measurements can also be linked to needed improvements and evaluation of stakeholder engagement practices, provider and enrollee surveys, and audit findings to better direct QAPI structure and initiatives.

Needed Improvement: Magellan's QAPI documentation did not detail processes for detection and action plans for over and underutilization of services.

The SOW between Magellan and WDH requires that Magellan include mechanisms to detect underutilization and overutilization of services as a component of their ongoing comprehensive QAPI. While Magellan discusses over and underutilization in its QAPI documentation, their definition of each and appropriate parameters for each were not provided or detailed. Further, the analysis provided in the QAPI documentation provided only demonstrated evaluations for year-to-year claims amounts instead of evaluations of a year's performance against the appropriate number of claims submitted per recipient.

Recommendation for Magellan: Define over and underutilization in QAPI documentations while outlining targets for utilization and evaluating utilization against those targets.

Magellan's current QAPI does not clearly indicate how it defines over and underutilization. As it moves to detect and address utilization challenges, it would be recommended that Magellan clearly outline how it describes appropriate and inappropriate utilization in its formal documentation, like the QAPI. Further, the current analysis conducted to address non-optimal service use does not compare to benchmarks or stated goals. It carries what may be suboptimal utilization across years, comparing one year to the next. While this approach does have its merits, it would be most effective when coupled with an evaluation of actual utilization to the expected appropriate number of claims submitted by a recipient. In doing so, Magellan will clearly define its utilization expectations and move towards a service volume goal while measuring changes in utilization over time.

Needed Improvement: Magellan's QAPI does not appropriately document evaluations for quality and appropriateness of care for enrollees.

The SOW between Magellan and WDH requires that Magellan include mechanisms in their QAPI to assess the quality and appropriateness of care coordination. Magellan's QAPI includes a list of accomplishments focused on changes to documents and completing contract requirements and responses to their satisfaction survey but does do not discuss survey results or meeting objective, measurable targets. Magellan's goals listed are aspirational but not directly measurable. There is also no mention of the performance measures used aside from the fact that they use performance measures and the rationale for the benchmarks used to determine adequate performance.

Recommendation for Magellan: Document the evaluation activities Magellan conducts for quality and appropriateness of care coordination along with the rationale for the quantitative measures and benchmarks used in the evaluation.

Magellan's current documentation would be improved by detailing the performance measures it uses and how they determined what value of each measure was acceptable performance. In particularly, Magellan's QAPI would be improved by detailing access standards, a list of performance metrics and how they are calculated, discussion on measurable objectives in the PIPs, documentation standards, and performance measures used as contractual requirements or quality incentives for providers. It would also improve with a discussion of measure goals, for example, why an acceptable level for provider audits is 70%.

Grievance and Appeals System

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

During the SFY 2023 review, Magellan provided detailed documentation on the timely and adequate notice of adverse benefit determination. They also answered any remaining questions regarding their grievance appeals processes to demonstrate compliance with system development and the assignment of liability for service costs pending during a hearing in which a denial of authorization for services is overturned. In doing so, Magellan fully satisfied the remaining contract requirement attached to Grievances and Appeals. As a result, Magellan fully complied with all 17 requirements set forth in 42 CFR § 438.402 – 438.420 for the Grievance and Appeals System.

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

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

Section VI. Validation of Network Adequacy

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

Guidehouse reviewed Magellan's network adequacy during SFY 2023 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 2023 SOW.

Based on these federal and State standards, Guidehouse identified 30 distinct elements to evaluate Magellan's compliance with network adequacy; however, only 12 of those elements are applicable to the CME Program. Appendix H includes Guidehouse's review tool for validating the adequacy of Magellan's provider network. The following network adequacy standards are not applicable to the CME Program:

- **Time and distance standards:** Time and distance standards do not apply to the CME Program during normal, in-person operations nor during full virtual operations which began during the COVID-19 public health emergency. During standard operations, the community-based nature of the HFWA model involves providers traveling to the members at a time and location that works best for members, rather than members traveling to a clinic or facility. Therefore, travel time and distance do not impact member access.
- **Capacity of certain provider types:** The CME Program provides care coordination services only and does not provide any clinical services. Providers must be certified in HFWA, but do not fall into typical clinical provider categories. Therefore, clinical provider categories (e.g., primary care, specialists, hospital, pharmacy, etc.) do not apply to the CME Program.
- **Long-term services and supports (LTSS):** Requirements related to LTSS do not apply to the CME Program, which delivers care coordination services to children with complex behavioral needs.
- **Indian health care providers (IHCPs):** Although Magellan serves tribal members, IHCPs are not involved because the program does not offer clinical services.
- **Exceptions process:** The provider-specific network adequacy standards do not apply to this program, and therefore there are not exceptions to the provider-specific network standards.

Table 21 provides an overview of Magellan's compliance levels with the applicable elements. Overall, Magellan and WDH met just over half of the applicable elements for network adequacy.

Table 21. Network Adequacy Assessment

42 CFR § 438.68 Standards	# Elements Met	# Elements Not Met	Total # Applicable Elements	# Elements Not Applicable
General Rule	0	1	1	0
Provider-Specific Network Adequacy Standards	1	0	1	10
Development of Network Adequacy Standards	7	2	9	4
Network and Coverage Requirements	0	0	0	1
Exceptions Process	0	0	0	3
Publication of Network Adequacy Standards	1	0	1	0
Total	**9**	**3**	**12**	**18**

Areas of Strength and Needed Improvement

WDH and Magellan complied with nine of the twelve (75%) federal and State-established network adequacy standards, an improvement from the prior year's EQR when Magellan demonstrated 58% compliance with the network adequacy standards. Strengths and areas for improvement are described below.

Strength: Magellan has made significant improvements in documentation provided for the EQR since the SFY 2021 review.

In both the SFY 2021 and SFY 2022 reviews, Magellan received recommendations that they improve their documentation that supports and defines any provider outreach, network adequacy standard measurement, and network adequacy information dissemination. This year's EQR showed substantial improvement in the robustness of Magellan's documentation and plans for future measure development. Magellan provided elevated maps from last year's geo-mapping tools that illustrated distance between participants and providers. They also more thoroughly documented their key barriers to respite provider recruitment and retaining as well as respite service utilization. By providing additional context to the status of their respite provider network, Magellan showed areas of focus for network improvement efforts.

Strength: Magellan has continued to grow and develop the WY CME provider network to meet the needs of program enrollees.

While the number of available respite providers still tends to fluctuate, Magellan has successfully improved their respite provider network. Further, Magellan has developed strategies to increase awareness of the range of services available through the HFWA program among contracted providers and current members.

Needed Improvement: Magellan's documentation does not clearly define provider recruitment, education, and support interventions.

During the EQR virtual on-site meetings, Magellan outlined the multiple pathways that they solicit feedback from enrollees, families, and their providers to provide valuate insight and opportunities for

stakeholder engagement. While these strategies and interventions are promising and address the CME's needs to improve its provider network, they are not detailed in Magellan's documentation.

Recommendation for Magellan: Detail specific provider recruitment, education, and support interventions and strategies in appropriate internal policies.

It is important that Magellan clearly document the specific network improvement activities it is undertaking in order to capture the value of such initiatives through outcome measures and outcome comparisons over time. Magellan could detail these specific activities in their Network Adequacy Framework or Network Development Plan to speak more directly to the manner through which they are addressing the needs and goals identified in those documents.

Needed Improvement: Magellan's documentation does not include considerations for the caseload of providers who deliver services across several regions via telehealth.

Magellan notes that all providers can deliver services remotely. However, Magellan's regional network maps and tables that align number of providers serving a region with the region's number of participants do not address instances where providers serve several regions. As such, Magellan's network map and additional documentation do not provide a meaningful picture of providers' caseloads and the number of participants being served by each provider.

Recommendation for Magellan: Adjust provider network reports to reflect the actual caseloads of providers and include average provider to participant ratios.

Magellan considers each request for services and provider caseloads weekly through committee meetings. As reported during the virtual on-site meetings, Magellan reviews the caseload of each provider and assigns participants seeking services with providers that demonstrate capacity, regardless of the participant and/or provider's location. This effectively allows Magellan to be constantly aware of any evolving network needs, but this practice and its results are not clear through Magellan's network adequacy reports. Magellan would better demonstrate its adherence to its network standards and the ability of participants to access services by developing a report that shows provider caseloads, provider to participant ratios, and reasonable physical access to a provider for participants receiving services from that provider.

Needed Improvement: Magellan emphasized use of network adequacy standards for the Family Care Coordination service that is required for all participants, but it does not leverage network adequacy standards and measures for the additional HFWA services.

Magellan provides geo-mapping and provider/participant counts by region for all services, but they do not apply rigorous goals and standards to the other three (3) HFWA services: Youth Support Partners, Family Support Services, and Respite. During the virtual on-site meetings, Magellan emphasized that the only "required" service is Family Care Coordination, so the same provider to participant standards by distance and ratio did not apply to the ancillary services. However, Magellan's contract with WDH does require that the services be accessible to individuals seeking them. Current network adequacy measures and goals do not address this.

Recommendation for Magellan: Develop targeted measures to assess access to all HFWA services and track progress towards related goals accordingly.

Magellan is undergoing efforts to improve provider education on all HFWA services, encouraging inclusion of additional services on participants' plans of care. During the virtual on-site meetings, Magellan noted their intent to develop clearer measures to assess access and network adequacy for Youth Support Partners, Family Support Services, and Respite. They mentioned interest in measures such as participants with a service on their plan of care compared to the number of participants receiving that service. Magellan's network development goals and strategies would benefit from Magellan constructing more detailed measures that accompany their provider

outreach efforts and speak to network growth progress and meaningful access to the full suite of HFWA services.

Section VII. Conclusion

Guidehouse identified in its review of Wyoming's CME Program, 13 areas of strength, 15 areas of needed improvement, and 17 recommendations in relation to quality, timeliness, and access to services. Overall, major strengths of the CME Program include, but are not limited to:

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

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

- PIP data analysis and evaluation design;
- Unclear data collection and validation processes that lead to discrepancies in data and reported measures; and
- Carrying network adequacy measures and improvement strategies across all services.

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

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