# Wyoming Department of Health
# Care Management Entity Program
# SFY 2024 External Quality Review
# Technical Report

April 2025


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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) 2024 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:

- 10 areas of strength
- 14 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 2017 | SFY 2018 | SFY 2019 | SFY 2020 | SFY 2021 | SFY 2022 | SFY 2023 | SFY 2024 |
|---|---|---|---|---|---|---|---|---|
| CME Youth Served | 431 | 494 | 402 | 402 | 385 | 366 | 307 | 482 |

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 services through a well-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 Children's Mental Health Waiver (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 been proven to be 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.

In January 2024, WDH submitted the waiver renewal application for both the 1915(b) and 1915(c) waivers. The waiver renewal process was completed, and the new waivers were approved by CMS for July 1, 2024. WDH also submitted an updated Quality Strategy in 2024 that was approved by CMS. The evaluation of the Quality Strategy included in this year's EQR report includes the review of the first year's activities towards the newly approved Quality Strategy.

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. |
| ***July 2024*** | CMS approved the renewal of the 1915(b) and 1915(c) waivers in Wyoming. |

## 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 VI 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: 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. For the SFY 2024 EQR evaluation, the State selected to specifically evaluate the Quality Assessment and Performance Improvement of EQR Protocol 3, since a full review was completed last year.*

- **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 2024 (July 1, 2023 to June 30, 2024). 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), SFY 2022 (July 1, 2021 to June 30, 2022), and SFY 2023 (July 1, 2022 to June 30, 2023). This EQR relies on interviews with WDH and Magellan staff, documentation provided by WDH and Magellan, and Guidehouse's industry experience working with CMS and health and human services agencies across the country. This report summarizes the findings of the EQR and provides recommendations for Magellan and WDH to improve operational and program performance.

## Results of SFY 2023 External Quality Review

Guidehouse's SFY 2023 review of Wyoming's CME Program resulted in identification of 14 areas of strength, 16 areas of needed improvement, and 17 recommendations in relation to quality, timeliness, and access to services.

Of the 17 recommendations for WDH and/or Magellan:

- 2 – recommendations have been fully addressed;
- 5 – recommendations have been partially addressed;
- 6 – recommendations have not been addressed; and
- 4 – recommendations were not applicable to the SFY 2024 review.

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 2023 review period.

**Table 3. Status of SFY 2023 Recommendations**

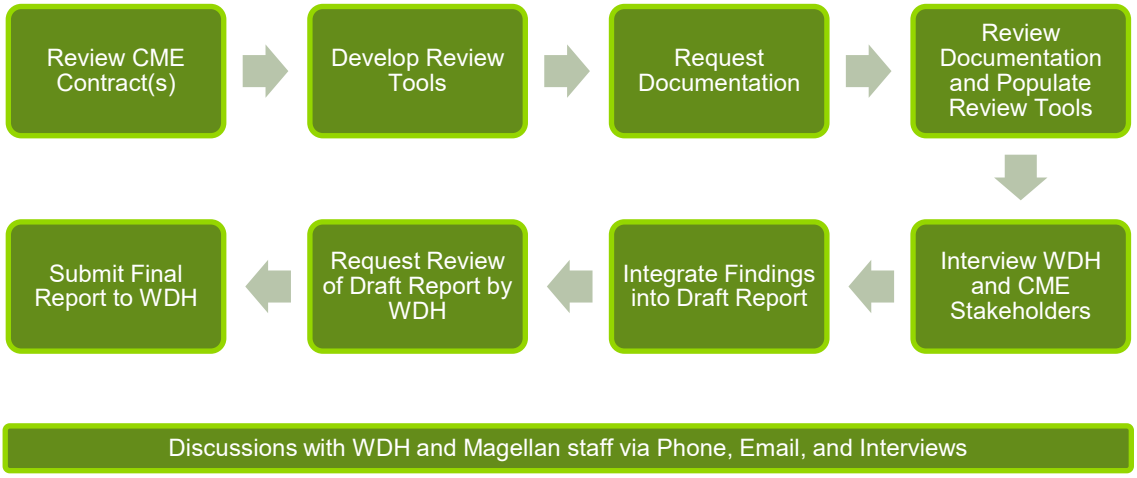
| EQR Protocol | SFY 2023 Recommendations for: | | Total | Total # of Recommendations, by SFY 2024 Status | | | |
|---|---|---|---|---|---|---|---|
| | Magellan | WDH | | Fully Addressed | Partially Addressed | Not Addressed | N/A |
| **Protocol 1**. Validation of Performance Improvement Projects | 4 | 0 | **4** | 2 | 1 | 1 | 0 |
| **Protocol 2**. Validation of Performance Measures | 2 | 2 | **4** | 0 | 1 | 2 | 1 |
| **Protocol 3**. Compliance with Medicaid Managed Care Regulations | 6 | 0 | **6** | 0 | 2 | 1 | 3** |
| **Protocol 4.** Validation of Network Adequacy | 3 | 0 | **3** | 0 | 1 | 2 | 0 |
| **TOTAL** | 15 | 2 | **17** | 2 | 5 | 6 | 4 |

****Note:** Three Protocol 3 recommendations made in SFY 2023 fell under *MCP Standards, Including Enrollee Rights and Protections.* This section of Protocol 3 was not assessed this year; therefore, progress towards these three recommendations also was not assessed.

## 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 2 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 and annual reports to WDH (including SFY 2024 Quarters 1 – 4 as well as SFY 2024 annual reports)
- 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 2024 to February 2025
- Virtual interviews and review sessions with Magellan staff on February 10 - 25, 2025
- 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 2024 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 2024:

- 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 a 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 two validation ratings assigned by Guidehouse for the overall design, methodology, and impact of each PIP. Validation Rating #1 is an assessment of the PIP's methodology for "all phases of design and data collection" and the accuracy of the PIP's data analysis and results interpretation. Validation Rating #2 is an assessment of overall confidence that the PIP produced significant evidence of improvement. Validation ratings for SFY 2024 are summarized in Table 4. Possible validation ratings include:

- ***High Confidence***: Strong project design / few areas of improvement in Worksheets 1.1-1.9; 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 1.1-1.9; data analysis plan and methodology provided, and evidence of improvement linked to interventions;
- ***Low Confidence***: Weak project design / multiple areas of improvement in worksheets 1.1-1.9; 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 1.1-1.9; unclear or missing data analysis plan and methodology, and no evidence of improvement.

**Table 4. SFY 2024 PIP Validation Ratings**

| Performance Improvement Project (PIP) | Intervention | Validation Rating #1 (Methodology) | Validation Rating #2 (Improvement) |
|---|---|---|---|
| **Prior Authorization Process PIP** | Evaluated the impact of educational initiatives for providers related to Plan of Care development. Also evaluated the impact of changes in the HFWA Plan of Care review process on successful continuous authorizations and the rate of Plan of Care non-authorizations. | Moderate Confidence | 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 | 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 | Low 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 assesses improvements to administrative elements in the prior authorization process to ultimately improve downstream member outcomes from continuous service delivery. It looks to evaluate the direct impact of altering the HFWA plan of care review process on the frequency of non-authorizations and continuous 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 summarizes the Prior Authorization PIP evaluation 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 Magellan's PIP workgroup's professional experience, provider feedback, downstream impacts of non-authorizations, and program restructuring goals.<br>• The PIP was constructed as an opportunity to improve provider compliance with prior authorization documentation and Plan of Care submissions to ultimately improve the rate of continuous authorizations.<br>• The target population is the entire population served by Wyoming's youth behavioral health HFWA program.<br>• The PIP aligns with the CMS priority area of Access for All and Engagement. |
| **Aim Statement** | • Magellan developed the following aim statements for the PIP:<br>1) "Will the introduction of changes in the High-Fidelity Wraparound Plan of Care review process (documents required for the prior authorization at the initial Plan of Care submission versus documents that can be submitted after the authorization) and provider communications result in a lower rate of service non-authorizations for the Wyoming Care Management Entity youth ages 4- 20 years old with a Serious Emotional Disturbance (SED diagnosis) who are enrolled during Standard Fiscal Year (SFY) 2024?"<br>2) "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 of the Plan of Care versus documents that can be submitted after the authorization) 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?"<br>• 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.<br>• While the aim statements meet the criteria regarding the construction of the siloed aim statements themselves, the content of each does not fully link 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."<br>• 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.<br>• The QIA form clearly identified that sampling was not used for the PIP. |
| **Variables and Performance Measures** | • Magellan outlined two (2) performance measures for the first period for this PIP:<br>1) **Numerator:** Number of non-authorizations issued.<br>**Denominator:** Number of Plans of Care submitted.<br>2) **Numerator:** Number of authorizations issued.<br>**Denominator:** Number of Plans of Care submitted.<br>• Magellan's PIP variables define evaluation periods as weekly and are assessed weekly.<br>• Magellan also produces data reports monthly, quarterly, and annually. |

| Evaluation Category | Findings |
|---|---|
| | • Magellan's variables clearly relate to the identified aim statements and PIP narrative. |
| **Data Collection** | • In the Prior Authorization Process PIP form, Magellan stated that data is collected from medical/treatment records (FidelityEHR).<br>• Magellan noted that the data they plan to collect includes member ID, name, enrollment status, enrollment date, non-authorization date, non-authorization letter delivery information, non-authorization comments, and service name.<br>• Magellan's documentation did not include links between the data being collected and an analysis plan.<br>• Data was pulled and reviewed weekly, monthly, quarterly, and annually. |
| **Data Analysis** | • Magellan did not provide an analysis plan in their PIP documentation. Magellan did provide a verbal description of the process during virtual on-site interviews.<br>• Magellan did not include a list of the qualifications required for each role in the PIP's data analysis or an intended staffing plan in the PIP documentation. Magellan did provide a list of data analysis personnel and their qualifications following virtual on-site interviews.<br>• Magellan has not conducted analyses to consider confounding variables or measures to assess the effectiveness of individual interventions.<br>• Magellan's PIP documentation acknowledges that there are potential discrepancies in the data collected and that changes will be made to key processes in the following year. |
| **Improvement Strategies** | • Magellan identified primary drivers of challenges and secondary drivers to be addressed by targeted interventions.<br>  ○ Primary Driver 1: Providers see documentation as a burden.<br>  ▪ Prior authorization requests are not submitted in a timely manner by providers.<br>  ▪ Providers lack a clear understanding and acceptance of importance of documentation.<br>  ▪ Providers submit incomplete documentation.<br>  ▪ Providers perceive that too much documentation is required.<br>  ○ Primary Driver 2: Providers perceive that feedback on prior authorization submissions is inconsistent.<br>  ▪ Interpretation of authorization request information may differ depending on the Clinical Reviewer who is assigned to the review.<br>  ▪ Providers may not enter documentation in the correct fields within the electronic health record.<br>  ○ Primary Driver 3: Families may not receive services for a period of time pending the receipt and approval of the plan of care submitted by the provider.<br>  ▪ Prior authorization requests are not submitted in a timely manner by providers.<br>  ▪ Providers submit incomplete documentation.<br>• Magellan developed the following interventions to address the identified primary and secondary drivers: |

| Evaluation Category | Findings |
|---|---|
| | ○ Streamlined the number of documents required for the Plan of Care submission<br>○ Magellan CME worked with WDH to consider a reimbursement increase for providers<br>○ Provider Surveys concerning activities in the PA process, External Quality Improvement Committee<br>○ Monthly Provider Calls, weekly training calls<br>○ Development of Provider Manual<br>○ Development of rating scale within the Clinical Review Tool<br>○ Reminders sent to providers 30 days prior to the POC being due for review.<br>• Magellan identified in the QIA form that they followed Institute for Healthcare Improvement's (IHI) PDSA rapid cycle approach to develop improvement strategies and ensured cultural and linguistic appropriateness within strategies.<br>• 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 improves on last year's documentation by constructing a more cohesive and targeted narrative that closely ties to the process Magellan aims to improve. Magellan tied interventions directly to identified challenges. However, continuous authorizations increased along with non-authorization rates. While the methodology follows a logical rationale, the outcome measures showed mixed effectiveness without clear understanding of what led to differing outcomes. Magellan has not assessed any confounding variables or assessed how specific interventions may be impacting outcome measures to reassess intervention designs. |

## Recommendations

Since this was first remeasurement year for the Prior Authorization Process PIP, Magellan has not yet assessed PIP elements that may have yielded mixed outcomes. Also, the narrative of the PIP showed 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 assessing confounding variables and outcomes, describing the process through which Magellan developed the PIP's interventions, and addressing any data inconsistencies. The recommendations to improve the Prior Authorization Process PIP include:

- Assessing, considering, and documenting the impact of any potential confounding variables on the PIP measures.
- Assessing why non-authorizations may have increased and discuss the analysis in the PIP documentations.
- Developing interventions to address potential causes for the increase in non-authorizations.
- Differentiating between how improvement in continuous authorizations accompanied by a greater volume of non-authorizations speaks to the overall success of the PIP.
- Describing how the interventions were developed in the PIP documentation.
- Including the individuals involved in the PIP measure data collection and evaluation process and their background in the PIP documentation.

- Considering including questions about the PIP interventions in provider surveys to collect data on provider response as another mechanism to assess and demonstrate PIP success.
- Addressing inconsistencies in reported data collection and analysis cadences in the PIP documentation.
- Providing clear qualifications required for the data analysis and collection staff working on the PIP.

## 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 summarizes the Network PIP evaluation based on criteria specified in CMS protocol.

**Table 6. Network PIP Evaluation**

| Evaluation Category | Findings |
|---|---|
| **Topic and PIP Selection** | • A Network Adequacy assessment was required in each SOW since the 2023 SOW between Magellan and WDH.<br>• 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. |
| **Aim Statement** | • Magellan developed the following aim statements for the PIP:<br>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?"<br>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?"<br>• The aim statements did not clearly define specific improvement strategies or key terms such as "targeted recruitment," "training and support," and "stakeholders."<br>• The aim statements 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.<br>• 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. |

| Evaluation Category | Findings |
|---|---|
| **Variables and Performance Measures** | • Magellan outlined two (2) performance measures to evaluate the success of the PIP:<br>1) Number of Family Care Coordinators in Network.<br>2) Number of Respite Providers in Network.<br>• Magellan set goals for each performance measure of:<br>1) Increasing Family Care Coordinators by two (2) providers each quarter; and<br>2) Increasing the network to eight (8) total respite providers by the end of SFY 2024<br>• Baseline evaluations were collected from SFY 2023. The baseline measures were:<br>o 64 Family Care Coordinators<br>o 1 Respite provider<br>• SFY 2024 was the PIP's first remeasurement period. The first remeasurements yielded:<br>o 52 Family Care Coordinators<br>o 3 Respite providers |
| **Data Collection** | • The Network PIP documentation included a description of the data collection procedure used to review the network provider roster, network provider applications, and number of active providers.<br>• The PIP noted that data collection cadences as monthly, quarterly, and annually.<br>• The PIP noted that data is validated monthly. |
| **Data Analysis** | • The Network PIP documentation did not include a description of a data analysis plan, as no analysis was conducted. Magellan only leveraged raw provider counts as PIP measurements.<br>• Measurements were not subjected to statistical significance tests.<br>• The PIP documentation does not provide a description of analyses informing the measure goals. |
| **Improvement Strategies** | • Magellan identified primary drivers of challenges and secondary drivers to be addressed by targeted interventions.<br>o Primary Driver 1: Frontier nature of the state.<br>▪ Limited number of qualified individuals to recruit.<br>▪ Time and distance for providers to travel to rural areas.<br>o Primary Driver 2: Community stakeholders, behavioral health providers, and other professionals lack awareness and knowledge of the HFWA program.<br>▪ Communication gaps between community stakeholders and providers.<br>▪ Learning curve of the HFWA process.<br>o Primary Driver 3: Challenging to maintain providers in areas with limited enrollees and families.<br>▪ Providers expressed that reimbursement rates are insufficient.<br>▪ Providers are dependent on enrollees and their families' availability for scheduled services.<br>o Primary Driver 4: HFWA program network provider contract and training requirements.<br>▪ Limited knowledge in provider understanding of basic business practices. |

| Evaluation Category | Findings |
|---|---|
| | • Magellan developed the following interventions to address the identified primary and secondary drivers:<br>  ○ Hold a summit conference with current WY providers and stakeholders (focus on Natrona County).<br>  ○ Leverage current provider contacts throughout the State to recruit new providers.<br>  ○ Information in provider and member newsletter concerning recruiting for High Fidelity Wraparound providers and respite providers.<br>  ○ Updated High Fidelity informational brochures and one specifically about the Respite services. Brochures will be distributed by current network providers to stakeholders in the WY community.<br>  ○ Engagement with providers during Tuesdays at 2 (a weekly training call with providers and CME staff) and ad hoc provider calls about respite roles with Network manager.<br>  ○ Summit virtual conference held with current WY providers throughout the state as well as stakeholders (focus for Laramie County)<br>  ○ "Collaborative Connections" provider conference held in Casper, WY.<br>  ○ Distributed HFWA brochures and posters to providers to use in their office and to distribute in their communities for other stakeholders and families to raise awareness of the program.<br>  ○ WDH approved increase in unit reimbursement rates for providers.<br>• 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 PIP measures showed significant fluctuation in provider enrollment that could not meaningfully demonstrate improvement. Magellan also only used raw provider counts in their PIP measurements instead of more robust statistical measures. Further, Magellan was not able to define the number of providers that would adequately meet their program's needs or why their goals were set as they were. As such, the PIP evaluation currently produced low confidence of significant improvement. |

## Recommendations

As the Network PIP moves into its second remeasurement year, there are several opportunities for Magellan to further align with guidance provided in the CMS EQR Protocols and improve design and implementation of the PIP. Mainly, these improvements center on performance measurement, linking interventions directly with performance measures, and defining how Magellan determined what constitutes meaningful and needed improvement. The suggested improvements include:

- Tracking reasons for provider enrollment and disenrollment.
- Developing statistical measures to assess the PIP besides raw provider counts.
- Defining rationale driving the measure goals (i.e., how does Magellan determine the number of providers necessary to improve the network in a capacity that is meaningful to members and potential members).

- Defining how demand for providers is assessed.
- Clearly discussing in the PIP narrative how new provider recruitment is intended to be driven by events with current providers.
- Providing data collection and analysis personnel and backgrounds in the PIP documentation.
- Determining methods to assess the effectiveness of individual interventions in making progress towards the PIP's goals.
- In the PIP documentation, detailing the outreach efforts Magellan is undertaking to improve coordination with Indian Health Service providers and increase Native American provider enrollment to meet the needs of Native American enrolled youth.

## 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 2024.

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 2024 Statement of Work between Magellan and WDH.<br>• 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.<br>• 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.<br>• The Engagement and Implementation PIP aligns with CMS Aims and Priorities (i.e., *Outcomes / Alignment and Access for All / Engagement*). |
| **Aim Statement** | • Magellan developed the following aim statements for the PIP:<br>○ "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 2024?"<br>○ "Does the change in authorization process improve the percent of Wyoming CME youth (aged 4-20 years old who were discharged during the |

| Evaluation Category | Findings |
|---|---|
| | measurement period), and their families reach implementation threshold (>180 calendar days) for SFY 2024?"<br>• The aim statements met all requirements identified by CMS in the PIP Review Worksheet, including requirements for statement specificity, measurability, answerability, conciseness, and time restrictions. |
| **Population** | • Magellan lists the population for the Minimum Contacts PIP as "All Wyoming CME youths aged 4-20 years old discharged during the measurement period (SFY 2024)."<br>• 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.<br>• 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:<br>○ **Measure #1:** "Engagement: percent of youth and families not reaching engagement threshold (>60 calendar days)"<br>○ **Measure #2:** "Implementation: percent of youth and families reaching implementation threshold (>180 calendar days)"<br>• Magellan specified objective, time-specific continuous variables for each performance measure in the SFY 2024 QIA form:<br>○ **Measure #1: *Numerator*:** "Count of youth >60 calendar days of HFWA ("not engaged")." ***Denominator*:** "Count of discharged youth HFWA."<br>○ **Measure #2: *Numerator:*** "Count of youth >180 calendar days of HFWA ("implemented"). ***Denominator:*** Count of discharged youth HFWA."<br>• 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 2024.<br>• To collect data for this PIP in SFY 2024, 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.<br>• 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.<br>• Data collected for the PIP include member data, enrollment status and discharge data, and Plan of Care data, including provider name.<br>• 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:<br>○ **Measure #1 Engagement:** "Percent of youth and families not reaching engagement threshold (>60 calendar days)"<br>▪ Baseline (May 2018 – August 2018): 16%<br>▪ Remeasurement 1 (SFY 2019, July 2018 – June 2019): 16%<br>▪ Remeasurement 2 (SFY 2020, July 2019 – June 2020): 15%<br>▪ Remeasurement 3 (SFY 2021, July 2020 – June 2021): 15% |

| Evaluation Category | Findings |
|---|---|
| | ▪ Remeasurement 4 (SFY 2022, July 2021 – June 2022): 13%<br>▪ Remeasurement 5 (SFY 2023, July 2022 – June 2023): 13%<br>▪ Remeasurement 6 (SFY 2024, July 2023 – June 2024): 15%<br>○ **Measure #2 Implementation:** "Percent of youth and families reaching implementation threshold (>180 calendar days)"<br>▪ Baseline (May 2018 – August 2018): 59%<br>▪ Remeasurement 1 (SFY 2019, July 2018 – June 2019): 62%<br>▪ Remeasurement 2 (SFY 2020, July 2019 – June 2020): 61%<br>▪ Remeasurement 3 (SFY 2021, July 2020 – June 2021): 64%<br>▪ Remeasurement 4 (SFY 2022, July 2021 – June 2022): 70%<br>▪ Remeasurement 5 (SFY 2023, July 2022 – June 2023): 59%<br>▪ Remeasurement 6 (SFY 2024, July 2023 – June 2024): 62%<br>• 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.<br>• Magellan increased the comparison goal of 10% in SFY 2023 for measure one (1) to less than 16%, citing the goal change as reflecting initial baseline results.<br>• Magellan increased the comparison goal of 80% in SFY 2023 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:<br>○ Provider awareness of their performance.<br>○ Lack of understanding of the importance of engagement and implementation with the youth and their families.<br>○ New providers may not be educated on measures and understand the impact of the measures.<br>○ Providers may not view feedback in a positive manner.<br>○ A few providers can have a negative impact on the overall engagement and implementation process.<br>• 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 6 (SFY 2024):<br>○ Sharing of quarterly Provider Scorecard.<br>○ Discussing performance measures in Monthly Provider Calls.<br>○ Sending provider communication emails.<br>○ Updating website information.<br>○ Conducting RISE trainings concerning requirements and processes of HFWA.<br>○ 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.<br>○ Prompting Family Care Coordinators to complete radio buttons with the level of family engagement in the FEHR. |

| Evaluation Category | Findings |
|---|---|
| | ○ Encouraging providers to become familiar with the Provider Dashboard in the FEHR and to complete the dashboard consistently.<br>○ Providing feedback to providers on performance based on consistently completed Provider Dashboard.<br>○ Providing coaching and training support to providers.<br>• Magellan included a comprehensive table in the QIA form that included all interventions implemented from SFY 2018 to SFY 2024 and the identified barrier that each intervention addressed. |
| **Likelihood of Significant Improvement** | • Magellan has not observed sustained improvement with the Engagement and Implementation PIP. The engagement and implementation measures met the stated target after the benchmarks were lowered.<br>• Since this is the final year of the PIP and both Magellan and WDH have stated that they do not intend to redevelop or reimplement this PIP, the EQRO did not present any recommendations for PIP improvement. |

### Recommendations

The submitted PIP documentation was consistent with federal requirements, but the PIP continued to fail to reach statistically significant, sustained, and consistent improvement. Since this is the final year of the PIP and both Magellan and WDH have stated that they do not intend to redevelop or reimplement this PIP, the EQRO did not present any recommendations for PIP improvement.

## 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 2024 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 2023 EQR continues to be seen in the SFY 2024 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.

***Strength:*** Magellan considerably improved aspects of their documentation based on previous years' EQR recommendations.

Magellan's PIP documentation featured improved links between the PIPs' interventions and identified barriers. Magellan outlined primary drivers of challenges and related secondary drivers, designing interventions to address the secondary drivers. The PIP documentation was clear, logical, and well supported with best practice literature and peer-reviewed studies.

***Needed Improvement:*** Magellan's PIP designs do not account for confounding variables that may

contribute to performance measures.

In Magellan's Network and Prior Authorization Process PIPs, Magellan notes that it is unclear if there are any variables that are influencing the PIPs' performance measures beyond their designed interventions. As such, Magellan cannot ultimately determine the effectiveness of the interventions themselves. It is then difficult to attribute changes in the performance variables to intended program changes rather than surrounding conditions.

> ***Recommendation for Magellan:*** Assess contributory elements to the PIPs' performance measures and leverage additional performance measures to directly assess the interventions' effectiveness.

During the virtual on-site meetings, Magellan's team noted that they plan to examine their interventions and determine if there are other factors contributing to the PIPs' performance measures. Magellan would benefit from including this assessment in their PIP documentation. The PIPs could also be improved by designing performance measures to directly assess the interventions and isolate the interventions' impacts from external elements.

***Needed Improvement:*** Despite previous PIPs showing limited sustained and statistically significant improvement, current PIPs do not objectively evaluate specific improvement activities from the previous year.

As was noted in the SFY 2023 EQR report, evaluations of the PIPs' effectiveness do 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:*** Magellan's Network PIP does not leverage robust statistical measures to determine the PIP's effectiveness.

Magellan's Network PIP relies on raw provider counts to assess the PIP's effectiveness. The analysis plan and measures do not include tests for statistical significance or meaningful measures with context such as percent change in provider enrollment.

> ***Recommendation for Magellan:*** Develop performance measures with greater context and meaning, moving away from provider counts as the PIP's performance measure.

The PIP would be improved by using raw provider counts as a component of the PIP's performance measures but not using the provider counts as the performance measure itself. Magellan may choose to do so by using percent change in provider counts as a performance measure or tie provider counts to member to provider ratios or regional access to local providers.

***Needed Improvement:*** Magellan's Network PIP does not leverage objective analytic rationale for the PIP's performance measure goals.

Magellan's Network PIP defines the PIP's performance measure goals as provider enrollment growth by a static number of providers by each quarter or reaching a particular number of providers at a particular point in time. According to the PIP documentation and virtual on-site meetings with Magellan, Magellan did not conduct analyses to determine demand for services that may be better met by an increased

number of providers. The performance measure goals were not directly tied to a demonstrated need in the HFWA program.

***Recommendation for Magellan:*** Develop objective, analytical rationale for the PIP's performance measure goals.

The Network PIP would be improved by tying the PIP's performance measures to clear rationale based on a demonstrated need. Magellan may consider conducting an analysis to determine current and potential demand for services across Wyoming and basing network goals on that analysis. They may consider a regional / local access approach to the network goals. Tying performance measure goals to demonstrated needs would add credibility to the PIP and allow Magellan to better showcase their interventions' effectiveness and benefit to the program.

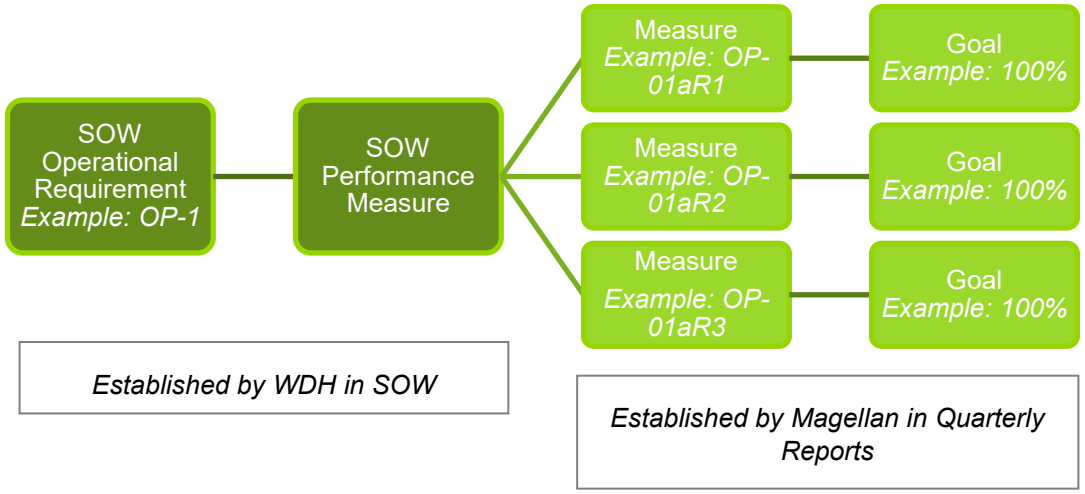
## Section IV. Validation of Performance Measures

**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.

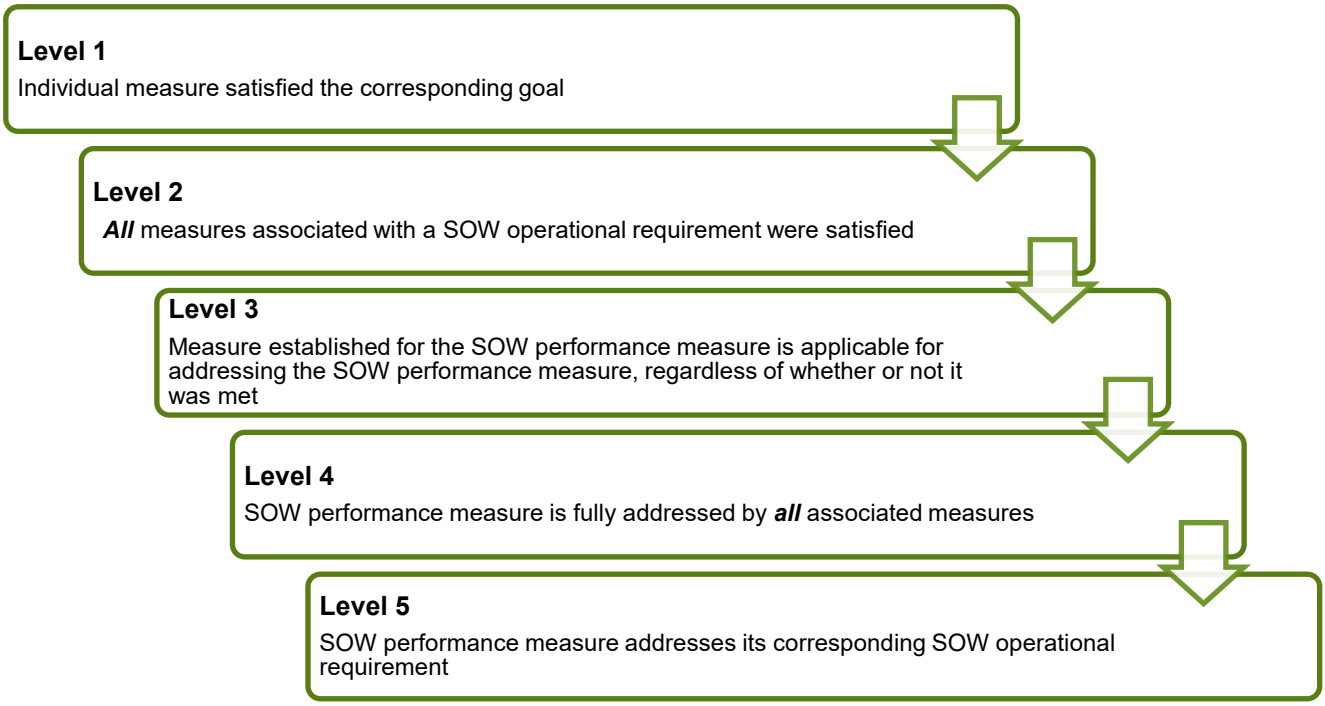
**Figure 3. SOW Requirements, Performance Measures and Goals**



### 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 2024, review and validation of reported data included 26 unique measures (goals) established by Magellan for 23 SOW operational requirements.

2. **Outcome Measures:** The SOW includes 10 outcome measures with specific measurement instructions for each measure. Annually, Magellan reports on outcomes to WDH and may be subject to payment penalties for failing to meet outcome measure goals.

**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 | 53.8% |
| Goal Not Met | 15.4% |
| 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 | 60.9% |
| No | 17.4% |
| Not Applicable | 21.7% |
| Insufficient Data | 0.0% |
| **Total** | **100.0%** |

## 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% |

[1] Throughout this section "Not Applicable" indicates there was no applicable data in SFY 2024 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.

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

| Level 3 Evaluation | Percent of Measures *(n=26)* |
|---|---|
| **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%** |

## 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 | 100.0% |
| Partially[4] | 0.0% |
| No | 0.0% |
| **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. Selected SOW operational requirements include the following:

- **OUT 13-2:** Decreased Length of Stay (LOS) for OOH Placement
- **OUT 13-4**: Graduates Moving to Higher LOC
- **OUT 13-5**: Primary Care Practitioner Access (EPSDT)

[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 13-2:** Decreased Length of Stay (LOS) for OOH Placement | WY Custom | EHR | 3* | 5* | 5 | 13 | Moderate |
| **OUT 13-4**: Graduates Moving to Higher LOC | WY Custom | EHR | 3• | 3• | 5 | 11 | Moderate |
| **OUT 13-5**: Primary Care Practitioner Access (EPSDT) | WY Custom | EHR | 4+ | 5 | 5 | 14 | High |

**As currently stated, the numerator and denominator were properly calculated. See notes below.*
*• Teams met in November 2024 to review and correct the measure going forward. See notes below.*
*+ On two samples, following detailed review, numerator was manually reduced by one to correct. On one sample, a date was corrected to calculate the full quarter.*

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. Per the requirements set forth in Protocol 2, Guidehouse led discussions and viewed demonstrations supporting the applicable questions outlined in Worksheets 2.2-Calculation Method, 2.5 & 2.6-Data Integration & Control Personnel, 2.7-Documentation Review, 2.8-Data & Process, 2.9-Policies & Procedures, 2.10-Audit Elements, and 2.14-Framwork for Summarizing. 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 one of the three SOW operational requirements (OUT 13-5).

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

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

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

- 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 13-2: Decreased Length of Stay (LOS) for Residential Treatment admissions for youth enrolled in the CME**<br>• **Numerator**: Average Length of Stay for CME enrolled youth in Out of Home placement. (Psychiatric Residential Treatment Facility and Acute Psychiatric)<br>• **Denominator**: The number of youth enrolled with the CME Contractor | | | |
| 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.<br>**Numerator**:<br>• While Magellan reported the numerator as an average per the numerator description, the entire measure (numerator/denominator) should be the average.<br>• WDH should consider updating both the description and the CDF display of the numerator as a whole number counting the total number for PRTF and/or Acute Psychiatric admission days for youth enrolled greater than or equal to 6 months in the reporting period.<br>• The incorrect calculation of the numerator for OUT 13-1 results in the incorrect calculation of the numerator for OUT 13-2. For OUT 13-1, the query filter display shows only one taxonomy 323P00000X (PRTF) as well as program code P07, but the underlying query source revealed a total of three taxonomy codes, thus overstating the numerator by including other stays. Magellan noted that the measure initially included the acute hospital stays, but that requirement will be removed for CY2025. WDH noted that once a youth enters a PRTF, they are removed from P07, so this should not be in the numerator criteria. The average PRTF stay is historically ~200 days.<br>**Denominator**:<br>• While Magellan reported the denominator as currently defined, the number of youth enrolled in CME program greater than or equal to 6 months in the reporting period, the denominator should include only those youth enrolled greater than or equal to 6 months *and having a PRTF stay during this time*.<br>• WDH should consider updating both the description and the CDF display of the denominator to count youth enrolled greater than or equal to 6 months in the reporting period and who were admitted to a PRTF for at least one day. This will reduce the denominator but allow the overall rate to include only those who are eligible for consideration in the measure, thus calculating the accurate average LOS.<br>**Overall Findings:**<br>• The year-end annual rating should be a re-calculation for the calendar year, so each youth and each youth's PRTF and/or Acute Psychiatric day count are unduplicated. Since a youth with >= 6 months enrollment may be counted in multiple quarters, it is important to count them only once for the year.<br>• In the CDF, the *Result* row should display a percentage reflecting the current numerator description, 'Average Length of Stay for CME enrolled youth in Out of Home placement. (Psychiatric Residential Treatment Facility and Acute Psychiatric)'.<br>• We recommend comparing the current year rating to the previous year rating to determine if ALOS is decreasing per the measure title.<br>• Verify if P07 should/should not be in the report criteria. If WDH removes a youth from P07 upon admission, they would not be counted in the report. | No | Yes | Yes |

**Table 16. Protocol 2 Measures and Findings**

| Measures and Findings | Accurate Creation of Numerator | Accurate Creation of Denominator | Accurate Source Data |
|---|---|---|---|
| **OUT 13-4: Recidivism (LOC) at six (6) months post CME graduation**<br>• **Numerator**: The number of graduated youth moved to a higher level of care (Psychiatric Residential Treatment Facility) within six (6) months of graduation from the CME<br>• **Denominator**: The number of youth graduated from the CME | | | |
| 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.<br>**Numerator**:<br>• The numerator is likely understated as the description states 'the number of graduated youth moved to a higher level of care (Psychiatric Residential Treatment Facility) within six (6) months of graduation from the CME', but we believe the intent is 'the number of youth *who graduated from the CME in the in the 6 months prior to the end of the measure quarter and* moved to a higher level of care (Psychiatric Residential Treatment Facility) *during that time*'.<br>• Magellan found and immediately corrected a date span error to properly include the full quarter under review.<br>• Consider updating both the description and the CDF display of the numerator to count the number of youth who graduated from the CME in the in the 6 months prior to the end of the measure quarter and moved to a higher level of care (Psychiatric Residential Treatment Facility) during that time. If counting the graduates from the current quarter, they will not have had the full 6 months to move to HLOC and be counted.<br>**Denominator**:<br>• The denominator is likely overstated as the description states 'the number of youth graduated from the CME', but we believe the intent is not all graduates, but 'the number of youth who graduated from the CME *in the 6 months prior to the end of the measure quarter*'.<br>• Consider updating both the description and the CDF display of the denominator to count the number of youth who graduated from the CME in the 6 months prior to the end of the measure quarter.<br>• Measure creator corrected criteria for Discharge Date to accurately reflect a full year lookback for PRTF admission, not inpatient admission, within the SFY.<br>**Overall Findings**:<br>• Re-calculate distinct counts at year-end rather than adding quarters; some youth can appear more than once and should be de-duplicated as they can only graduate once even though the 6-month timeframe encompasses two quarters.<br>• Remove CDF display of 99% Goal on *Result* row.<br>**Magellan and WDH met in November 2024 to review and correct the measure going forward.* | No* | No* | Yes |

**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)**<br>• **Numerator**: Number of participants who have identified a Primary Care Provider<br>• **Denominator**: Number of youth enrolled in CME Program | | | |
| **Numerator**:<br>• There is some risk to the manual de-duplication process which decreases then overlays the query results.<br>• We believe the intended count is youth "newly enrolled in the reporting quarter and having an identified PCP". EQR participants agreed the source code is an accurate representation of the measure intent, and the description shall be clarified.<br>**Denominator:**<br>• We believe the intended count is youth "newly enrolled in the reporting quarter". EQR participants agreed the source code is an accurate representation of the measure intent, and the description shall be clarified.<br>**Overall Findings**:<br>• Consider validating manual entries and overrides. For two of the four quarters reviewed, the numerator should have been decreased by one but was pasted into the CDF incorrectly.<br>• Re-calculate distinct counts at year-end rather than adding quarters; some youth appeared more than once and should be de-duplicated as they can only be *newly* enrolled in a single quarter.<br>• If errors/discrepancies are found following a reported quarter, notify WDH so they can determine if CMS, MACPAR, or other reports require updates.<br>• Clarify Intent of Measure:<br>  ○ Each time this measure is executed after the quarter and/or year under review, the average CME youth with an identified PCP gets closer and closer to 100%, although one can only be *newly* enrolled in one timeframe. While participants in the EQR exercise agreed that this is the intent, there is no measure of the time that lapses between an enrollee joining the program and having an identified PCP. If the PCP is identified any time before the report runs, the updated numerator results in a positive value. Some PCP identifications may take only a week and others as long as 12 months, but each counts equally at year end. If the intent is to understand how many days the youth have no PCP identified or how quickly the support staff is able to get a PCP identified, the measure is not describing the activity.<br>  ○ For a youth returning to the program, a PCP is counted if a previous crisis plan noted a PCP, even when the current crisis plan does not include one. If the youth has moved or is no longer involved with the previous PCP, they may not currently have a PCP (but they would be counted as if they have a PCP). | 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 2024. 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<br>The Contractor shall report the number of OOH placements of Contractor youth.<br>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<br>The Contractor shall report the overall LOS for inpatient and residential treatment for youth enrolled in the CME. | Meets Requirements |
| **OUT 13-3:** Recidivism<br>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<br>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)<br>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)<br>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<br>• The Contractor shall report fidelity to the HFWA model as measured by the Wraparound Fidelity Index (WFI-EZ)<br>• 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<br>The Contractor shall report family and youth participation on State-level Steering Committees. | Meet Requirements |
| **OUT 13-10:** Family and Youth Participation in Communities<br>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.

- Project team is comprised of knowledgeable staff with years of experience with the program, the measure, and the EQR process.
- 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.
- 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).
- Previous EQR recommendations were implemented, and measure creation documentation updated to reflect conversations surrounding intent of measure.
- Measure creator could successfully display prior run results, perform manual tasks, and match counts across systems.
- Clinical Team could locate and extract samples to display confirmation.
- Quality Improvement Committee (QIC) remains a key part of the program.

***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.

In some cases, Magellan noted measures where they worked with WDH to adjust and correct to properly describe, query, and calculate each measure according to its intent.

*(This is a continued strength from SFY 2021, 2022, and 2023).*

***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.

*(This is a continued strength from SFY 2023).*

***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, 2022, and 2023).*

***Needed Improvement:*** Consider assigning a measure owner.

To ensure accurate measure definition, creation, reporting, and evaluation, we recommend WDH and Magellan assign an owner for each measure. In some cases, the quarterly or annual variance is a good indication of improper calculation or reporting. A measure owner would have final review and approval of the content entered into the CDF.

***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.

- Consider updating the criteria for Measure OUT 13-2 to calculate the total number for PRTF and/or Acute Psychiatric admission days for youth enrolled greater than or equal to 6 months in the reporting period over the number of youth enrolled greater than or equal to 6 months and having a PRTF and/or Acute Psychiatric stay during this time. See notes above regarding use of P07 in query.
- Consider updating the criteria for Measure OUT 13-4 to calculate the total number of youth who graduated from the CME in the in the 6 months prior to the end of the measure quarter and moved to a higher level of care (Psychiatric Residential Treatment Facility) during that time over the number of youth who graduated from the CME in the 6 months prior to the end of the measure quarter.
- Consider updating the criteria for Measure OUT 13-5 to calculate the total number of newly enrolled in the reporting quarter and having an identified PCP over the number of youth newly enrolled in the reporting quarter.

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

For measures, such as OUT 13-2, 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 13-4, Magellan is currently calculating the annual value as the average of the quarterly averages, and this does not allow for proper weighting and de-duplication. For a measure such as OUT 13-5, the CDF reflects the annual count as 'Sum of Quarters', but rather than a manual calculation, this should be a new SFY query after the close of the fourth quarter, even though the end results may be more or less than the sum of the quarters.

## 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. SFY 2024 was not a year of full compliance evaluation. As such, the State selected to specifically evaluate the Quality Assessment and Performance Improvement of EQR Protocol 3.

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 10 elements applicable to the CME Program.[5] This compliance review encompassed the standards listed in Table 18.

**Table 18. Compliance Standards Reviewed by the EQRO in SFY 2024**

| Standard Reviewed by the EQRO | Subpart D and QAPI Standard | Last Reviewed |
|---|---|---|
| **Quality Assessment and Performance Improvement**:<br>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 2023 |

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.

[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

- **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 40 percent of applicable elements and partially met 50 percent in SFY 2024. 10 percent of applicable elements were considered "not met" in SFY 2024.

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. As previously mentioned, in SFY 2024 and in coordination with the State, Guidehouse completed a partial assessment of Protocol 3, focusing in on Quality Assessment and Performance Improvement.

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 | Quality Assessment and Performance Improvement *(438.330)* | |
|---|---|---|
| | No. | Percent |
| Fully Met | 4 | 40% |
| Partially Met | 5 | 50% |
| Not Met | 1 | 10% |
| Not Reviewed in SFY 2024 | 0 | 0% |
| **Total Applicable** | **10** | **100%** |
| Not Applicable[6] | 4 | -- |

Additionally, there are four (4) 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 438.330 (b).** Basic elements of quality assessment and performance improvement program (2 elements)<br>**42 CFR 438.330 (c).** Performance measurement (1 element) |

[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.

| Elements Not Applicable to the CME Program | Subpart D and QAPI Standard |
|---|---|
| ***Regulations regarding the dual eligible population****:* The CME Program member population does not qualify for Medicare. | **42 CFR 438.330 (d).** Performance Improvement Projects (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

### Quality Assessment and Performance Improvement

***Strength:*** Magellan's Quality Assessment and Performance Improvement (QAPI) Report is complete and organized. All general and appropriate parameters are included in the document related to quality activities.

The Magellan Quality Assurance Performance Improvement Program Evaluation for SFY 2024 adequately summarizes all major quality initiatives that took place throughout the year, including all three Performance Improvement Projects. The document additionally calls out, among other details, the components of the quality work plan, screening programs and self-management tools, experience and satisfaction surveys, grievances and complaints, appeals, and enrollee, family member, and stakeholder involvement. The structure and content demonstration a complete foundation for quality program growth and continued evaluation. Furthermore, it is clear the document reflects that the Magellan team reviews each area of quality activity on an annual basis.

***Strength:*** Magellan's team holds regular, formal team and external meetings to consider quality

improvement progress for the WY CME program.

The Magellan Quality Assurance Performance Improvement Program Evaluation for SFY 2024 demonstrates regular Magellan team consideration of quality activities and progress throughout the year. The report describes both an internal and external Quality Improvement Committee. Also, Magellan maintains a QAPI committee, which includes three subcommittees: the Network Strategy Committee, Cultural Humility Work Group, and Compliance Committee. A Member Advisory Group additionally contributes to the QAPI process. In interviews with the Magellan team, Magellan staff described monthly calls with providers as well as a PIPs workgroup. It is clear formalized and regular conversations are happening throughout the year to examine quality practices and activities, including opportunities for provider, member, and family input.

***Needed Improvement:*** The QAPI goals and focus areas are general and repeated across years, reflecting limited adjustment year to year based on Wyoming program-specific needs. The objectives are also not measurable and do not reflect a period for achievement.

The prioritized goals presented in the SFY 2024 QAPI report, also presented in the Quality Work Plan, are listed as follows:

1. Positively Influencing Enrollee Health, Well Being and Safety,
2. Enhance Service and the Experience of Care, and
3. Meet and Exceed Contractual, Regulatory, and Accreditation Requirements.

All three of these goals are non-specific and minimally quantified in the presented analysis. In particular, the third goal of meeting relevant requirements should be reassessed for a mature program such as WY CME. Furthermore, the goals are repeated over multiple years, as evident in the QAPI report introduction where these goals are also listed as the priorities for SFY 2025.

The QAPI plan, and subsequent report, are updated on a regular basis as part of the SOW requirements. However, the priority goals do not appear to be adjusted based on year-to-year program outcomes and findings. Additionally, because the priority goals are general in nature, it is difficult to assess true progress and quantify outcomes year-to-year.

> ***Recommendation for Magellan:*** QAPI prioritized goals should directly reflect yearly changes and needs of the WY CME program and include quantifiable metrics to track progress.
>
> The Magellan team can improve the QAPI report by updating the priority goals based on annual findings and outcomes of the WY CME program. The QAPI plan and related activities for a given year should be tied to the most significant gaps in quality or outcomes. To determine such needs, goals from year to year should be connected to key metrics and quantifiable outcomes that demonstrate what is changing, positively or negatively, in regard to program outcomes over time. Applying additional objective, quantitative measures to performance will improve the validity of the QAPI and evaluation.

***Needed Improvement:*** Over/under utilization tracked metrics are limited, high-level, and provider prescribed. There does not appear to be a mechanism to assess utilization based on member needs or acuity.

The SOW between Magellan and WDH requires that, “Activities of the QAPI program must include mechanisms to detect both underutilization and overutilization of service.” The SFY 2024 QAPI report includes a formal section titled, *Evaluation of Over/Under Utilization of Services*. The section documentation includes multiple ways the CME program monitored over/under utilization in SFY 2024. Monitoring included plan of care authorizations by the Clinical Department, provider documentation audits completed by the Quality Department, and monthly, quarterly, and annual Quality monitoring of service utilization results. Additionally, the CME SOW requires that all Family Care Coordinators have a minimum of two contacts per month with the member and family.

The current mechanisms for understanding over/under utilization appear to be provider-led and closely tied with alignment to the plans of care. However, the only quantified, reported value related to over/under utilization in the QAPI report was the percentage of Family Care Coordinators who met the minimum of at least two contacts with the member or designated caregiver or legal guardian per month. What does not appear to be currently assessed systematically by the Magellan team is how a member's acuity, diagnosed conditions, family circumstances, or other factors impact what their service utilization should look like as part of the CME program.

***Recommendation for Magellan:*** Magellan should expand their assessment of over/under utilization to include more quantifiable metrics and consideration of member acuity.

Magellan's current approach to review of over/under utilization is multifaceted, with several different mechanisms to consider service utilization in the context of provider written Plans of Care. However, what is absent from the over/under utilization analysis presented in the QAPI report is consideration of whether or not the prescribed services in the Plan of Care are appropriate for that specific member in the first place, taking into account their specific acuity, diagnosed conditions, family circumstances, or other factors. The EQRO team recognizes this assessment may be a part of the Quality Department's Plan of Care reviews; however, those review findings are not a part of the QAPI report and are not quantified in reported metrics for the CME program. As such, there is no presented assessment of the appropriateness of assigned services, and subsequent utilization. To build upon the current over/under utilization analysis in the QAPI report, consideration of services pursued based on member acuity would strengthen the overall understanding of utilization across the CME program. Furthermore, the EQRO team would recommend incorporating additional quantifiable metrics to all for concrete analysis and tracking of utilization over time.

***Needed Improvement:*** The Magellan team presented limited examples of program readiness to meet member special health care needs.

The Medicaid and CHIP Payment and Access Commission (MACPAC) identifies children and youth with special health care needs (CYSHCN) as having a wide range of health care needs, including physical, mental and behavioral conditions, and levels of limitations that require health and related services beyond that required by children generally.[7] By this definition, all CME program youth have special health care needs. However, in addition to mental and behavioral conditions, CME youth may also have physical conditions that should be taken into consideration when developing that youth's plan of care. Furthermore, the active Scope of Work for the Wyoming CME program states, "The Contractor must include mechanisms to assess the quality and appropriateness of care coordination furnished to enrollees with special health care needs."

In review of all documents transferred by the Magellan team, including the *Accessibility of Service and Care Policy*, the EQRO team found no reference to policy and/or procedures for providers to meet additional special health care needs for members.

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[7] MACPAC (August 2024). *Access in Brief: Children and Youth with Special Health Care Needs.* https://www.macpac.gov/publication/access-in-brief-children-and-youth-with-special-health-care-needs-2/#:~:text=Children%20and%20youth%20with%20special%20health%20care%20needs%20(CYSHCN)%20have,between%20CYSHCN%20and%20non%2DCYSHCN.

***Recommendation for Magellan:*** Magellan should establish explicit policy and procedures to address special health care needs of CME youth members, with specific resources and mechanisms for providers to offer additional support as needed within the CME program.

Magellan's current documentation does not acknowledge special health care needs, particularly outside of CME qualifying needs. To improve upon this gap, Magellan should develop specific policy and procedure for providers that establish expectations for meeting special health care needs for members. Once policy and procedures acknowledge the potential for special health care needs, the EQRO team would also recommend the Magellan team accompany this new documentation with specific resources and mechanisms for providers to ensure they are prepared to meet special health care needs that may be outside of qualifying diagnoses for the CME program.

## 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 2024 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 2024 SOW.
- Criteria outlined in CMS EQR Protocol 4 Guidelines

CMS updated the EQR Protocol 4 assessment process for the SFY 2023 assessment year. As noted in the SFY 2023 EQR Report, WDH and Magellan originally planned to adjust their network adequacy standards and reporting practices to align with the EQR Protocol 4 Assessment process for the SFY 2024 review. The updated Protocol 4 process follows a logical and stepwise process based on network adequacy standards and reporting practices that a state requires contracted managed care plans to adhere to.

- **Network Adequacy Standards** are quantitative parameters set by the state to establish expectations for managed care plan networks.
- **Network Adequacy Indicators** are quantitative metrics used to assess adherence to the standards required by the state.

The Protocol 4 worksheets start by listing and describing the state's network adequacy standards. Based on those standards, the following worksheets describe the related network adequacy indicators, the data sources for network adequacy measure reporting, network adequacy data concerns, and assessments for each individual indicator.

Magellan's network adequacy standards and indicators did not yet align with the guidelines put forth in CMS' updated Protocol 4. WDH's contract with Magellan largely relied on Magellan to self-monitor network adequacy and determine their own standards. As such, the elements required in the contract between WDH and Magellan states requirements such as "Magellan must develop a sufficient network of providers to ensure access to services and supports with all participants" without any specific indicators or descriptions of what defines adequate access. Further, Magellan did not report on measures that demonstrated compliance with some self-imposed standards and contractual requirements. Importantly, even where there were indicators specified, the indicators often did not line up directly with contractual requirements.

Guidehouse completed the Protocol 4 assessment with the updated guidelines, but Guidehouse used indicators and standards that did not cleanly align with the Protocol 4 assessment process. Guidehouse leveraged the indicators and standards available to demonstrate to WDH and Magellan areas for improvement necessary to bring network adequacy standards and measures in line with federal guidance.

Table 21 provides an overview of the validation scores and ratings Guidehouse determined for each of Magellan's Network Adequacy Indicators.

**Table** 21. Protocol 4 Network Adequacy Indicators Validation Scores and Ratings

| Network Adequacy Standard (from WDH-Magellan Contract) | Network Adequacy Indicator | Validation Score | Validation Rating |
|---|---|---|---|
| (PM 10-1 & PM 10-2) Magellan must develop a sufficient network of providers to ensure access to services and supports to all participants. | None in SOW – Determined by Magellan through caseload reviews and member service reviews weekly. | 11.8% | Low Confidence |
| (PM 10-4) Training shall be completed for each provider within ninety (90) calendar days of the start of the training for ninety-five percent (95%) of network providers. | Proportion of providers that complete trainings within 90 calendar days of the start of training. | 53.3% | Moderate Confidence |
| (PM 10-8) All network providers must be available during their defined business hours equal to those offered to commercial enrollees. | Manual reviews of "assigned hours" as they align with the working hours indicated in providers' Medicaid applications. | 25% | Low Confidence |
| (PM 10-11) Magellan must implement a regional approach to its provider network as approved by WDH. | 8 regions with associated counties and Geomaps with provider counts. | 41.3% | Low Confidence |
| (PM 10-13) Maximum caseload of 10 members for each Family Care Coordinator provider. | List of members and their assigned provider(s) (intended to demonstrate caseload ratios). | 11.8% | Low Confidence |
| (PM 10-13) Maximum caseload of 15 members for each Family Care Coordinator provider. | List of members and their assigned provider(s) (intended to demonstrate caseload ratios). | 11.8% | Low Confidence |
| (PM 10-13) Maximum caseload of 25 members for each Youth and Family Support Partner provider. | List of members and their assigned provider(s) (intended to demonstrate caseload ratios). | 11.8% | Low Confidence |

## Areas of Strength and Needed Improvement

As noted above, the contract between WDH and Magellan does not yet align with the network adequacy reporting system required in the EQR Protocol 4 assessment worksheets. WDH still delegates setting most network adequacy standards and reporting indicators to Magellan. The data sources Magellan provided also often lacked full context of the values provided or a lack of quantitative values to demonstrate compliance. As such, the strengths and recommendations below largely outline the foundational steps that WDH and Magellan should take to achieve a clear, standardized, and compliant network adequacy reporting and improvement structure.

***Strength:*** Magellan has made significant improvements in developing and documenting their targeted provider outreach and recruitment efforts.

During the SFY 2023 review, Magellan received recommendations that they improve their documented provider outreach and recruitment efforts and tie their identified network challenges to those recommendations. Magellan's SFY 2024 Network Development Plan expanded significantly upon the plan submitted during the previous EQR, examining potential time and distance standards, potential regional need for services based on Severe Emotional Disturbance (SED) prevalence in each region, and

physical provider locations. Magellan identified regions that may need a stronger provider network in the future. Magellan also outlined the barriers to recruiting providers and detailed their outreach and recruitment activities to address those barriers. As such, Magellan's Network Development Plan showed significant improvement from the previous evaluation year's documentation.

***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 weekly caseload reports do not clearly demonstrate compliance with provider caseload requirements.

Magellan's contract with WDH requires that Family Care Coordinators that have only completed "Tier 1 trainings" are limited to a client ratio of 1 provider per 10 members. Family Care Coordinators that have completed advanced "Tier 2 trainings" are limited to a greater client ratio of 1 provider per 15 members. It also requires that Youth and Family Support Partner providers are limited to a client ratio of 1 provider per 25 members.

Magellan noted that they assess provider caseloads through weekly meetings regarding members, their assigned providers, and provider caseload. Magellan also produces weekly caseload reports. However, the caseload reports:

- Do not define the type of service the provider delivers,
- Do not provide clear provider caseload ratios or any quantitative measures,
- Do not identify the level of training the providers have completed, and
- Feature duplication of providers' names with the same member while assigned to several agencies.

Magellan also did not provide any aggregate statistics regarding provider caseloads or caseload reports from periods beyond one week. As such, Magellan did not objectively demonstrate compliance with contractual caseload standards to WDH.

***Recommendation for Magellan:*** Incorporate caseload ratio calculations as regular measures reported to WDH to demonstrate compliance with contractual requirements.

Magellan's caseload report does not feature a quantitative measure to demonstrate provider caseloads at a glance. To demonstrate compliance with the caseload requirements in Magellan's contract with WDH, Magellan's caseload reports should demonstrate individual provider caseloads clearly as quantitative values. This will better demonstrate compliance with caseload standards to WDH through objective quantitative indicators properly evaluated through the EQR Protocol 4 review tool.

***Recommendation for Magellan:*** Develop aggregate caseload measures.

Magellan's caseload report would benefit from demonstrating compliance with general caseload requirements through aggregate caseload measures. Magellan can pull together caseload averages by provider type and training level to provide average caseload measures and compare those measures to the established standards.

***Recommendation for Magellan:*** Provide caseload measures for additional periods beyond weekly.

Currently, Magellan provides weekly caseload reports. Magellan would better demonstrate compliance by reporting additional caseload measures applied to average caseloads over additional periods such as monthly, quarterly, and/or annually.

***Recommendation for Magellan:*** Improve caseload report documentation to provide WDH with meaningful context.

Magellan's caseload reports would be improved by denoting the provider type, explaining why providers delivering services to one member are listed with that member several times as affiliates of different agencies, and the providers' training levels.

***Needed Improvement:*** WDH's contract with Magellan largely delegates network adequacy standard setting and reporting to Magellan instead of providing standards and reporting measures required by WDH.

WDH's contract does not require specific network adequacy indicators for Magellan to demonstrate network adequacy. It also does not detail the network adequacy standards that Magellan must adhere to. Rather, the contract states that "the provider network must be sufficient to provide adequate access to all services covered under the contractual agreement for all enrollees." It also states that "the Contractor's Network Management Plan must address this requirement, and any deficiencies related to provider network adequacy." As such, WDH does not have an enforceable set of network standards and reporting requirements to hold Magellan accountable to.

The updated EQR Protocol 4 assessment guidelines are built around network adequacy requirements set by the state. Magellan's network adequacy standards and reporting measures have historically been inconsistently set and measures to demonstrate compliance with those standards have been inconsistently reported to WDH.

***Recommendation for WDH:*** Develop formal and measurable network adequacy standards and indicators and incorporate them in WDH's contract with Magellan.

To consistently measure compliance and adhere to well-informed network adequacy standards, WDH can incorporate specific network adequacy standards and indicators into their contract with Magellan. This will also allow for direct compliance and quality assessments through EQR Protocol 4.

***Needed Improvement:*** Magellan and WDH do not have a definition or formal measures to determine what constitutes adequate access to services.

As noted previously, Magellan and WDH's contract delegates network adequacy standards and compliance to Magellan, requiring that the provider network provide sufficient access to services for members. However, Magellan does not provide a formal, objective description for what constitutes as adequate access to services. During on-site interviews, Magellan was also unable to define what adequate access to services looks like beyond noting that all members are paired with Family Care Coordinators and that member and family surveys did not note access to services as a grievance. The lack of a clear definition on how adequate access is defined and demonstrated creates challenges for WDH in determining that Magellan is compliant with their contractual requirement to provide access to services.

***Recommendation for WDH and Magellan:*** Detail what qualifies as adequate access to services in the contract between WDH and Magellan.

WDH and Magellan can work together to determine how adequate access can be defined in line with Magellan's administrative processes and professional understanding of network adequacy within WDH's program. Doing so would provide a foundation for WDH and Magellan to develop

network adequacy standards in their contract based on a clear definition for adequate access to services.

***Needed Improvement:*** Magellan does not have a process to define demand for services that inform network needs and goals.

Magellan was unable to provide clear analytic rationale for demand for services. As such, Magellan's network goals were not based on objective analyses and a clear description of why the network goals are necessary to meet the member population's needs. It is important that Magellan clearly determine the process through which it assesses demand for services to justify network goals and inform meaningful network adequacy standards and subsequent improvement efforts.

***Recommendation for Magellan:*** Develop a process and measures to assess and define current and potential members' demand for services / providers.

Magellan can develop an analytic process to determine what number of providers the current member population and the future member population may require to experience full access to services that meet their needs. Developing a clear and objective assessment of member demand will allow for clear goal setting and improvement efforts.

## Section VII. Conclusion

Guidehouse identified in its review of Wyoming's CME Program, 10 areas of strength, 14 areas of needed improvement, and 18 recommendations in relation to quality, timeliness, and access to services. Overall, major strengths of the CME Program include, but are not limited to:

- 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 PIP designs that create a clear, logical narrative regarding methods to improve the program.

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
- Developing robust, meaningful network adequacy standards, measures, and reporting requirements that speak to elements of the SOW between Magellan and WDH and align with the expectations outlined in the updated EQR Protocol 4 process.

While Magellan has made several improvements to the program, it is important to note that the first two needed areas of improvement noted above were also highlighted during the SFY 2023 EQR report.

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.