Wyoming Department of Health
Care Management Entity Program
SFYs 2021 – 2023 Independent Assessment

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Executive Summary

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

As required by CMS and in accordance with guidance to states for Section 1915(b) Waiver Program Independent Assessments, this report conveys the findings of the Independent Assessment (IA) of the access to, quality, and cost effectiveness of the CME Program as determined by Guidehouse Inc. (Guidehouse). This IA review is for services Magellan delivered for the CME Program in State Fiscal Years (SFYs) 2021, 2022, and 2023.

Based on a comprehensive review of submitted reports, data, and provider documentation from WDH and Magellan, as well as ongoing conversations with WDH and Magellan staff, Guidehouse identified multiple areas of strength in the CME Program. Strengths include robust community outreach activities, alignment between Magellan's data reporting practices and contractual responsibilities, and operating a cost-effective program during the measurement period.

Guidehouse also identified areas that needed improvement. To improve access to care and subsequent access improvement efforts, Magellan and WDH should collaborate to develop clearer access standards, measurements, and mechanisms to leverage reported data in access improvement activities. Magellan and WDH would also benefit from developing processes to tie quality reporting data to utilization management and strategic planning activities to continuously improve the program and the services delivered through it. Lastly, Magellan should work to standardize Plan of Care documentation to ensure high-quality service delivery across providers.

Section I. Introduction

Wyoming's Care Management Entity Program

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

waiver. Table 1 below quantifies the number of youths served in the CME Program since the program's inception.

Table 1. CME Enrollment[1]

Year	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
CME Youth Served	328	431	494	402	402	385	366	472

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

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

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

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

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

In August 2015, CMS approved WDH's application for a 1915(b) waiver to operate the CME Program as a PAHP (effective September 1, 2015), a risk-based managed care arrangement in which WDH paid Magellan a capitated per member per month (PMPM) amount to provide

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

covered services to eligible youth. The capitated payment methodology aimed to incentivize Magellan to meet specific outcome measures.

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

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

Figure 1. CME Implementation Timeline

July 2006	CMS approves WDH's 1915(c) waiver application.
February 2010	Wyoming is awarded a grant under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to support creation of a CME program for Medicaid and CHIP-enrolled children with serious behavioral health challenges.
June 2013	WDH implements a seven-county CME pilot program.
July 2015	Magellan begins statewide expansion of CME Program.
August 2015	CMS approves WDH's 1915(b) waiver application for the CME Program.
July 2018	CME Program shifts from capitated payment to FFS payment.
July 2024	CME approves WDH's latest 1915 (b)/(c) Waiver Renewal

Overview of the Independent Assessment

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

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

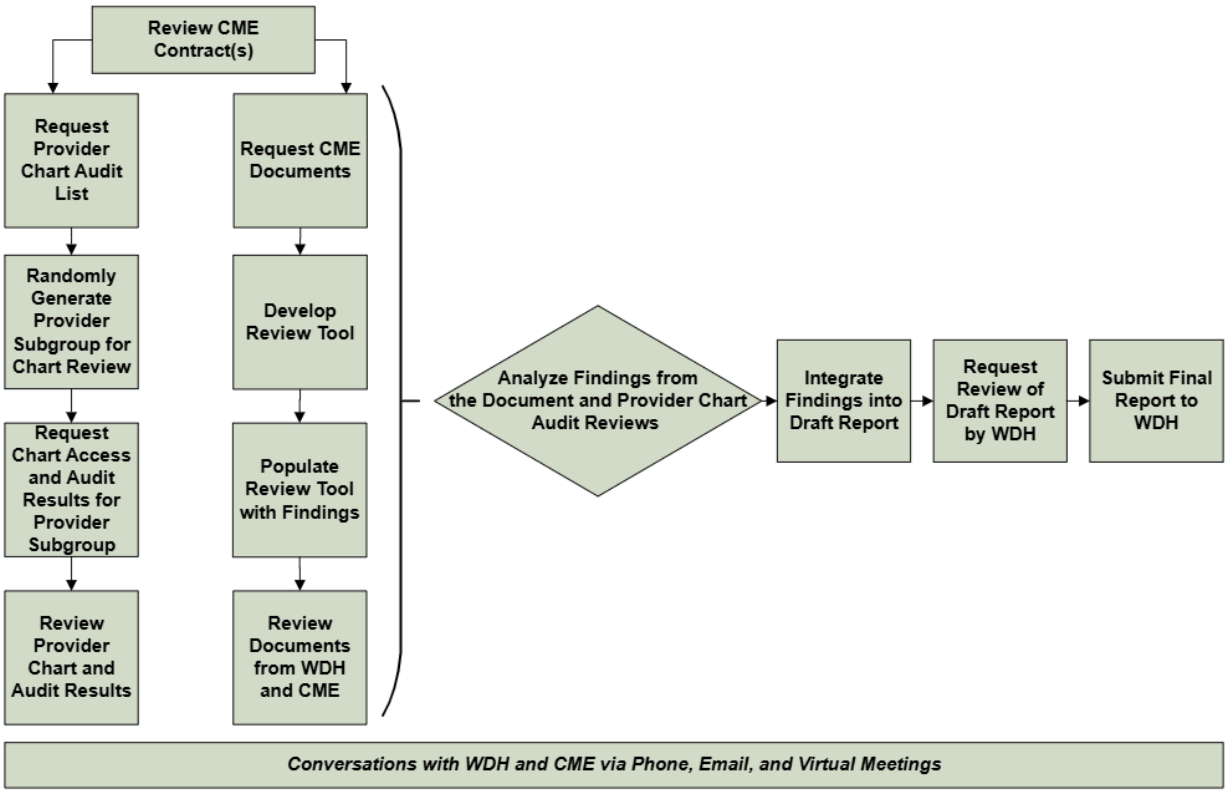
WDH contracted with Guidehouse Inc. (Guidehouse) as the entity to conduct the IA for SFY 2021 (July 1, 2020 to June 30, 2021), SFY 2022 (July 1, 2021 to June 30, 2022), and SFY 2023 (July 1, 2022 to June 30, 2023). The IA relies on discussions with WDH and Magellan staff, documentation provided by WDH and Magellan, and Guidehouse's industry experience working with health and human services agencies in 49 states and Washington, D.C. This report summarizes findings of the IA and provides related recommendations to improve access to care, quality of care, and cost effectiveness of the CME Program.

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

Section II. Methodology

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

Figure 2. Key Assessment Steps



CMS suggests that states incorporate the IA report and recommendations as tools to improve the waiver program. Determining areas applicable for the IA required mapping relevant language from the effective statement of work (SOW) between WDH and Magellan for SFYs 2021 - 2023 to the key elements for review designated by CMS guidance. Guidehouse identified the SOW sections which operationalized the relevant federal recommendations, then requested and reviewed relevant documentation effective in SFYs 2021 - 2023 including, but not limited to, the following:

- Magellan corporate policies and procedures (and, where different, Magellan of Wyoming policies and procedures) related to access to care, quality of care, and cost effectiveness
- Enrollee and provider handbooks
- Outreach and marketing templates and materials
- Quarterly reports to WDH
- Applications for enrollee and provider enrollment with the CME Program

- Geographic information on enrollee residences and provider service areas
- Provider agreements for individual and agency providers
- Training rosters and presentations for providers
- Wyoming Administrative Rules

Guidehouse reviewed all submitted documents in accordance with CMS's suggested elements. Guidehouse also reviewed findings from past External Quality Review (EQR) Technical Reports and communications from CMS for the assessment. However, given the non-clinical nature of the CME Program, there were several assessment elements that are not applicable to this program and not included in this review because they are not covered benefits (see Appendix B). WDH verified all applicable elements prior to review of documents and completion of the review tool for each area of assessment included in Appendix B.

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

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

Guidehouse also considered Magellan's provider documentation and provider documentation review process as part of the SFY 2024 Independent Assessment. The Guidehouse team reviewed Magellan's documentation audits for 15 providers, conducted in SFY 2021, SFY 2022, and SFY 2023. Through this process, the Guidehouse team reviewed a total of 42 member charts. Thirteen provider document sets were reviewed via access to Magellan's electronic health record system, Fidelity EHR. The Guidehouse team reviewed the remaining two provider document sets via document transfer because the documentation was completed prior to Magellan's transition to Fidelity EHR. Throughout the review process, protected health information (PHI) was exchanged between parties with the appropriate precautions. The review of provider documentation and Magellan audit processes informed the overall evaluation of quality of services for the SFY 2024 Independent Assessment.

Section III. Access to Care

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

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

Table 2. Elements for Evaluating Access

Topic	Summary of Findings	Evaluation
1. Evaluation of the State Program's Access Monitoring and Analysis		
Service Delivery in Amount, Duration, and Scope	*The SOW, Member Handbook, and Provider Manual clearly describe the services provided by the CME Program. The documents also describe services available to enrollees when they need to access service after normal business hours.*	Fully Met
2. Enrollment Information		
Materials	*Distributed materials are understandable, regularly updated, and provided to enrollees in a timely manner. Translation and accessibility services are available to all enrollees. The materials submitted by Magellan for review did not detail a process through which distributed materials are submitted to WDH for review and approval.*	Partially Met
Enrollment	*The CME Program enrollment process begins with client referrals and includes contacting a potential enrollee's guardian, provider selection, and completing a Plan of Care (POC). While Magellan's reporting practices align with their contract with WDH, they do not tie closely to the standards put forth by CMS.*	Fully Met
Disenrollment and Transition of Care	*The goal of the CME Program is to transition youth from the program to a lower level of care. Additionally, the CME Program operates under "Family Voice and Choice" allowing enrollees to*	Partially Met

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

Topic	Summary of Findings	Evaluation
	disenroll from the program at any time for any reason. The process to disenroll youth was clearly demonstrated via program policies. Disenrollment rates and data were not included in reports to WDH with necessary context to frame raw disenrollment values.	
3. Education and Customer Service Information		
Outreach Plan	*Magellan communicates with enrollees and providers via emailed newsletters, the CME Program website, and social media. Magellan regularly tracks engagement with the communication material through email open rates, site clicks, and social media reports.*	Fully Met
Comprehension of Program	*The Enrollee Handbook and Provider Manual contain clear descriptions of the CME Program. The documents include definitions of the services and providers available through the program, and a description of HFWA and what to expect from the program. The documents do not include a discussion of the full scope of services available to members and service authorization requirements, as required in Magellan's contract with WDH.*	Partially Met
Beneficiary Hotline	*Magellan operates a toll-free phone line that enrollees can call twenty-four (24) hours a day, seven (7) days a week. Magellan reports hotline data to the State on a quarterly basis.*	Fully Met
4. Provider Capacity		
Provider Network and Provider-to-Beneficiary Ratios	*Magellan maintained a constant number of FCC and FSP providers across the State and maintained the FCC and FSP provider-to-beneficiary ratios set by Wyoming in the SOW. Magellan, however, has very few YSPs and Respite providers, but is taking steps to recruit more providers. The CME Program does not include a provider-to-beneficiary ratio for respite providers or YSPs. Magellan also does not include provider-to-beneficiary ratios in their network development documentation and did not submit materials that demonstrated monitoring of their established time and distance standards.*	Partially Met
5. Urgent / Emergent Care		
Availability of Care	*CME Program enrollees have access to a telephonic hotline twenty-four (24) hours a day,*	Not Met

Topic	Summary of Findings	Evaluation
	seven (7) days a week. Enrollees are informed of their access to the hotline in the Enrollee Handbook. Magellan's policies do not, however, clearly ensure member access to telephonic crisis intervention services through the hotline as required by Magellan's contract with WDH.	

Areas of Strength and Needed Improvement

Guidehouse initiated the evaluation process through an initial desk review of documents including the EQR Technical Reports and annual evaluation materials. Guidehouse then requested multiple document transfers aligned with the recommended assessment focuses by CMS in the State Medicaid Director letter and related elements in Magellan's contract with WDH.

Guidehouse evaluated Magellan's adherence to contractual provisions and assessment focuses through their desk reviews and follow up document reviews. There were some areas in which Magellan did not supply Guidehouse with all requested documents needed to complete Guidehouse's review such as provider caseload reports, quarterly reports to WDH, and marketing material development policies. Guidehouse completed the assessment with the documents submitted by Magellan and documents submitted for previous years' EQRs.

Notable areas of strength and needed improvement identified through the assessment are outlined below.

Enrollment Information

Strength: Magellan has well established policies for provider directory and data maintenance that encourage timely updates to the member-accessible provider directory following any changes to a provider's location, contact information, or enrollment status in the program.

Magellan's submitted policies and procedures outlined a provider directory and data maintenance process that called for expeditious provider information updates. Their policy requires that Magellan update the directory within two days of receiving any new information from providers. Providers are contractually required to send any changes to information to Magellan within ten business days of the change occurring.

Strength: WDH has developed an effective method to internally track disenrollments, reasons for disenrollments, and progress towards program goals based on Magellan's disenrollment reports.

Magellan's policies outline an effective and timely process of immediately communicating any member disenrollments to WDH. Magellan immediately uploads disenrollment letters to a virtual WDH inbox. Through this system, WDH and Magellan effectively collaborate to monitor disenrollment trends and identify further refinement of program goals based on demonstrated needs.

Needed Improvement: The disenrollment data Magellan sends to WDH through quarterly reports does not include full context to determine disenrollment rates. Magellan's contract with WDH also does not require data measures to demonstrate average time from member enrollment to receipt of services.

CMS' Independent Assessment criteria specifically request information regarding managed care plans' disenrollment rates. It requests information that show both voluntary and involuntary disenrollment. While Magellan does collect total disenrollment data, Magellan's contract with WDH does not require enrollment context or additional measures to demonstrate disenrollment rates.

Similarly, Magellan's contract does not require that Magellan report on the time from enrollment to service delivery. As such, Magellan's quarterly reports to WDH do not feature a data measure to answer the CMS Independent Assessment question "what is the average time between enrollment and ability to get care."

> ***Recommendation for WDH:*** Work with Magellan to introduce additional data elements into their contract for the High-Fidelity Wraparound program that closely align with CMS standards.
>
> WDH would benefit from requiring that Magellan report data measures on voluntary disenrollment rates, involuntary disenrollment rates, total disenrollment rates, and the average time between enrollment and service delivery. These measures may be required in the quarterly reports Magellan provides to WDH.

Needed Improvement: The materials submitted by Magellan did not feature any description of Magellan's process and / or policy in receiving approval from WDH prior to releasing any marketing materials.

Magellan's contract with WDH requires that Magellan "submit all marketing, including plans and materials, to the Agency for review before release." While WDH reported that Magellan does send WDH materials for approval, this process is not documented in the materials Magellan provided for the Independent Assessment.

> ***Recommendation for Magellan:*** Update the "Medicaid Enrollee Communication and Information Requirements" document (or another appropriate policy document) to reflect Magellan's policy / procedure for acquiring WDH approval for marketing materials.
>
> Magellan would benefit from formally documenting the process WDH confirmed they undergo to receive approval for marketing materials.

Education and Customer Service

Strength: WDH and Magellan have effectively collaborated to increase and improve outreach efforts to unenrolled providers, tribal communities, and students to create new avenues for growth in enrollment and provider networks.

WDH and Magellan have taken a targeted approach to reaching out to communities that may include individuals eligible for enrollment in the HFWA program. They are also working to connect with tribal communities to improve not only member enrollment, but also provider

enrollment to offer American Indian / Alaskan Native (AI / AN) members the option of receiving services from tribal providers. Lastly, WDH and Magellan are coordinating with the Wyoming Department of Education to connect with students and increase awareness of the HFWA program. Their intention is that this targeted outreach and collaboration will result in improved uptake by students eligible to enroll in the program.

Needed Improvement: Magellan's member handbook does not include a detailed description of member benefits, the scope of members' benefits, or the service authorization requirements / process.

Magellan's contracts with WDH states that "the Contractor's enrollee handbook must include information regarding the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled and the procedures for obtaining such benefits, including requirements for service authorizations." This contract provision is intended to promote transparency for members and their representatives regarding the services they are entitled to as HFWA program members and outline the service authorization requirements required to then receive those services.

Magellan has previously noted that thorough information on benefits and service authorizations are not included in the handbook due to the potential confusion that this information could create for members and their representatives. Magellan has noted that this information is available to all members and their representatives by contacting Magellan staff.

> ***Recommendation for Magellan:*** Include a description of the service authorization process and member benefits in the member handbook.
>
> While it is understandable that Magellan intends to limit misunderstandings by including technical information in the member handbook, members and their representatives may also benefit from this information being readily accessible to them without needing to contact a third party. Additionally, excluding such information from the member handbook does not satisfy the requirements and intentions outlined in Magellan's contract with WDH. Members may benefit from a simplified overview of the services to which they are entitled accompanied with the authorization requirements for each service in their member handbooks. This overview would be most useful if written in plain language while still holding adequate detail for members and their representatives to fully understand the scope and components of available services.

Provider Capacity

Needed Improvement: The documentation Magellan submitted for review did not demonstrate any clear progress in reaching goals for or monitoring access to services beyond the Family Care Coordinator service.

During the SFY 2023 EQR and the previous Independent Assessment, the assessors found that Magellan's provider network did not allow for comprehensive access to services such as Youth Support Partners, Family Support Partners, and Respite. The previous assessments recommended that Magellan consider the number of non-FCC providers in the program and whether the service should continue to be provided based on Magellan's ability to expand its provider network.

Magellan's contract with WDH states that "The Contractor must submit documentation to the Agency demonstrating that the Contractor offers an appropriate range of services that is adequate for the anticipated number of enrollees and maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the enrollees in the service area…" While Magellan submits geomaps that includes the number of each provider types enrolled in the program, Magellan does not feature clear network goals or development plans for non-FCC services.

> ***Recommendation for Magellan:*** Clearly define network goals, standards, and development plans for Youth Support Partners, Family Support Partners, and Respite in Magellan's documentation such as the Network Adequacy Framework and / or Network Development Plan.

Despite ongoing efforts, Magellan has not been able to secure a sufficient network of YSPs and Respite providers to fully serve program enrollees. It is unclear whether the lack of providers impacts the program's ability to provide services to enrolled youth. WDH and Magellan should collaborate and evaluate whether the lack of YSPs negatively impacts program enrollee. Further, Magellan would benefit from clearly outlining goals, standards, and network development plans for non-FCC services in their internal documentation.

Needed Improvement: Magellan's Network Development Plan does not reference the measures and requirements outlined in Magellan's contract with WDH.

Magellan's contract with WDH defines FCC to member ratio standards as 1:10 for FCCs and 1:15 for FCCs that have completed tier 2 trainings. It also defines the FSP to member caseload ratio standard as 1:25. Magellan's Network Development Plan and Network Adequacy Framework do not include any discussion of these provider to member ratios. Magellan also did not submit the requested documentation for the assessment demonstrating provider caseloads and adherence to its contractual caseload requirements established with WDH.

> ***Recommendation for Magellan:*** Build contractually required caseload standards for FCCs and FSPs into documentation on network adequacy monitoring and network development initiatives.

Magellan would benefit from aligning their network development documentation and planning with the standards agreed upon by WDH and reflected in their contract. This would clarify network goals and progress towards meeting those goals while establishing consistency in the manner through which Magellan approaches network maintenance and improvement.

Needed Improvement: Magellan defines time and distance standards for access to services, but Magellan does not provide data in their reports to reflect adherence to those standards or progress towards meeting those standards.

While Magellan's contract with WDH does not outline explicit time and distance standards, Magellan has focused their Network Adequacy Framework and Network Development Plan on a time and distance standard of a provider located within 10 miles of a member living in an urban location and 50 miles from a member living in a rural / frontier location. The distance between

providers and members is not reported in Magellan's quarterly reports to DMS or their submitted geomaps.

> ***Recommendation for Magellan:*** Monitor and report on adherence to time and distance standards for all providers.

To better collaborate with WDH in shaping network adequacy standards and goals, Magellan may benefit from demonstrating their monitoring activities in reaching their time and distance standards. Since Magellan's documentation reflects a shift towards relying on time and distance standards as a primary measure for network adequacy, Magellan and WDH may benefit from Magellan closely monitoring time and distance requirements within the program and shaping network development activities around those standards.

Urgent / Emergent Care

Needed Improvement: Magellan's Accessibility of Service and Care Policy does not align with the contractual requirements for telephonic crisis intervention access as outlined in Magellan's contract with WDH.

Magellan's contract with WDH requires that Magellan have staff available 24 hours a day, 365 days a year to respond to member calls. The contract states that "calls may range from non-urgent requests for referral to behavioral health crises" and that the telephone hotline "shall include telephone crisis intervention, risk assessment, and consultation to callers." However, Magellan's Accessibility of Service and Care Policy notes that staff are intended to refer members instead to 911 and other emergency services if members are in crisis. The policy also notes that "non-life-threatening callers may be routed to Care Managers for de-escalation and connection to the youth and guardian's Family Care Coordinator." It does not guarantee access to the telephone crisis intervention services required by Magellan's contract with WDH.

> ***Recommendation for Magellan:*** Ensure that Magellan staff answering member calls are trained to provide crisis intervention services beyond referring members to external resources.

To remain compliant with their contract with WDH, Magellan should train all member hotline staff to provide behavioral health crisis intervention in the event that a member was to call the hotline in crisis. Hotline staff may still refer members to emergency services and work with a member's FCC, but they should also provide crisis intervention services themselves. If hotline staff are trained in crisis intervention and expected to provide such services, Magellan would benefit from updating their documentation and policies to more closely align with contract language and clearly describe member access to telephonic crisis intervention.

Section IV. Quality of Care

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

Table 3. Elements for Evaluating Quality

Topic	Summary of Findings	Evaluation
1. Evaluation of the State Program's Quality Monitoring Elements		
Standards of Care	*Magellan's quality, timeliness, and access to services are outlined in policy standards and assessed on a quarterly and annual basis in a systematic manner.*	Fully Met
Sanctions	*WDH did not impose penalties or sanctions during this review timeframe.*	Fully Met
Information Systems	*Magellan transitioned to Fidelity Electronic Health Record on 1/1/2021. Magellan's information system provides information on areas including denials of referrals, authorization requests; utilization; claims; enrollee and provider grievances, complaints, and appeals; and disenrollment for reasons other than loss of Medicaid eligibility including disenrollment requests made by an enrollee.*	Fully Met
2. Clinical Review of Utilization Patterns		
Patterns for Select Beneficiaries	*Magellan's enrollee and provider demographic data is included at a baseline level in the annual Quality Program Evaluations. Additional analysis and program alignment with cultural competence not detailed in quality plans.*	Fully Met
Improving Utilization Patterns	*Magellan submits enrollment and utilization data to WDH in the form of quarterly and annual reports. WDH and Magellan have joint meetings to collaborate on program improvement and action items.*	Partially Met
3. Grievances and Appeals		
Grievance Process	*Magellan's policies outline baseline compliance with 42 CFR 438.400 and 438.424 and provide processes for filing grievances, monitoring notices of grievances and dispositions, tracking turnaround times, and defining enrollees' rights in the grievance process.*	Fully Met
Comprehension of Grievance Process	*Enrollee and provider handbooks describe Magellan's grievance process including enrollees' rights to file a grievance, what can be included and how to file, turnaround times, appeal information and rights, timing of appeals and*	Fully Met

Topic	Summary of Findings	Evaluation
	timeframes for resolution, rights to a fair hearing, and continuation of services during the process.	
4. Beneficiary, Provider, and Subcontractor Satisfaction		
General Satisfaction	*Magellan complies with annual enrollee and provider survey requirements. Magellan submits the survey results to WDH. Magellan can more fully meet satisfaction standards by improving upon explicit communication of a member's right to request a change in provider.*	Fully Met
Involvement in Quality Activities	*Magellan submits annual Quality Work Plans and evaluations to WDH. Consumer, family member and provider input are garnered through the Quality Improvement Committee, annual member and provider satisfaction surveys, grievance processes, monthly provider calls, and provider quarterly listening sessions.*	Fully Met
5. State Quality Improvement Measures		
Quality Improvement Plan	*Magellan submits annual CME Quality Program Evaluation reports and annual Quality Work Plans to WDH. WDH and Magellan meet weekly to address quality and any concerns reported by providers. The quality plans did not change over the three-year period.*	Partially Met

Areas of Strength and Needed Improvement

Guidehouse initiated the evaluation process through a desk review of documents including the EQR Technical Reports and annual evaluation materials. Guidehouse then requested multiple document transfers aligned with the recommended assessment focuses by CMS in the State Medicaid Director letter. In response to the Guidehouse document request, Magellan transferred 599 documents organized to the evaluation criteria.

In review of Quality of Care documents, there were several document repetitions, multiple unsubmitted prompts, and differences in documents transferred for each of the three years. At the same time, there are core documents that drive quality standards and activities for the WY CME program across SFY 2021-2023, which largely drive the findings of this evaluation.

Evaluation of the State Program's Quality Monitoring Elements

Strength: Magellan has established policy and procedures for systematic quarterly and annual review and collection of quality metrics that are consistent across SFY 2021-2023.

As part of the evaluation process, Magellan submitted policies and procedures for all key quality activities and oversight. These documents align with the contracted scope of work and provide the roadmap for the key quality activities pursued on an annual basis. Magellan clearly maintains standards and objectives to launch efforts related to program quality.

Strength: Magellan provides annual and quarterly reports to WDH that include all contractually obligated data collection, and additional data points, for the State to consider and use to inform quality activities.

Magellan systematically provides WDH with quarterly and annual reports with consideration to key quality metrics, including but not limited to, denials of referrals, requests, utilization claims, enrollee and provider grievances, and demographic information. For SFY 2023, quarterly reports demonstrate further thematic breakdown, with quarterly reports provided to the State on Enrollee Management, General Operations, C Waiver General Operations, and Provider Management.

The data included and regular delivery of quarterly and annual reports provide a strong information base for considering the quality of care provided as part of the CME program. Moving forward, these reports are a useful foundation for driving quality projects and oversight in the upcoming years.

Needed Improvement: Magellan reports population and demographic data to the State on annual basis, but there is no documented evidence that Magellan, or the State, apply this data for utilization management or strategic planning.

As previously discussed, Magellan provides WDH with incremental utilization measures, such as enrollee numbers and member and provider demographic data, including gender, age, and race/ethnicity. However, accompanying analytics of overutilization and underutilization, trends in member enrollment, and overall quality program adjustments based on these metrics are not evident in the documentation provided.

> ***Recommendation for Magellan:*** Magellan and the State should partner to establish a systematic process for examining program utilization and service provision to specific populations.

Recognizing that Magellan and WDH have weekly meetings to discuss quarterly and annual reports, Guidehouse recommends that Magellan and WDH document conversations and decisions made based on utilization-related metrics. Currently, the data provided largely stands alone based on provided documentation, rather than accompanying clear program planning and quality efforts aligned with population measures.

Needed Improvement: Over SFY 2021-2023, Magellan's Quality Improvement Work Plans remain largely the same, with limited evidence of Quality of Care analysis or adjustment in coordination with program goals.

A key finding across the Quality of Care document review, was quality activities, planning, and program standards remained almost exactly the same across the three years reviewed, SFY 2021-2023. The programs appear to follow central focus areas, but do not appear to adjust significantly based on data collected, utilization, or special population needs. As such, it is a recommendation at this stage in the WY CME program that annual Quality Work Plans are expanded to address program challenges, special population needs, and State goals.

Recommendation for Magellan: Magellan should expand its Annual Quality Work Plan and activities to tailor to current program needs more accurately and align with data findings.

At this stage in the WY CME Program maturation, there is an opportunity to expand upon quality work planning to align with the current program priorities and areas more accurately for improvement. Additionally, the Quality Work Plans could connect more directly to the data findings from the previous year to inform quality efforts to reflect current programmatic needs more accurately.

Needed Improvement: Magellan submitted partial or incomplete documentation for multiple Independent Assessment criteria, requiring the evaluation team to search previously submitted documents from past annual evaluations to fill in gaps.

Recommendation for Magellan: Magellan should develop a standardized system for maintaining documentation to met annual and multi-year evaluations with more complete readiness.

Section V. Provider Documentation Review

The Independent Assessment provides an opportunity for state-specific review activities to further examine the quality of provided services. For the SFY 2024 Independent Assessment, the Wyoming Department of Health selected to add a review of Magellan's provider documentation audit process for the Wyoming Care Management Entity (CME). The following section presents the methodology for the provider documentation audit process and key review findings, including areas of strength and needed improvement.

Methodology

Magellan of Wyoming CME Documentation Audit Methodology

Magellan maintains a formal audit procedure for Wyoming CME provider documentation review. The purpose of the audit procedure is to:

- Establish a standard process for collecting data for the evaluation of the quality of services delivered as part of the High-Fidelity Wraparound program.
- Provide relevant feedback to providers on documentation standards.
- Monitor provider compliance with Medicaid waiver assurance performance measures.
- Verify that record keeping practices meet Magellan standards.
- Investigate quality concerns and reported deficiencies of providers.
- Investigate grievances related to the services of providers.
- Meet the specific requirements of the Wyoming Department of Health Statement of Work.

To select providers for documentation review, the Magellan Clinical Analytics department compiles a list of providers, specifically Family Care Coordinators, with paid claims information using the Wyoming Cognos system. The Clinical Analytics Department provides this list to the Quality Department upon request and on a quarterly basis. The Quality Director removes from the list any providers audited in the previous year and confirms all remaining providers are in Magellan's network. The Quality Director then reviews the list of claims and chooses up to three cases for each provider to assess in the quarterly audit. Following the audit, written reports are

sent to the providers containing the results, including strengths and opportunities for improvement noted by the reviewer. Table 4, below, lists the number of providers audited following this process in SFY 2021, SFY 2022, and SFY 2023.

Table 4. Magellan of Wyoming CME Provider Documentation Audits

Year	Number of Providers Audited by Magellan of Wyoming CME
SFY 2021	10
SFY 2022	19
SFY 2023	44

Magellan's Quality team reviews all submitted provider documentation using a standard audit tool titled the *Treatment Record Review Tool*. For each provider chart audited, a reviewer completes this document, with the opportunity to mark "met", "partially met", or "not met" and include any feedback notes. To mirror Magellan's review process, the Guidehouse team used the same tool to review each chart for completeness and quality. Table 5, below, outlines the documentation sections included in the *Treatment Record Review Tool*. The full *Treatment Record Review Tool* template can be found under Appendix C.

Table 5. Magellan Health Services – Treatment Record Review Tool, Wyoming CME

Treatment Record Review Tool Sections
A. Application Packet
B. Orientation of Child and Family to CME during the Application Process
C. Strengths, Needs, and Culture Discovery
D. Child and Family Team Meeting-CFT
E. Plan of Care
F. Omit this item from scoring results, Authorization WY Clinical responsible for this item
G. Crisis/Safety Plan
H. Contact Notes
I. Assessments
J. Transition OOH
K. Discharge or Transition Planning
L. Coordination of Care
M. As Needed Documentation

Guidehouse Wyoming CME Documentation Audit Review Methodology

As previously described, to replicate Magellan's documentation review process for the Wyoming CME program, the Guidehouse team followed Magellan's procedures and audit tool for a random subgroup of providers audited in SFY 2021, SFY 2022, and SFY 2023.

To select providers for review, the Guidehouse team requested the full list of Wyoming CME providers audited by Magellan across all three fiscal years. The Guidehouse team then used Microsoft Excel random selection to choose a subgroup of providers for each fiscal year proportional to the provider audits completed. Table 6, below, provides the number of Guidehouse reviewed provider audits for SFY 2021, SFY 2022, and SFY 2023 for the Wyoming CME Independent Assessment.

Table 6. Guidehouse Reviewed Magellan of Wyoming CME Provider Documentation Audits

Year	Number of Provider Audits Reviewed by Guidehouse Team
SFY 2021	2
SFY 2022	5
SFY 2023	8
Total	15

Wyoming CME Documentation Audit Review Considerations

To complete the review of Magellan's provider documentation audits, the Guidehouse team was granted full access to each selected member chart previously audited in Magellan's electronic health record system, Fidelity EHR. Throughout the provider documentation review process, the Magellan team, the Guidehouse team, and the Wyoming Department of Health maintained appropriate safeguards regarding all necessary parties accessing and exchanging protected health information (PHI).

The Guidehouse team aimed to replicate the Magellan procedure for provider documentation review for SFY 2021, SFY 2022, and SFY 2023 as closely as possible. However, as external auditors there are limitations to this review. One limitation of this review is the Guidehouse team did not review provider claims as part of documentation audit review. As such, The Guidehouse team could not assess the alignment of documentation with claims billed by providers. Claims are filed in a separate system than that used for this review, Fidelity EHR.

Additionally, Magellan of Wyoming CME transitioned to Fidelity EHR during the provider documentation review period. As such, two provider documentation sets audited from SFY 2021 were reviewed via document transfer from the Magellan team to the Guidehouse team, because the charts were completed prior to the transition to Fidelity EHR. While Guidehouse reviewed relevant documentation for each audit category, reviewing selected documents rather than the member chart as a whole altered the review process.

Despite these limitations, the Guidehouse team's total review of 15 providers and 42 member charts across all three fiscal years served as a useful representation of Wyoming CME documentation and Magellan's current audit system for quality oversight.

Areas of Strength and Needed Improvement

Across the Guidehouse team's review of 42 member charts completed by 15 total providers across three state fiscal years, patterns in documentation arose that may inform future documentation review processes and quality improvement efforts for Magellan Wyoming CME providers.

Strength: Across reviewed provider documentation, contact notes were frequent, detailed, and considerate of members' needs and family circumstances.

All charts reviewed for the SFY 2024 Independent Assessment included contact notes that are detailed and relevant to each member's goals as a part of the High-Fidelity Wraparound Program. Contact notes reflect regular provider engagement with the member and the member's family, including thorough description of engagement techniques and activities

pursued on behalf of the program. Across the charts reviewed, the provider contact notes showed the most specificity and completeness across all documentation sections.

Strength: Documentation of team meetings is consistent across providers, and the team meetings demonstrate collaboration among professionals and with families to support member goals.

Team meetings were regularly documented across reviewed member charts, demonstrating attentiveness to family priorities, strength-based communication, and inclusivity. In most reviewed documentation, team members involved multiple professionals for alignment of support and services for High Fidelity Wraparound members.

Strength: After identifying gaps in documentation in SFY 2021, provider documentation showed improvement in SFY 2022 and SFY 2023, suggesting Magellan has used the documentation audit process to improve documentation quality standards for Wyoming CME.

For the SFY 2024 Independent Assessment, the Guidehouse team considered provider documentation and accompanying audits from SFY 2021, SFY 2022, and SFY 2023. As the years progressed, provider documentation improved in thoroughness and content details, particularly in the Plan of Care. While comparing different provider documentation inherently demonstrates variation, the consistent improvement and movement towards standardization demonstrates attention to documentation review and the audit process as it pertains to quality improvement.

Needed Improvement: The Plan of Care documentation, including Crisis Plans, shows significant variety in content, length, and quality across providers. Crisis planning documentation, and more specifically safety planning with consideration of suicidal and homicidal risks, appears to be largely at provider discretion without program-wide uniformity in safety planning.

The Plan of Care is the guiding documentation for a member's chart and planned activities for High Fidelity Wraparound services. As such, this section of documentation contains a significant amount of information regarding the member's history and needs, including a plan for crisis events. Reviewing the charts from SFY 2021 – SFY 2023 revealed significant differences in approach, detail, and quality across Plans of Care, especially in the Crisis Plan sections.

Of note, the most significant discrepancies in documentation were identified in SFY 2021 charts, with improvement noted in SFY 2022 and SFY 2023 charts. However, some discrepancies in Plan of Care and Crisis Plan documentation persisted. For example, across reviewed Plans of Care, many providers did not document barriers or natural supports consistently for members. For Crisis Plans, the level of detail and planning varied significantly across providers, including the inclusion of external safety supports.

Additionally, in documentation review, it appears to be at the discretion of the provider if suicidal and homicidal risk was relevant to crisis planning, which could result in the omission of key safety considerations. For example, in SFY 2021, there were two charts where crisis documentation did not include consideration of suicidal risk, but critical incidents involving suicidal ideation were then documented within the year.

Recommendations for Magellan: Magellan should further standardize Plan of Care documentation through more specific guidelines for documentation requirements, with particular attention to improving the standards for the Crisis Plan section.

Creating more specific standards for the Plan of Care format, Plan of Care level of detail, and the Crisis Plan, particularly safety plans, could result in more uniform documentation and quality standards for the Wyoming CME program. Safety planning standards, including when suicidal and homicidal risk must be addressed in documentation, should be thorough, explicit, and reflect provider attention to family and member safety needs to address this critical component of each Crisis Plan.

Needed Improvement: 5 providers out of the 15 providers considered for this review received notification that they had documentation missing or misaligned from bills filed.

As previously noted, the Guidehouse team review of Magellan's provider documentation audits from SFY 2021 – SFY 2023 did not include a review of provider claims. However, the Guidehouse team was able to review the provider audit result letters, which listed identified strengths and challenges in documentation, including billing and charting discrepancies.

Recommendations for Magellan: Magellan could implement a provider-wide training or educational program on billing and documentation alignment to minimize events of misalignment.

Reviewing provider documentation audit result letters revealed that a third of providers had discrepancies between services billed and services documented. The frequency of these occurrences suggest that Magellan providers may benefit from a review of documentation and billing standards in the form of a formal training or educational communication.

Needed Improvement: The current Magellan documentation audit tool is a checklist, filled out by reviewers with minimal notes and a succinct follow-up letter. This format results in limited constructive feedback given directly to providers at the end of the documentation review process.

While Magellan's current documentation review process yielded positive quality improvement from SFY 2021 through SFY 2023, the audit checklist format could be expanded for further positive impact. Across all three reviewed fiscal years, the completed audit tools include only a few notes regarding completion status and the accompanying provider feedback letters were often succinct, with only a few bullets of feedback.

Recommendations for Magellan: Magellan could expand the provider documentation audit tool to create additional sections for further content and service provision feedback to drive further quality progress through the audit process.

Rather than only focusing on completion of given documentation items, an enhanced focus on documentation thoroughness, uniformity, and attention to safety planning could progress quality goals. To accompany this approach, provider feedback should be expanded to offer further constructive notes for providers to apply to their documentation moving forward.

Section VI. Cost Effectiveness

Guidehouse's actuarial team reviewed WDH's 1915(b) waiver application and associated cost effectiveness submissions, financial reporting, quarterly cost effectiveness regional office submissions to CMS, and CMS-64 reporting to validate WDH's determination of cost effectiveness for its 1915(b) waiver program for SFYs 2021, 2022, and 2023. This technical review involved validating the base data used against CMS-64 reports and regional office submissions. Per CMS guidance, the total costs of the waiver, including program service costs and administrative costs, must not be greater than the cost of providing like services without a waiver.

At the direction of WDH, Guidehouse conducted a comparison of expenditures for services under the waiver, including administrative costs. By comparing actual costs by period and quarter against what was estimated in the waiver submissions for SFYs 2021 – 2023, Guidehouse determined that actual expenditures were less than what was initially projected, both in aggregate and in per member per month (PMPM) costs, as shown in Table 7. *Furthermore, the program was cost effective for every quarter for these three state fiscal years.* Please note that in the table, "P1" represents SFY 2021, "P2" represents SFY 2022, and "P3" represents SFY 2023.

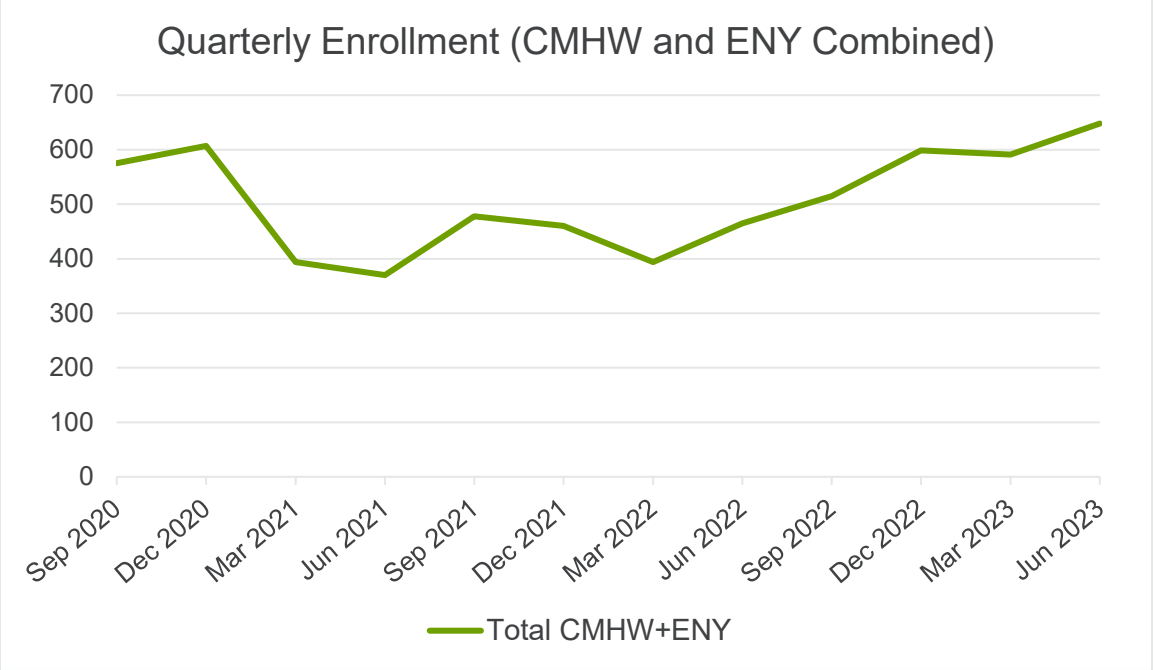
Table 7. Comparison of Projected Versus Actual Waiver Expenditures

	Projected			Actual			Difference		
	MMs (Member Months)	Total Cost	PMPM Costs	MMs	Total Cost	PMPM Costs	MMs	Total Cost	PMPM Costs
P1 Total	4,150	$16,567,755	$3,992	1,946	$6,304,151	$3,240	(2,204)	($10,263,603)	($753)
P2 Total	4,774	$19,309,493	$4,045	1,797	$5,366,718	$2,986	(2,977)	($13,942,775)	($1,058)
P3 Total	5,338	$21,871,387	$4,097	2,353	$5,888,064	$2,502	(2,985)	($15,983,324)	($1,595)

For the entire period for which actual costs were available (Q1 of P1 through Q4 of P3, or July 1, 2020, through June 30, 2023), the total costs amounted to $39.1 million less than originally estimated ($57.7 million). The lower actual costs are mostly attributable to the lower-than-expected membership, but the PMPM data reflects additional cost savings. On a PMPM basis, expenditures are $753 lower in SFY 2021, $1,058 lower in SFY 2022, and $1,595 lower in SFY 2023.

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

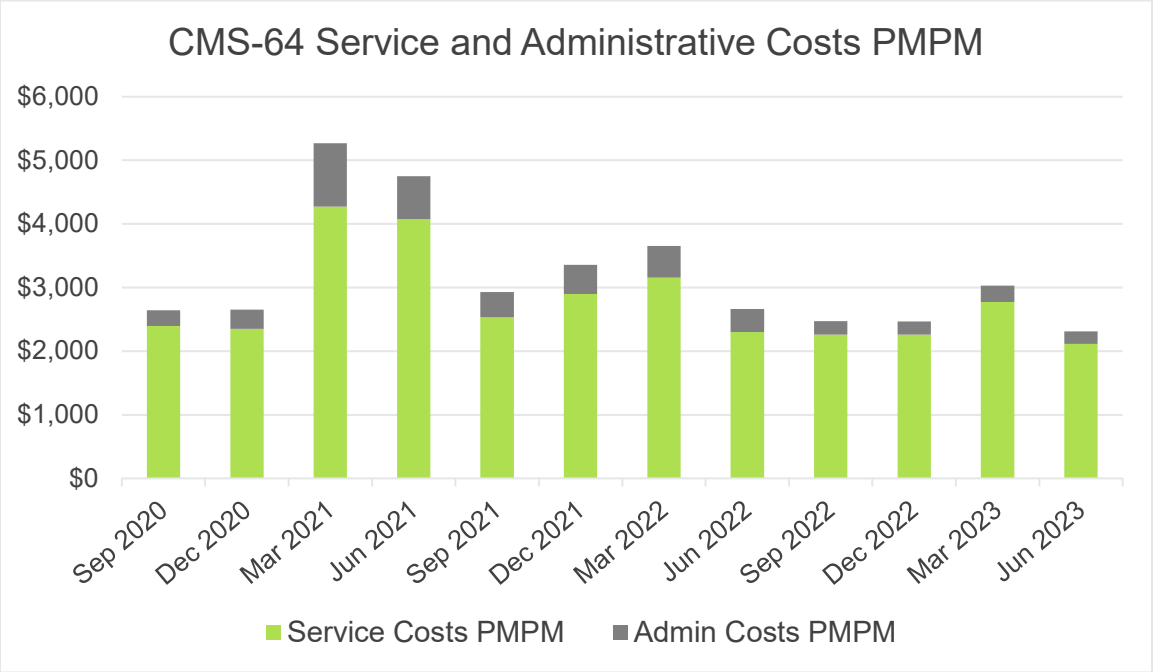
Figure 3. CMS-64 Quarterly Enrollment, Quarters Ending September 2020 – June 2023, CMHW and Enrolled Youth (ENY)



As illustrated in the above graph, enrollment was about 600 quarterly enrollees for September 2020 – December 2020, sharply declined to a trough of 370 quarterly enrollees for June 2021, and then enrollment resumed increasing from March 2022 to June 2023, ending at 648 quarterly enrollees by the end of the review period in June 2023.

Figure 4. CMS-64 Quarterly Administrative Expenses and Service Costs, Quarters Ending September 2020 – June 2023

The below chart helps to illustrate that administrative expenses represent a small portion of total expenditures, or 12 percent on a total dollar basis, across SFYs 2021 - 2023. Administrative expenses PMPM did grow significantly in SFY 2021 Q3 likely due to a large decline in enrollment. From SFY 2021 through SFY 2023, enrollment increased slightly beyond previous levels. Corresponding to this increase, both overall and administrative PMPM costs decreased steadily. The program PMPMs declined from $3,578 in SFY 2021, to $2,566 in SFY 2023. Due to the program's extremely small size, data and costs are quite volatile quarter to quarter.


CMS-64 Service and Administrative Costs PMPM
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
Sep 2020
Dec 2020
Mar 2021
Jun 2021
Sep 2021
Dec 2021
Mar 2022
Jun 2022
Sep 2022
Dec 2022
Mar 2023
Jun 2023
Service Costs PMPM
Admin Costs PMPM

Section VII. Conclusion

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

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

- Magellan and WDH partnering to improve targeted outreach in efforts to increase knowledge of the program across Wyoming and increase enrollment to those that most require services.
- The CME Program maintaining cost effectiveness for every quarter of SFY 2021 to SFY 2023 while actualizing lower expenditures than projected.

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

- Magellan developing stronger data collection and reporting processes for access to care.
- Leveraging and documenting use of population specific quality data in utilization management and strategic planning initiatives.
- Standardizing Plan of Care documentation across providers through detailed guidelines.

Following WDH's review of this report, WDH and Magellan will need to determine which opportunities for improvement they anticipate moving forward with to improve the CME Program and operation of the 1915(b) waiver.

Appendices

Appendix A: Abbreviations and Acronyms

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

Appendix B: Independent Assessment Review Tool

See attached.

Appendix C: Magellan Health Services-Treatment Record Review Tool

Table X. Wyoming CME Audit Tool Template

Section	Response	Comments
A-Application Packet	*Met, Not Met, Partially Met, N/A*	***Auditor Notes*
1) Complete packet is in the member file		
2) Demographics completed		
B-Orientation of Child and Family to CME during the Application Process		
3) Youth and family have enough information to make decision to participate in HFWA, FCC has basic information.		
C-Strengths, Needs and Culture Discovery		
4) A family and youth informed SNCD is written in family language and consensus from the team is reached. Some items may be found in other areas of the record in addition to the SNCD.		
D-Child and Family Team Meeting-CFT		
5) Team meetings are strength based, inclusive, allow for information sharing so families can make informed decisions.		
E-Plan of Care		
6) Plan of Care present in the record		
7) Team Mission		
8) Youth and Family Needs Prioritized		
9) Natural supports added to team		
10) Strategies for needs of youth and family		
11) Tasks to address each strategy		
12) FSP, YSP, and Respite Needs		
13) Youth and Family Training requested, if C Waiver youth		
14) CFT held and Plan of Care updated		
15) Barriers to process		
16) Placement changes		

17) Return home/transition plan		
18) Plan of Care has applicable signatures		
19) Plan of Care aligns with HFWA phases and requirement-CANS and crisis planning		
20) Primary Care Physician (PCP) noted		
F-Omit this item from scoring results Authorization WY Clinical responsible for this item		
21) Authorization completed accurately		
G-Crisis/Safety Plan		
22) Crisis Plan present in the record		
23) Identify potential crises and safety situations		
24) Crisis Plan content		
25) Crisis history		
26) Baseline behavior		
27) Prevention Plan		
28) Triggers/signs of crisis behaviors starting		
29) Action steps when crisis occurs		
30) Safety Plan		
31) High Risk such as suicidal and homicidal issues		
32) External and internal signs of end of crisis		
33) Crisis lessons learned		
H-Contact Notes		
34) There are thorough notes that help inform the POC and there's documentation of at least the minimum needed contacts		
35) Progress notes contain successes/gains made by family/youth		
36) Youth/family involvement in decision-making		
37) All contact (attempted or successful) with enrollee/families documented		
I-Assessments		
38) WFI-EZ completed within expected time frame		

39) CASII completed and present in file		
40) CANS completed and present in file		
J-Transition OOH		
41) When youth are moving placement there is a good transition plan in place.		
K-Discharge or Transition Planning		
42) There is a plan in place to support a family's continued movement forward and leaving wraparound.		
L-Coordination of Care		
43) Coordination of Care demonstrated in the file		
M-As Needed Documentation		
44) Documentation in member case file: Flex Fund Out of Home, Placement (Custody Status), Return to Community (Custody Status), Critical Incident, Reports Current Youth Medication		