Wyoming Department of Health Care Management Entity Program SFY 2025 External Quality Review

Technical Report

April 2026

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Contents

I. Executive Summary

1. EQR Background and Purpose

The Wyoming Department of Health (WDH) statewide Care Management Entity (CME) Program ("The CME Program") began in 2015 to provide targeted case management (TCM) services. The CME Program functions as a high-fidelity wraparound (HFWA) delivery model for Medicaid eligible youth ages 4 – 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 expanded from a seven-county pilot initiated in 2013 to a statewide benefit in 2015. It operates under the State's concurrent 1915(b) and 1915(c) waivers. Wyoming contracts with Magellan Healthcare, Inc. ("Magellan") to serve as their single statewide prepaid ambulatory health plan (PAHP) for the CME Program.

Federal regulations require states to conduct an annual external quality review (EQR) of Medicaid services delivered through managed care entities (MCEs), including PAHPs. The purpose of the EQR is to assess the quality, timeliness, and access to services provided under the contract between WDH and Magellan. This report presents the results of the SFY 2025 EQR of Wyoming's CME Program, including the scope of review activities conducted, key findings, identified strengths, areas of needed improvement, and recommendations to support continued program oversight and quality improvement.

2. Scope of EQR Activities Conducted

For State Fiscal Year (SFY) 2025, WDH contracted with Guidehouse, Inc. ("Guidehouse") to serve as the External Quality Review Organization (EQRO) and conduct the required EQR activities in accordance with 42 CFR § 438.364. Guidehouse conducted the following EQR activities:

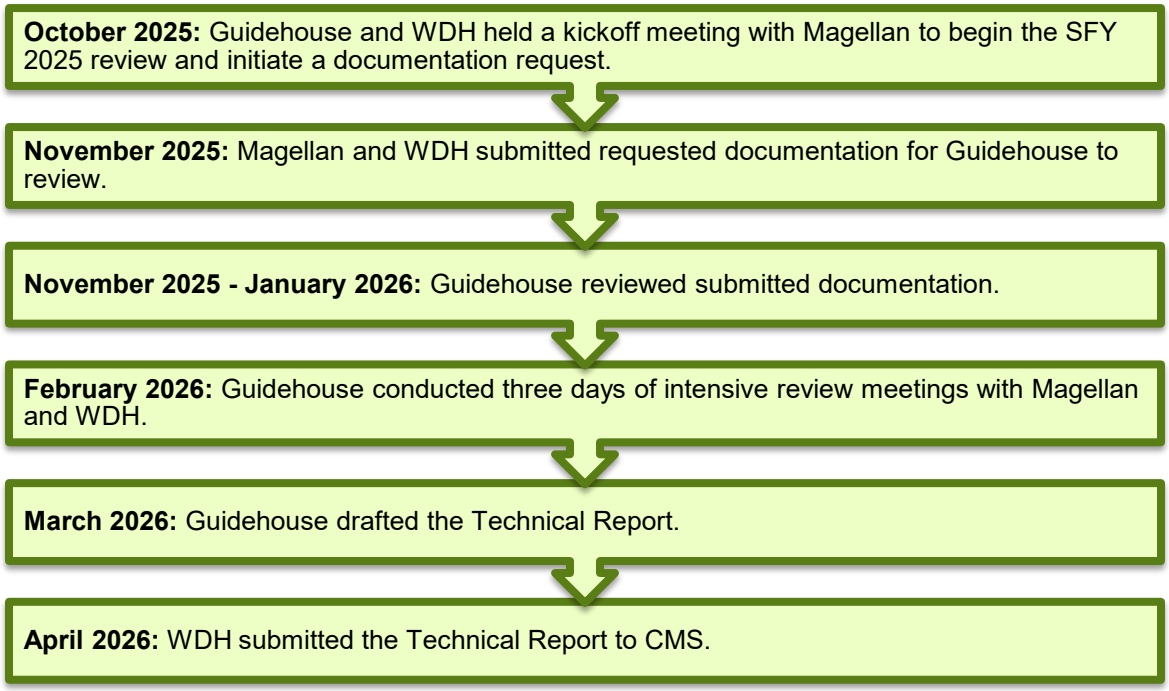
1. Completed an assessment of the four mandatory CMS EQR Protocols, in accordance with 42 CFR § 438.358:
   - **Protocol 1**: Validation of Performance Improvement Projects (PIPs)
   - **Protocol 2**: Validation of Performance Measures
   - **Protocol 3**: Review of Compliance with Medicaid Managed Care Regulations
   - **Protocol 4**: Validation of Network Adequacy
2. Completed the Information Systems Capabilities Assessment (ISCA) to evaluate the information systems used to collect, analyze, and report data relevant to program oversight and performance monitoring, in accordance with 42 CFR § 438.358.
3. Reviewed compliance with the State's Quality Strategy and developed findings and recommendations to support continued alignment with the State's quality goals and performance priorities, in accordance with 42 CFR § 438.340.

Federal regulations allow states flexibility in how they conduct their annual compliance review of each managed care plan (MCP). While a complete compliance review is required only once every three years for each MCP, states must address any EQR findings and recommendations provided one year in the subsequent reporting year. Due to Wyoming's program leadership changes, the SFY 2023 CME EQR encompassed all applicable federal requirements at the State's request, including requirements that were fully met in the prior review cycle. Thus, WDH selected to limit their Protocol 3 review to specific requirements during subsequent years. WDH reviewed only the Quality Assessment and Performance Improvement (QAPI) requirements under Protocol 3 in SFY 2024 and reviewed Enrollee Rights and Protections in SFY 2025, which is described in this report.

Figure 1 below outlines the key phases of the SFY 2025 EQR process, from initial planning through final report submission. The EQR process included a kickoff and document request, iterative document review, intensive review meetings, and development of the SFY25 EQR Technical Report ("Technical Report"),

culminating in submission to CMS. This phased approach supported comprehensive review, validation, and synthesis of findings across the review period.

Figure 1. Timeline of EQR Activities



3. Overall Review Findings

Guidehouse reviewed the CME Program documentation and supplemented this review with three days of intensive review meetings resulting in the following high-level findings:

- **13** areas of strength
- **10** areas of needed improvement
- **13** recommendations around quality, timeliness, and access to services

These findings reflect both sustained areas of strong performance and targeted opportunities for improvement to enhance analytic rigor, documentation clarity, and external validation.

II. Technical Report

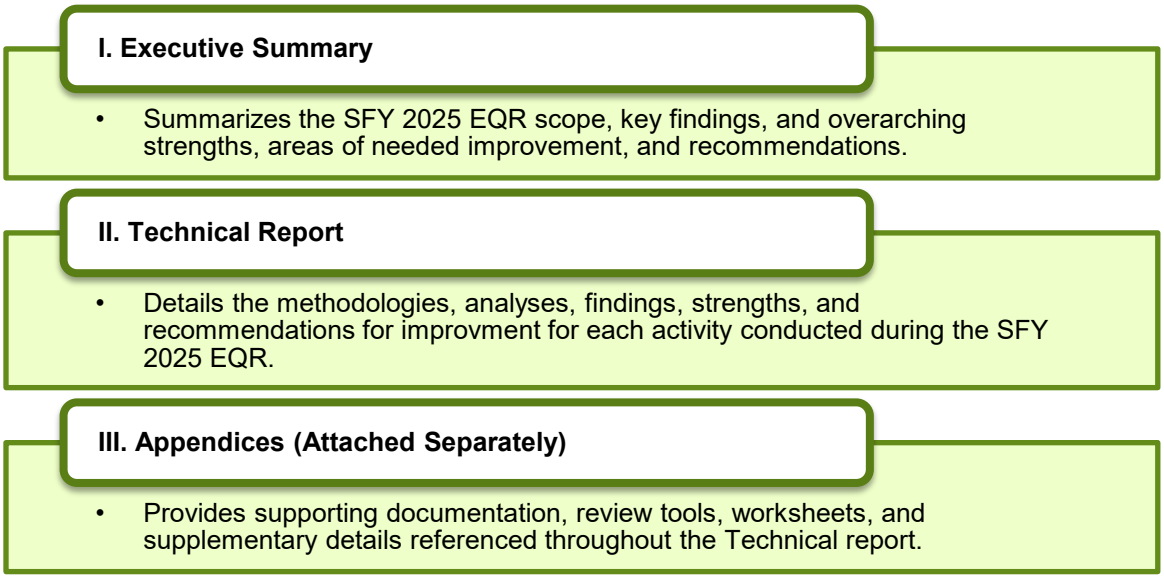
1. Introduction

A. Technical Report Purpose

This Technical Report presents the background, methods, results, and recommendations of the EQRO's review of the CME Program during SFY 2025. The Technical Report is intended to support WDH's oversight of the CME Program, inform program management and quality improvement efforts, and demonstrate compliance with federal EQR requirements under 42 CFR § 438, Subpart E. This report presents findings and recommendations designed to assist WDH and Magellan in identifying program strengths, prioritizing areas for improvement, and guiding decision-making related to program operations, performance monitoring, and access to services for enrolled youth and families. The Technical Report also serves as a key accountability and transparency tool for CMS and other stakeholders by documenting the State's annual evaluation of the quality, timeliness, and access to services delivered through the CME Program.

The report is organized into three primary sections, as outlined in **Figure 2.**

Figure 2. Technical Report Organization



Note: Findings and recommendations across these sections address program operations, quality improvement activities, regulatory compliance, provider network capacity, and alignment with State quality priorities. Because the CME Program provides TCM services and does not furnish acute or direct clinical services, several EQR requirements did not apply to the CME Program; Guidehouse notes these instances throughout the report. In addition, certain findings particularly related to PIPs should be interpreted in the context of program size, evolving operational processes, and changes implemented during the review period, which limited the ability to conduct full longitudinal or statistical analyses in some areas.

B. Wyoming's Care Management Entity Program

The CME Program is a community-based delivery service model for providing TCM services via four provider types, including the 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**. Figure 3** summarizes CME Program enrollment from program enrollment began in SFY 2017 through SFY 2025. This data is captured through WDH's HeathStat Report which is a program performance and evaluation initiative that helps WDH leaders respond to program issues in an informed, timely, and coordinated fashion.

Figure 3. CME Enrollment

Year	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
CME Youth Served	431	494	402	402	385	366	307	482	**475**

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

The CME Program operates via authority granted under two concurrent waivers, 1) Wyoming Medicaid's Youth Initiative 1915(b) waiver and, 2) the CMHW 1915(c) waiver. Youth enrolled in Wyoming Medicaid who meet the 1915(b) waiver's clinical eligibility criteria may enroll with the CME and receive the CME Program's care coordination benefits. Youth who are not eligible for Wyoming Medicaid but meet the clinical and financial eligibility criteria specified in the CMHW 1915(c) waiver may also access CME services and must participate in the CME Program to maintain waiver eligibility.

The following timeline outlines the key milestones in the development and evolution of Wyoming's program. It highlights major policy decisions, waiver approvals, and programmatic updates that shaped the current structure of the CME Program. The timeline in **Figure 4** outlines how the CME Program developed.

Figure 4. CME Implementation Timeline

July 2006	**CMS approved WDH's 1915(c) waiver application** CMS approved Wyoming Medicaid's CMHW 1915(c) waiver, establishing access to specialized services for youth with serious behavioral health needs, including youth and family training and support services unique to waiver participants.
February 2010	**Wyoming was granted CHIPRA funding** Wyoming is awarded a grant under Children's Health Insurance Program Reauthorization Act (CHIPRA) to support creation of a CME Program for Medicaid and CHIP-enrolled children with serious behavioral health challenges.
June 2013	**WDH launched CME Pilot Program** WDH launched a seven-county CME pilot program to support a coordinated and accountable service delivery model. This was informed by Wyoming's CHIPRA grant and federal guidance from CMS and Substance Abuse and Mental Health Services Administration (SAMHSA).
July 2015	**Magellan expanded CME Program** Wyoming expanded the CME Program to offer it statewide by contracting with Magellan as the single PAHP.
August 2015	**CMS approved WDH's 1915(b) waiver application** CMS approved Wyoming's 1915(b) waiver in August 2015, effective September 1, 2015, allowing the State to operate the CME Program under a managed care framework and integrate care coordination for Medicaid-enrolled youth ages 4–20 with SED or SPMI. This waiver was combined with its existing 1915(b) waiver, enabling the State to contract with a single CME to deliver care coordination services.
July 2018	**CME Program shifts from capitated payment to FFS** Wyoming amended the 1915(b) waiver effective July 1, 2018, transitioning the CME Program from a capitated payment model to a fee-for-service (FFS) payment structure. This update aligned payment methodology with program scale and service utilization patterns while maintaining statewide access to care coordination services.
July 2024	**CMS approved the renewal of the 1915(b) and 1915(c) waivers in Wyoming.** In January 2024, Wyoming submitted renewal applications for the 1915(b) and 1915(c) waivers, which CMS approved effective July 1, 2024. The State also submitted an updated CME Quality Strategy, reviewed by CMS in May 2024.

D. External Quality Review Requirements and Components

i. EQR Requirements

In accordance with 42 CFR § 438, subpart E, states must conduct an EQR of contracted MCEs, including managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), PAHPs, and primary care case management (PCCM) entities. The EQR should analyze and evaluate the quality, timeliness of, and access to health care services provided to Medicaid recipients.

The final step of the EQR process is preparing the Technical Report, which describes the methodologies used to aggregate and analyze data across all EQR activities and the results for each activity conducted, including objectives, data sources, analytical methods, and conclusions. The report also assesses each MCP's strengths and opportunities for improvement, evaluates progress on prior-year recommendations, and offers targeted recommendations to support quality improvement and inform the State's managed care quality strategy. Once finalized, the report must be posted on the State's website by April 30th of each year.

ii. EQR Components

The CMS EQR includes a combination of mandatory and optional review activities designed to assess performance improvement, regulatory compliance, data integrity, and access to care. The mandatory EQR activities represent a structured set of defined CMS protocols designed to evaluate MCP performance across key domains, including performance improvement, regulatory compliance, network adequacy, data integrity, and information systems capabilities, with each CMS Protocol corresponding to specific review objectives addressed in Section II of this EQR Technical Report. Below (**Figure 5**) are the mandatory EQR activities and their descriptions that were reviewed in this report.

Figure 5. Mandatory EQR Activities

	Activity
Mandatory	**Protocol 1: Validation of PIPs** • MCOs, PIHPs, and PAHPs are required to implement 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)).

	Protocol 2: Validation of Performance Measures and ISCA:
	• MCPs must report standard performance measures as specified by the State. The State must provide 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)).
	• 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.

	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.
	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.

States may also elect to conduct optional EQR activities based on program needs. These activities allow states to tailor the EQR to unique priorities and emerging policy needs. WDH did not elect to conduct any of the optional activities (listed in **Figure 6**) during the review of SFY 2025.

Figure 6. Optional EQR Activities

	Activity
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 PIPs
	Protocol 9: Conducting Focus Studies of Health Care Quality
	Protocol 10: Assist with the Quality Rating of Medicaid and CHIP MCOs, PIHPs, and PAHPs

E. Results of SFY 2024 External Quality Review

The SFY 2024 EQR results are presented below to establish a baseline for tracking progress and responsiveness to prior-year findings and recommendations. This look-back supports transparency and continuity across review cycles and informs interpretation of the current review's scope, focus, and outcomes. The SFY 2024 review of Wyoming's CME Program identified **10** areas of strength, **14** areas of needed improvement, and **18** recommendations in relation to quality, timeliness, and access to services.

Of the **18** recommendations for WDH and/or Magellan:

- **6** – recommendations have been fully addressed;
- **5** – recommendations have been partially addressed;
- **6** – recommendations have not been addressed;
- **1** – recommendation was not applicable for review.

Figure 7 summarizes the status of recommendations issued during the SFY 2024 EQR and shows progress on those recommendations as of the SFY 2025 review. The figure is organized by EQR protocol and shows the number of recommendations issued in SFY 2024, whether they were directed to Magellan or WDH, and their resolution status as of SFY 2025 (Fully Addressed, Partially Addressed, Not Addressed, or Not Applicable). In total, 18 recommendations were issued in SFY 2024. As of the SFY 2025 EQR, 6 were fully addressed, 5 were partially addressed, and 6 were not addressed. One recommendation under Protocol 3 was marked as Not Applicable, as it related to QAPI requirements that was outside the scope of the SFY 2025 Protocol 3 review. **Appendix B** provides detailed information on each SFY 2024 recommendation and its status.

Figure 7. Status of SFY 2024 Recommendations

EQR Protocol	Count of Recommendations (as of SFY 2024)		Total	Count of Recommendations by Resolution Status (as of SFY 2025)			
	Magellan	WDH		Fully Addressed	Partially Addressed	Not Addressed	N/A
Protocol 1. Validation of PIPs	4	0	**4**	1	2	1	
Protocol 2. Validation of Performance Measures	1	2	**3**	3	0	0	
Protocol 3. Compliance with Medicaid Managed Care Regulations	3	0	**3**	0	2	0	1
Protocol 4. Validation of Network Adequacy	6	2	**8***	2	1	5*	
TOTAL	**15**	**3**	**18**	**6**	**5**	**6**	**1**

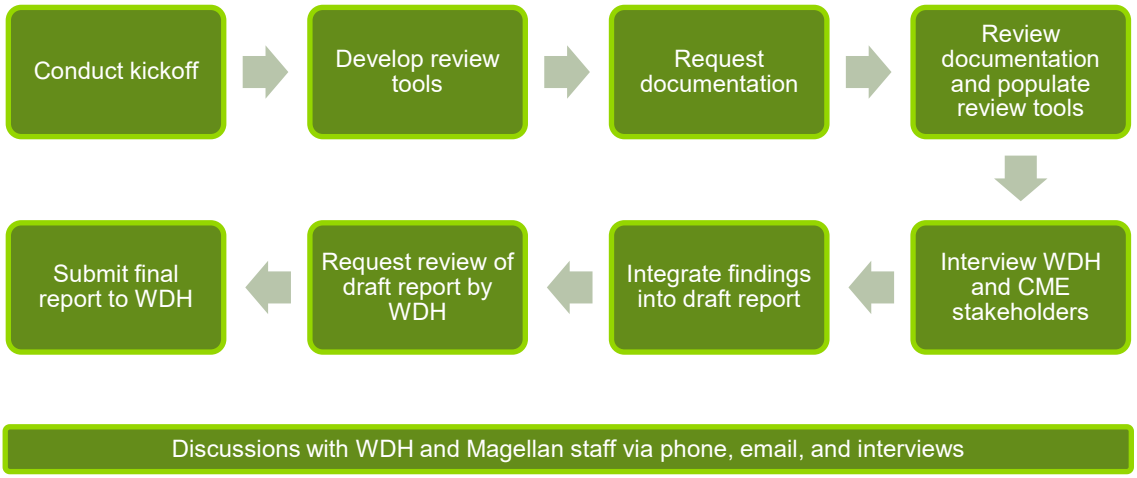
*In Appendix B (number 16) the total count of recommendations under Protocol 4 is 7 rather than 8 since the EQRO suggests WDH and Magellan collaborate on implementing recommendations provided for each. As a result, the total count of recommendations in Appendix B is 17, rather than 18.

2. EQR Process

A. EQR Review Process at Glance

WDH contracted Guidehouse to serve as the EQRO for the Wyoming CME Program. Guidehouse has served in this role since SFY 2018, providing continuity across multiple review cycles and institutional knowledge of the CME Program's structure, evolution, and operating context. For the SFY 2025 EQR, Guidehouse applied a structured, multi-phase approach spanning planning, information gathering, analysis, and reporting, while tailoring review activities to reflect the CME Program's TCM model, program size, and areas of focus for the current review year. The EQR process emphasized ongoing collaboration with WDH and the CME Program to support transparency and compliance with all federally required activities. **Figure 8** provides an overview of the key phases of the EQR process, which are described below:

Figure 8. Key Assessment Steps



The EQR process began with initial planning and coordination activities including a formal kickoff call and regularly scheduled status meetings to confirm scope, timelines, and expectations. During these discussions, Guidehouse and WDH confirmed the SFY 2025 scope of review, clarified protocol-specific focus areas, established key milestones, and aligned on expectations for documentation submission, intensive review sessions, and reporting timelines. Planning activities also incorporated lessons learned from prior EQR cycles, including areas where additional clarification or documentation detail was needed to support efficient review and minimize follow-up requests later in the process.

Throughout the review period, Guidehouse maintained ongoing coordination with WDH to address questions as they arose, confirm interpretations of contractual or regulatory requirements, and adapt review activities as needed based on program changes or emerging findings. This approach supported consistent alignment and ensured that review activities remained responsive to the CME Program's operational realities during SFY 2025.

B. Documentation Request and Review Period

Following initial planning, Guidehouse conducted a desk review by requesting and reviewing documentation from WDH and Magellan to support completion of the required EQR-related activities, consistent with CMS EQR protocol guidance. Rather than relying on a single static document submission, Guidehouse reviewed materials on an iterative basis throughout the review period, allowing early observations to inform follow-up requests, interview questions, and protocol-specific analyses. This approach supported a more efficient and targeted review process to prepare for intensive review sessions.

Reviewed materials included contracts, policies, reports, and program documentation relevant to CME program operations, quality oversight, compliance with federal and State requirements, and performance reporting, consistent with CMS expectations for documentation-based EQR review activities. Guidehouse evaluated documentation not only for completeness, but also for internal consistency, alignment with contractual requirements, and consistency between written policies and operational practice.

Guidehouse requested and reviewed the following documentation from Magellan:

- Corporate policies and procedures, including Wyoming-specific policies where applicable, related to quality, timeliness, and access to services
- Member and provider handbooks

- Outreach and marketing templates and materials
- Quarterly and annual reports submitted to WDH, including SFY 2025 Quarters 1–4 and the SFY 2025 annual report
- Geographic information on member residences and provider service areas
- Provider agreements, provider certification requirements, and provider training materials
- Wyoming Administrative Rules
- Wyoming Medicaid Managed Care Quality Strategy

C. Stakeholder Engagement

In parallel with documentation review, Guidehouse engaged in regular communication with WDH and Magellan staff to support understanding of program operations and to validate information, clarify program operations, and obtain additional context necessary to interpret documentation and reported data. Guidehouse structured engagement activities to validate compliance and deepen understanding of how policies and processes were implemented in practice.

Key engagement activities included:

- Weekly virtual coordination meetings with WDH staff from October 2025 through April 2026
- Three days of intensive review sessions with Magellan and WDH conducted February 9 – 12, 2026, which focused on validating preliminary findings, discussing protocol-specific methodologies, and addressing questions identified during documentation review; and
- Ongoing ad hoc communication via email and meetings, as needed, to resolve outstanding questions and confirm interpretations.

These discussions were instrumental in verifying documentation accuracy, understanding operational nuances, resolving discrepancies identified during review, and developing the contextual understanding necessary to support protocol-specific findings and recommendations.

D. Analysis and Validation Activities

Using the information gathered through documentation review and stakeholder engagement, Guidehouse conducted the required EQR analyses across all applicable activities, including PIP validation, performance measure validation, compliance review, network adequacy assessment, and Quality Strategy assessment. Guidehouse conducted these activities concurrently to allow findings from one protocol to inform interpretation of others and to identify cross-cutting themes affecting program performance.

For Protocol 2, Guidehouse conducted targeted data validation activities to assess the accuracy, reliability, and appropriateness of performance measure reporting under the SFY 2025 Statement of Work (SOW). These activities included detailed review of measure specifications, data sources, calculation logic, reporting outputs, validation of numerator and denominator construction, and alignment with State-defined requirements. Guidehouse evaluated both operational and outcome measures and evaluated consistency between reported results, supporting documentation, and underlying data systems.

Across all protocols, Guidehouse synthesized findings from documentation review, interviews, data validation activities, and intensive review sessions to identify findings and recommendations grounded in observed practice and documented evidence. This integrated approach supported identification of program strengths, areas of needed improvement, and recurring themes affecting quality, timeliness, and access to services.

E. Reporting and Review

Guidehouse compiled the draft findings and recommendations into this Technical Report and shared the draft with WDH. WDH's input was carefully reviewed and incorporated to ensure accuracy and clarity while maintaining the EQRO's independent assessment. The report was then finalized for submission to CMS in accordance with federal EQR reporting requirements and timelines.

3. Protocol 1: Validation of PIPs

A. Protocol 1 Overview

EQR Protocol 1 assessed the validity and reliability of selected PIPs. Per CMS EQR protocol guidance, this mandatory EQR activity validated the PIPs required as part of the MCP's QAPI Program. Guidehouse reviewed MCP documentation and conducted interviews with MCP staff. The CME Program's TCM model, small program size, and evolving operational environment informed findings and recommendations. Because the CME Program does not furnish acute or direct clinical services, and because one PIP experienced mid-program changes, the availability of consistent longitudinal data was limited. These factors directly influenced the scope of review, interpretation of results, and the strength and framing of recommendations, particularly where robust trend or statistical analyses were not feasible.

Per WDH's direction, Guidehouse reviewed the following two PIPs which were active during SFY 2025:

1. **Improving the Prior Authorization (PA) Process PIP ("Prior Authorization Process PIP" or "PA PIP") that began during SFY 2023 as its baseline year and was terminated early during SFY 2025.**

   The PA PIP assessed improvements to administrative elements in the PA process to ultimately improve downstream member outcomes from continuous service delivery. Although this PIP began in SFY 2023, it was terminated on March 27, 2025, following changes to Magellan's PA process. The updated process shifted from using a "non-authorization" status to a "pending" authorization status, allowing enrollees to begin receiving services while provider documentation and approvals were still in progress. Given the small size of the CME Program and the goal of maximizing enrollee access to services, this approach reduced unnecessary service delays rather than denials. As a result of these process changes, the original PIP measures no longer aligned with current operations, and the PIP was discontinued. Accordingly, Guidehouse did conduct a full validation review, but did not provide recommendations for additional improvement, and findings related to this PIP are limited and should be interpreted in the context of the updated PA process.

2. **Increase the Number of Providers in the Wyoming CME Network PIP that was implemented in SFY 2023 and completed its second remeasurement period in SFY 2025.**

   The Network PIP employed recruitment, training, and support initiatives for the HFWA Program for stakeholders across Wyoming. It aimed to increase the CME Program's volume of enrolled FCCs and Respite providers through increased exposure to the CME Program for individuals that may not have been aware of its existence, how to enroll in it, or lack adequate support to feel comfortable delivering the CME 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.

B. Review Methodology

Guidehouse based its validation process and the identification of areas of strength and needed improvement for each PIP on the structure outlined in the CMS-developed EQR Protocol 1 Worksheets.

As part of this validation process, Guidehouse reviewed the following:

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 include two validation ratings that Guidehouse assigned for the overall design, methodology, and impact of each PIP. Validation Rating #1 assesses whether the PIP methodology appropriately addresses "all phases of design and data collection" and whether the data analysis and interpretation of results are accurate. Validation Rating #2 assesses overall confidence that the PIP produced significant evidence of improvement. The validation ratings described below reflect Guidehouse's overall level of confidence in each PIP's design, methodology, and demonstrated impact, based on a standardized review of CMS EQR Protocol 1 worksheets.

For purposes of this review, worksheet-level determinations of *Yes*, *No*, and *Not Applicable (N/A)* were used to document whether specific CMS-required PIP design and evaluation elements were present and appropriate, absent or insufficient, or not applicable based on the scope or structure of the PIP. An *N/A* designation reflects an element that was not applicable and does not indicate a deficiency. Worksheet responses were not interpreted as equally weighted checklist items. Instead, they were considered collectively and in context, with greater analytical weight assigned to elements that materially affect interpretability, attribution of outcomes to interventions, and confidence in demonstrated improvement. Accordingly, validation ratings were not derived from the proportion of *Yes* responses, but from the EQRO's assessment of whether the PIP's overall design and analysis support reliable conclusions regarding improvement.

The confidence ratings are defined as follows:

- ***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.

C. PA PIP Performance Findings

Magellan worked with the State to restructure the PA process to more efficiently finalize enrollee plans of care and support service delivery, while maintaining alignment with CME Program requirements and CMS-approved waiver authority. As a result, the PA PIP was terminated early at the end of March 2025. Below, Guidehouse validated the PIP but did not provide recommendations for improvement due to the PIP's termination.

Findings show that the PA PIP documents demonstrated alignment with the CMS priority of increasing access and engagement, described a clearly defined population, developed logically constructed aim statements, and included provider-focused improvement strategies. Magellan demonstrated a thoughtful approach to identifying challenges within the PA process and selected interventions intended to reduce service delays and support continuous authorizations. Both performance measures improved from the previous measurement periods.

However, while the percentage of authorizations met their stated performance goal, the percentage of non-authorizations did not. Both measures also were not statistically significant. Additionally, while Magellan developed a methodology with secondary drivers, the analysis did not measure the outcomes of those secondary drivers or provide evidence of their impact on the PIP's performance. Other missing elements in the PIP design and documentation included a linkage from the data collection to analysis plan or a thorough evaluation of their data validation process. **Figure 9** summarizes the SFY 2025 validation ratings for the PA PIP and **Figure 10** described Guidehouse's evaluation across CMS-required review categories.

Figure 9. SFY 2025 PA PIP Validation Ratings

PA PIP Validation		
Intervention: Evaluated impact of educational initiatives for providers related to POC development. Also evaluated the impact of changes to the HFWA POC review process on successful continuous authorizations and the rate of POC non-authorizations.		
Rating Type	**Rating Result**	**Validation Comments**
#1 Methodology	**Moderate Confidence**	The PIP methodology described interventions designed to improve the efficiency of the POC approval process. Yet, the PIP methodology did not evaluate the secondary drivers they identified as part of their methodology to determine impact on the interventions and performance outcomes. While the PIP includes an analysis plan, it did include the method for data validation including the process for reviewing possible data inconsistencies.
#2 Improvement	**Low Confidence**	While the PIP performance measures demonstrated improvement from SFY 2024, they were not shown to be statistically significant. One of the two measures achieved Magellan's performance target while the other did not. Documentation submitted for review reflected a reduction in the number of POCs reviewed from SFY 2024 to SFY 2025 without describing the factors contributing to this change. While both performance measures showed improvement from the prior measurement period, the results did not demonstrate statistically significant improvement, and one measure did not meet its established performance target. This rating is similar to last year's rating.

Figure 10. SFY 2025 PA PIP Findings by CMS Evaluation Category

Evaluation Category	Findings
Topic and PIP Selection	• The PA PIP was selected by Magellan based on Magellan's PA PIP workgroup's professional experience, provider feedback, downstream impacts of non-authorizations, and program restructuring goals. • The PA PIP was constructed as an opportunity to improve provider compliance with PA PIP documentation and POC submissions to ultimately improve the rate of continuous authorizations and more efficiently allow enrolled youth to receive services. • The target population was the entire population served by Wyoming's youth behavioral health HFWA Program. • The PA PIP aligned with the CMS priority area of Access for All and Engagement.
Aim Statement	• Magellan developed the following aim statements for the PA PIP: 1) "Will the introduction of changes in the HFWA POC review process (documents required for the prior authorization at the initial POC 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) 2025?" 2) "Will the introduction of changes in the HFWA POC review process (documents required for the prior authorization at the initial submission of the POC 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) 2025?" • The aim statements met all requirements identified by CMS in the PA PIP Review Worksheet, including requirements for statement specificity, measurability, answerability, conciseness, and time restrictions.
Population	• Magellan listed the population for the PA PIP as "All WY CME enrolled youth, ages 4-20 with a Serious Emotional Disturbance (SED) diagnosis." • The population description statement met all requirements identified by CMS in the PA PIP Review Worksheet.
Sampling Method	• Magellan stated the entire eligible population was included in the PA PIP. • The Quality Improvement Activity (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 remeasurement period for the PA PIP: 1) **Numerator:** Number of non-authorizations issued. **Denominator:** Number of POCs submitted. 2) **Numerator:** Number of authorizations issued. **Denominator:** Number of POCs submitted. • The PA PIP variables defined evaluation periods as weekly and were assessed weekly and data reports monthly, quarterly, and annually. • Magellan's variables clearly related to the identified aim statements and PA PIP narrative. • Baseline evaluations were collected by Magellan from SFY 2023. The baseline measures were:

Evaluation Category	Findings
	○ 5.3% rate of service non-authorizations ○ 94.66% rate of continuous authorizations • SFY 2024 was the PA PIP's first remeasurement period. The first re-measurements by Magellan yielded the following results: ○ 7.6% rate of service non-authorizations ○ 92.31% rate of continuous authorizations • SFY 2025 was the PIP's second measurement period. The second remeasurement by Magellan yielded the following results: ○ 5.9% rate of service non-authorizations ○ 94.06% rate of continuous authorizations
Data Collection	• In the PA PIP form, Magellan stated that data is collected from medical/treatment records (Fidelity EHR). Although the documentation identified medical records as the data source, only administrative data (i.e., the number of authorizations) were utilized by Magellan. • Magellan noted that the data they collect includes member ID, name, enrollment status, enrollment date, non-authorization date, non-authorization letter delivery information, non-authorization comments, and service name. • The performance measures are the number of authorizations approved. • Data was pulled and reviewed weekly, monthly, quarterly, and annually by Magellan staff.
Data Analysis	• While they provided a data analysis plan, the documentation did not include links between the data being collected and an analysis plan. For example, there was no discussion on how the performance measures were then calculated and the results of the analysis validated. There was also not a discussion on procedures if the results produced inconsistencies, beyond a review of the EHR (source data) for data entry issues. • Magellan provided a list of data analysis personnel and their qualifications in the PA PIP documentation. • Magellan did not evaluate the secondary drivers they identified as part of their methodology to determine impact on the interventions and performance outcomes. • The PIP documentation reported that the PIP was terminated early with a new PA approval process being implemented.
Improvement Strategies	• Magellan identified the following primary drivers of challenges and secondary drivers to be addressed by targeted interventions. ○ Primary Driver 1: Providers see documentation as a burden. ▪ Secondary Driver 1.1: Providers do not submit prior authorization requests in a timely manner. ▪ Secondary Driver 1.2: Providers lack a clear understanding and acceptance of importance of documentation. ▪ Secondary Driver 1.3: Providers submit incomplete documentation. ▪ Secondary Driver 1.4: Providers perceive that too much documentation is required. ○ Primary Driver 2: Providers perceive that feedback on prior authorization submissions is inconsistent. ▪ Secondary Driver 2.1: Interpretation of authorization request information may differ depending on the Clinical Reviewer who is assigned to the review.

Evaluation Category	Findings
	▪ Secondary Driver 2.2: Providers may not enter documentation in the correct fields within the EHR. ○ Primary Driver 3: Families may not receive services for a period of time pending the receipt and approval of the POC submitted by the provider. ▪ Secondary Driver 3.1: PA requests are not submitted in a timely manner by providers. ▪ Secondary Driver 3.2: Providers submit incomplete documentation. • Magellan initiated the following interventions to address the identified primary and secondary drivers: ○ Streamlined the number of documents required for the POC submission. ○ Worked with WDH to consider a reimbursement increase for providers. ○ Provider Surveys concerning activities in the PA process, External Quality Improvement Committee (QIC). ○ Facilitated monthly provider calls and weekly training calls. ○ Developed a Provider Manual. ○ Developed a rating scale within the Clinical Review Tool. ○ Sent reminders to providers 30 days prior to the POC being due for review. • Magellan followed Institute for Healthcare Improvement's (IHI) PDSA rapid cycle approach to develop improvement strategies and ensure cultural and linguistic appropriateness within strategies in the QIA form. • A workgroup of Wyoming CME employees including the Quality Improvement Director, Account Operations Manager, Clinical Contract Advisor, Trainer, Quality Clinical Reviewer, and Network Manager conducted the development process and appropriateness review.
Likelihood of Significant Improvement	Magellan's submitted PA PIP documentation demonstrated improvement over the prior year by presenting a more cohesive and targeted narrative that clearly aligned with the process Magellan sought to improve. Interventions were directly linked to identified challenges in their documentation, although the interventions impacts were not evaluated. Both measures showed improvement from SFY 2024, and one met its target. However, neither was statistically significant. The PIP concluded early at the end of March 2025. Magellan used lessons learned from the PIP, along with provider feedback, to collaborate with the State on reforming the PA process, reducing administrative barriers, and supporting more timely enrollment and service delivery for youth while maintaining program intent and compliance with CMS waiver authority requirements.

D. Network PIP Performance Findings

During SFY 2025, Magellan undertook a broad range of provider engagement and support activities aimed at strengthening and sustaining the CME provider network. These efforts included targeted outreach to Eastern Shoshone Tribal Health to support the enrollment of tribal providers; facilitation of referral summits and regional convenings with providers and community stakeholders; distribution of program-specific outreach and marketing materials; and ongoing collaboration with community partners to raise awareness of the HFWA Program. Magellan also supported the existing provider network through regular provider calls, structured training and coaching opportunities, creation of provider-focused specialist roles, hosting of conferences and summits, and solicitation of provider feedback through multiple forums, including quality improvement meetings and workgroups. While the PIP documents

extensive provider engagement and outreach activities, the documentation does not include quantitative analysis evaluating the extent to which individual interventions contributed to changes in the reported performance measures.

Additionally, quantitative measures do not distinguish between new, retained, and terminated providers, and do not include percentage-based change measures or defined performance targets. These limitations constrain the ability to attribute observed changes to specific interventions or to assess the magnitude of improvement in a standardized and comparable manner across measurement periods.

Both PIP performance measures showed improvement compared to the prior measurement year, with increases in the number of active FCCs and Respite providers. However, statistical testing did not demonstrate statistically significant improvement and analysis of provider enrollment trends across multiple years indicates a pattern of fluctuation rather than sustained growth. Network PIP **Figure 11** summarizes the SFY 2025 validation ratings for the Network PIP and **Figure 12** summarizes Guidehouse's evaluation across CMS-required review categories.

Figure 11. SFY 2025 Network PIP Validation Ratings

Network PIP Validation		
Intervention: Evaluated the impact of targeted recruitment, training, and support initiatives for providers on the number of active FCCs and Respite providers in Magellan's HFWA network.		
Rating Type	**Rating Result**	**Validation Comments**
#1 Methodology	**Low Confidence**	Magellan conducted a range interventions to support provider outreach and sustain the current network. Despite these efforts, the PIP documentation does not quantitatively link the reported outcome measures with the interventions described in the PIP documentation. While Magellan acknowledges that training, support, and recruitment activities may have influenced changes in network size, the PIP does not include analytic evidence demonstrating the extent to which individual interventions contributed to observed performance. In addition, although potential confounding variables are identified in the PIP, the methodology does not evaluate how these factors may have affected intervention impact or performance outcomes. As a result, while the PIP reflects substantial and sustained provider engagement activity, limitations in the quantitative analysis constrain the ability to assess the relative effectiveness of specific interventions or to attribute observed changes in provider counts to particular strategies.
#2 Improvement	**Low Confidence**	The PIP performance measures showed improvement during SFY 2025. Yet, the changes were not statistically significant. Both measures increased from the prior measurement year, with the number of Respite providers increasing from three in SFY 2024 to nine in SFY 2025. The number of active Family Care Coordinators rose from 52 in SFY 2024 to 64 in SFY 2025; however, when examined over a longer time horizon (SFY 2021–SFY 2025), provider enrollment reflects a pattern of year-to-year fluctuation rather than consistent growth, limiting evidence of sustained improvement. In addition, while the PIP documents extensive provider engagement and outreach activities, the quantitative measures do not distinguish between new, retained, and terminated providers, and do not include

		percentage-based change measures or clearly defined performance targets. These limitations reduce the ability to attribute observed changes in provider counts to specific interventions or to assess the magnitude and consistency of improvement achieved through the Network PIP.

Figure 12. SFY 2025 Network PIP Findings by CMS Evaluation Category

Evaluation Category	Findings
Topic and PIP Selection	• A Network Adequacy assessment was required to be completed in each SOW since the 2023 SOW between Magellan and WDH. • Magallan clearly articulated the impacts of limited provider network capacity and the complexities of service delivery in a frontier state. • Magellan's PIP population included active FCCs 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: 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 FCCs active in the Network for SFY 2025?" 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 2025?" • The aim statements met all CMS-identified requirements for measurability, answerability, conciseness, and time restrictions.
Population	• Magellan's documentation for the 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. During the virtual onsite, Magellan confirmed that all providers in their network were included. • The PIP's population description statement met all requirements identified by CMS in the PIP Review Worksheet.
Sampling Method	• The PIP documentation clearly stated that Magellan did not use a sampling method for the PIP.
Variables and Performance Measures	• Magellan outlined two (2) performance measures to evaluate the success of the PIP: 1) Number of FCCs in network. 2) Number of Respite providers in network. • Magellan set goals for each performance measure of: 1) Increasing FCCs by two (2) providers each quarter. 2) Increasing the network to eight (8) total Respite providers by the end of SFY 2025. • Baseline evaluations were collected from SFY 2023. Magellan's baseline measures were: ○ 64 FCCs ○ 1 Respite provider • SFY 2024 was the PIP's first remeasurement period. The first remeasurement by Magellan yielded the following results: ○ 52 FCCs ○ 3 Respite providers

Evaluation Category	Findings

	• SFY 2025 was the PIP's second measurement period. The second remeasurement by Magellan yielded the following results:
	  ○ 64 FCCs
	  ○ 9 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. • The PIP documentation noted that data collection cadences by Magellan were monthly, quarterly, and annually. • The PIP documentation noted that data is validated monthly by Magellan.
Data Analysis	• The data analysis plan is missing key components such as a description of how Magellan calculated or clearly validated the measure results (e.g., detailed procedures if the results produced inconsistencies beyond rereviewing the staff rosters). • Measurements were evaluated for statistical significance by Magellan using unpaired, two t-tail tests. Magellan does not include performance targets for either measure.

Improvement Strategies	• Magellan identified primary drivers of challenges and secondary drivers to be addressed by targeted interventions.
	  ○ Primary Driver 1: Frontier nature of the state.
	  ▪ Secondary Driver 1.1: Limited number of qualified individuals to recruit.
	  ▪ Secondary Driver 1.2: Time and distance for providers to travel to rural areas.
	  ○ Primary Driver 2: Community stakeholders, behavioral health providers, and other professionals lack awareness and knowledge of the HFWA Program.
	  ▪ Secondary Driver 2.1: Communication gaps between community stakeholders and providers.
	  ▪ Secondary Driver 2.2: Learning curve of the HFWA process.
	  ○ Primary Driver 3: Challenging to maintain providers in areas with limited enrollees and families.
	  ▪ Secondary Driver 3.1: Providers expressed that reimbursement rates are insufficient.
	  ▪ Secondary Driver 3.2: Providers are dependent on enrollees and their families' availability for scheduled services.
	  ○ Primary Driver 4: HFWA Program network provider contract and training requirements.
	  ▪ Secondary Driver 4.1: Limited knowledge in provider understanding of basic business practices.
	• Magellan developed the following interventions to address the identified primary and secondary drivers:
	  ○ Outreach and collaboration with Indian Health Services.
	  ○ Held collaborative meetings with Eastern Shoshone Tribal Health throughout the year (Fremont County) concerning HFWA.
	  ○ Summit conference meeting held for Wyoming providers: Held Provider Summit virtually for Campbell in county in January of 2025. Topics included elevator pitches, working with stakeholders, and guest presentations (Campbell County DFS, ABLE, YES House, and Boys and Girls Club of Campbell County). Held Provider Summit virtually for Park County, May 2025.

Evaluation Category	Findings
	Topics included county population and household demographics along with barriers noted by the providers when working in that county. o Held the 2025 Collaborative Connections Conference in Wyoming for network providers: Conference sessions emphasized technical knowledge, sustainable practice, and workforce development. Sessions included deep dives into the CANS tool, Medicaid billing, planning strategies, and natural supports. Keynote speaker Dr. John Lyons provided a foundational address and technical workshop centered on using the CANS as a framework for effective care. o Outreach and collaboration with Indian Health Services. o Participation in the Eastern Shoshone Tribal Health Fair. o Collaboration with facility that provides both inpatient and outpatient services to become a HFWA provider. o In person visit with Fremont County DFS and Riverton High School. o Outreach and Tabling at various community events including 211's annual conference and The Children's Justice Symposium. o Availability of services via video conferencing which provided an alternative to in person services where circumstances present barriers to meeting with the youth and family face to face: This is an option for providers to use with families if circumstances dictate that a video conference is more convenient for the enrollee and their family. The family's voice and choice plays a predominant role here if they prefer an in-person meeting or if a Zoom meeting is acceptable. o Training to ensure appointment availability of providers is accurate. o Update to Statements of Work for Providers with training and examples of how to provide scheduled services and engage with families (16 trainings offered over 2 months to accommodate provider schedules). o Connection of solo providers to agencies which provides a broader level of support to providers, especially new providers. o Further collaboration with the Small Business Development Center.
Likelihood of Significant Improvement	Magellan demonstrated their commitment to attracting new providers through targeted outreach, developing partnerships, distributing marketing materials, and hosting workgroups. Magellan also supported their current provider network through collecting and addressing feedback, providing regular support calls, creating new provider specialist positions, and creating learning opportunities (e.g., conferences, summits). The PIP documentation describes interventions and contextual factors but does not include quantitative evaluation demonstrating the relative contribution of individual interventions to observed performance changes. While performance measures showed improvement from SFY 2024 to SFY 2025, trends observed across multiple measurement years beginning in SFY 2021 reflect fluctuation in provider enrollment rather than a sustained growth trajectory. In addition, the PIP does not define quantitative program targets (e.g., the number of providers needed to meet program demand), which limits the ability to assess the magnitude or sufficiency of improvement achieved. As a result, the PIP does not provide sufficient evidence to demonstrate confidence in meaningful or sustained improvement.

E. Protocol 1 Strengths, Opportunities for Improvement, and Recommendations

This section pertains to the Network PIP alone and does not include any recommendations for the PA PIP, as it terminated early. As the Network PIP moves into its third 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. Below are several strengths and areas for improvement:

S1. Strength: Documentation maintained for PIPs aligns directly with CMS requirements.

The QIA forms provided for the SFY 2025 EQR continued to include clearly labeled items and sections, comprehensive data tables, and identification of the IHI's PDSA process used to develop PIP development. The strengths in documentation exhibited during the SFY 2024 EQR continue to be seen in the SFY 2025 EQR, including addressing the few recommendations to strengthen the reporting. For example, Magellan strengthened its documentation by including staff experience and qualifications for individuals completing data analysis and by providing clearer explanations of aim statement development, including the potential impact on the CME Program if goals are not met.

S2. 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 staff has amassed considerable expertise in Wyoming, as well as the functional barriers and successful techniques for improving care services in the State. The team's institutional knowledge continues to provide meaningful insights into the continued development and improvement of the HFWA Program and its evolving goals. It is very clear the team knows issues in the State, the providers they work with, and the needs and challenges of the youth they serve. The close attention the Magellan team provides to the CME Program also allows for a hands-on approach to program improvement that considers the nuances and characteristics of the population served and the State agency overseeing the CME Program.

S3. Strength: Magellan proactively saw that performance in the PA PIP was still not being achieved as expected and proposed additional improvements to the State.

Magellan's regular evaluation of the PA authorization process, in addition to the performance on the PIP's performance measures led to an internal discussion on additional program enhancements that could be made to improve the overall process and more quickly allow the delivery of services to the youth they serve. While the process was not fully documented during the intensive review sessions, Magellan's team described in detail how they evaluated performance trends and provider feedback, which ultimately led to a recommendation to the State for further program revisions. These revisions were intended to enable providers to complete required documentation more efficiently, support timelier service delivery for youth, and remain aligned with State reporting requirements and CMS-approved waiver authority.

N1. Needed Improvement: The quantitative structure and statistical framing of the Network PIP limit the ability to clearly interpret the magnitude and significance of improvement attributable to the PIP interventions.

Magellan's Network PIP includes regular quantitative tracking of provider counts and applies statistical testing to changes in average monthly provider counts across remeasurement periods. However, the current measurement framework aggregates all active providers into single counts without distinguishing whether observed changes are driven by new provider recruitment, provider retention, or provider attrition.

In addition, the quantitative measures focus on absolute counts and averages without calculating percentage change over time or establishing predefined quantitative performance targets. As a result:

- Reported changes in provider counts cannot be interpreted in terms of relative growth or decline, particularly in the context of a small and fluctuating provider population.
- Statistical test results (significant or not significant) lack clear context for determining whether the magnitude of change represents meaningful improvement versus normal network churn.

- The absence of explicit targets limits the ability to assess whether observed changes meet, exceed, or fall short of the PIP's intended level of improvement, independent of statistical significance.

Together, these limitations reduce the clarity of the quantitative findings and constrain the ability to attribute observed changes to PIP interventions or assess progress in a consistent, statistically interpretable manner across measurement periods.

R1. Recommendation for Magellan: Strengthen the Network PIP's quantitative framework by incorporating percentage-based measures, provider status distinctions, and clearly defined performance targets.

To enhance the statistical interpretability of the PIP while building on existing data collection, Magellan should refine its quantitative measures to:

- Distinguish provider counts by status (e.g., newly enrolled, retained, and terminated providers) to clarify the drivers of observed network changes.
- Supplement absolute counts and averages with percentage-based measures (e.g., percent change in total providers, percent retained year-over-year) to better contextualize growth or decline in a small provider network.
- Establish and document quantitative performance targets or thresholds that define expected improvement, even where formal statistical significance may be difficult to achieve due to sample size limitations.
- Develop performance targets for the performance measures to provide a stated goal for the team to strive for while implementing the stated interventions.

Incorporating these elements would improve the consistency and interpretability of statistical results, support clearer conclusions regarding intervention effectiveness, and strengthen alignment with CMS EQR Protocol 1 expectations for quantitative performance assessment.

N2. Needed Improvement: Magellan's PIP design identifies secondary drivers but do not include evaluation of their impact on performance measures.

Magellan identified secondary drivers and contextual factors that may affect provider enrollment outcomes, such as provider turnover, geographic challenges, provider capacity, and timing of recruitment and training interventions. However, the PIP documentation does not include an analysis of how these identified factors influenced the performance measures or contributed to observed changes in provider counts over time.

As a result, while the PIP acknowledges that network performance may be affected by factors beyond the primary interventions, the absence of evaluation of these secondary drivers limits the ability to determine the extent to which observed performance changes are attributable to the PIP interventions versus external or contextual conditions. This constraint reduces clarity around the effectiveness of the Network PIP's strategies.

R2. Recommendation for Magellan: Evaluate secondary drivers within the Network PIP and refine measures to better assess intervention effectiveness.

During intensive review sessions, Magellan staff described consideration of additional factors that may influence Network Adequacy PIP outcomes. Magellan would benefit from formally documenting this evaluation within the PIP's methodology and analysis.
To strengthen attribution and interpretation of results, Magellan should consider:

- Evaluating the impact of identified secondary drivers and confounding factors on provider enrollment outcomes;
- Incorporating provider enrollment and disenrollment data, including reasons for activation and termination, to better target and assess recruitment and retention strategies; and

- Refining or supplementing performance measures to more directly assess the impact of specific Network Adequacy interventions and distinguish those effects from external influences.

Incorporating these elements would strengthen the analytic rigor of the Network PIP and improve the ability to interpret performance results in alignment with CMS EQR Protocol 1 expectations.

4. Protocol 2: Validation of Performance Measures

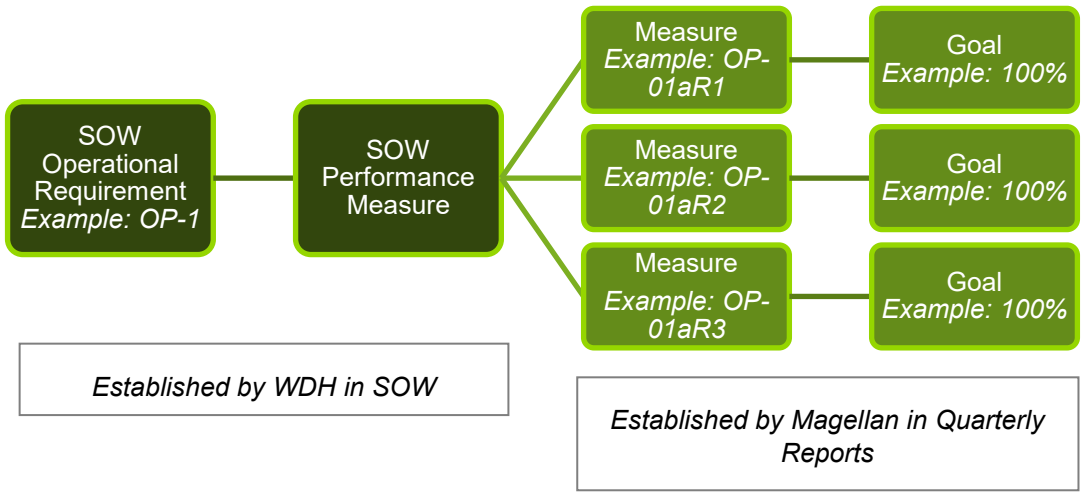
A. Protocol 2 Overview

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.

B. Review Methodology

Each SOW operational requirement was given an Operational Requirement (OP) number and assigned to categories (HFWA, Operations, Project Management, Provider Network, System of Care, Technical, or Financial). Each SOW operational requirement corresponded 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 included naming conventions which corresponded to the associated SOW operational requirement (e.g., Magellan's measure "OP-01aR1" corresponds to SOW operational requirement "OP-1.") The SOW also directed 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 13** displays the relationship between SOW operational requirements, SOW performance measures, measures, and goals.

Figure 13. SOW Requirements, Performance Measures and Goals



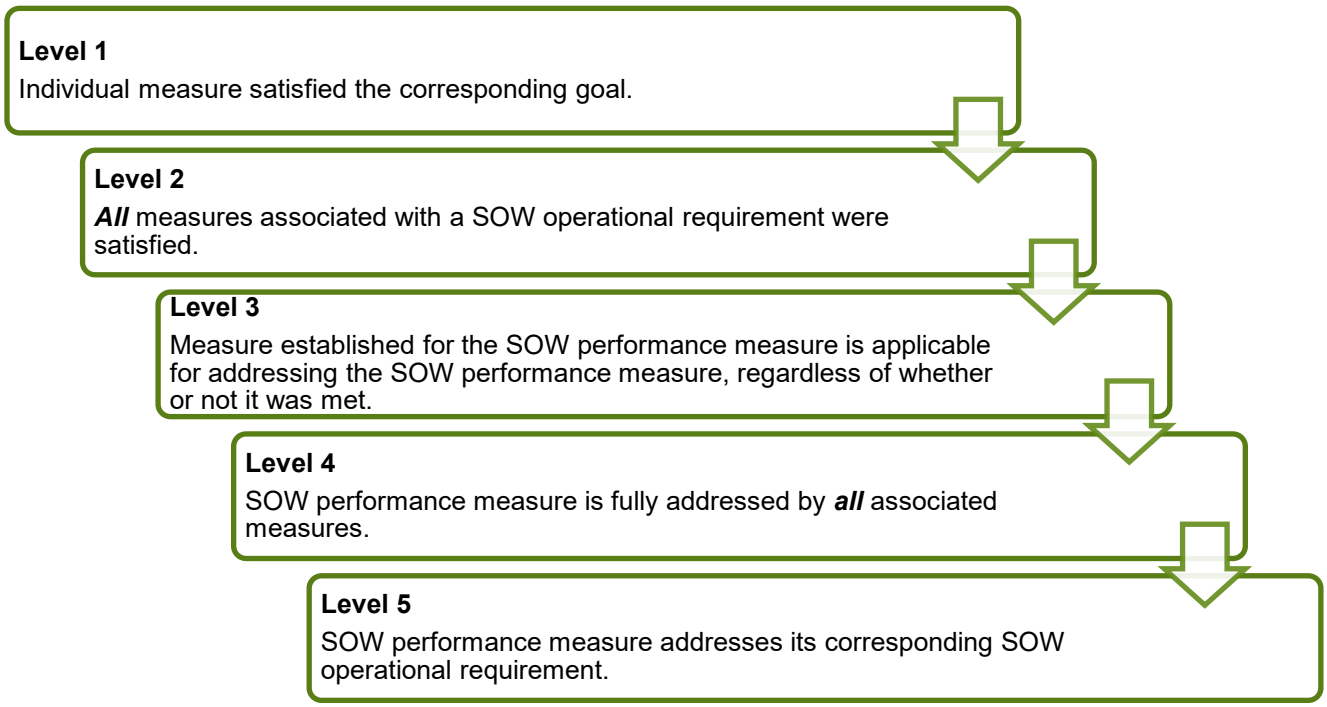
i. Levels of Analysis

Guidehouse conducted five levels of analysis for the measures and SOW operational requirements, displayed in **Figure 14** below. Please refer to **Appendix E** for additional details regarding how SOW

operational requirements, SOW performance measures, measures, and goals interact as well as example walk-throughs of the levels of analysis.

C. Statement of Work Reporting Requirements

Figure 14. Levels of Analysis



The SOW requires Magellan to submit two sets of performance data as described below and in **Figure 15**:

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 2025, review and validation of reported data included 25 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.

Figure 15. 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

Operational Requirement	Performance Measure Description	Measure / Goal
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 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 & 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. Exceptions may be made for sibling groups	EM 9-24
EM 9-29	Prompt and oversee that families complete the Agency's Wraparound Fidelity Index (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

D. Operational Requirements Performance Findings

i. 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. **Figure 16** 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]

Figure 16. Level 1 – Assess whether Magellan satisfied individual goals as set in the annual report.

Level 1 Evaluation	Percent of Goals *(n=25)*
Goal Met	56%
Goal Not Met	20%
Not Applicable	20%
Insufficient Data	4%
Total	**100.0%**

Figure 17 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).

Figure 17. Level 2 – Assess whether Magellan fully met all measures associated with a performance measure.

Level 2 Evaluation	Percent of PMs *(n=23)*
Yes	56.5%
No	21.1%
Not Applicable	21.7%
Insufficient Data	0%
Total	**100.0%**

ii. Relationship Between Goals and Performance Measures

Figure 18 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.

Figure 18. Level 3 – Assess whether a particular measure addresses its SOW performance measure, regardless of whether or not it was met.

[1] Throughout this section "Not Applicable" indicates there was no applicable data in SFY 2025 for this measure.

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

Level 3 Evaluation	Percent of Measures *(n=25)*
Yes	100.0%
Partially[3]	0.0%
No	0.0%
Total	**100.0%**

Figure 19 provides findings from Guidehouse's Level 4 analysis described previously, which assesses whether the listed measures fully address their associated SOW performance measure.

Figure 19. 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%**

iii. 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. **Figure 20** 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.

Figure 20. 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%**

iv. 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. **Figure 21** highlights the validation of the selected performance measures. For each measure, Guidehouse provided a score for each of three elements: Numerator (N), Denominator (D), and Source (S) Data. **Figure 21**

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

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

also identifies the measure steward if it is a nationally validated measure or if it is a WDH custom measure for the CME Program. Selected SOW operational requirements include the following:

- **OUT 13-2:** Decreased Length of Stay (LOS) for OOH Placement
- **OUT 13-9:** Family and Youth Participation at State-level Advisory Committees
- **OUT 13-10**: Family and Youth Participation in Communities

The scores and their corresponding selection meaning used by Guidehouse are defined in **Figure 22** further below.

Figure 21. 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 LOS for OOH Placement	WY Custom	EHR	3	5	5	13	**Moderate**
OUT 13-4: Graduates Moving to Higher LOC	WY Custom	EHR	5	5	5	15	**High**
OUT 13-5: Primary Care Practitioner Access Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	WY Custom	EHR	5	5	5	15	**High**

Guidehouse evaluated the information provided throughout the review, including intensive review sessions 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-Framework for Summarizing.

Figure 22. 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.

Figure 23 describes results of the measure validation and indicates that Magellan:

- Fully met two of the three SOW operational requirements (OUT 13-9 and OUT 13-10).

SOW operational requirement measures were 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 incorrect manual calculation, resulting in understated total, of Psychiatric Residential Treatment Facility (PRTF) Days based on interim claims and use of Excel DAYS() function when youth is still in PRTF.

Figure 23. Protocol 2 Measures and Findings

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
OUT 13-2: Decreased LOS for Residential Treatment admissions for youth enrolled in the CME • **Numerator**: Average LOS for CME enrolled youth in Out of Home placement. • **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. **Numerator:** • While Magellan reported the numerator as an average per the numerator description, the entire measure (numerator/denominator) should be the average. • 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. **Denominator:** • 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. • 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. **Overall Findings:** • In the Committee Data File (CDF), the Result row should display a percentage reflecting the current numerator description 'Average LOS for CME enrolled youth in Out of Home placement. (Psychiatric Residential Treatment Facility and Acute Psychiatric).	**No**	**Yes**	**Yes**
OUT 13-9: Family and Youth Participation at State-level Advisory Committees • **Numerator:** The number of state-level Advisory attendees who represent family and youth enrollees • **Denominator:** The number of CME enrollees			
Numerator: • Numerator is the result of a manual count of meeting attendees. **Denominator:** • Denominator is the count of all CME enrollees. See recommendations below for potential update. **Overall Findings:**	**Yes**	**Yes**	**Yes**

Figure 23. Protocol 2 Measures and Findings

Measures and Findings	Accurate Creation of Numerator	Accurate Creation of Denominator	Accurate Source Data
• While this is not a finding representative of an error or oversight, WDH may determine if it is important to understand if a meeting was held with no participants, or a meeting was not held, and modify the CDF display accordingly.			
OUT 13-10: Family and Youth Participation in Communities • **Numerator**: Number of family and youth participants • **Denominator**: Number of CME enrollees			
Numerator: • Numerator is the result of a manual count of attendees at advisory council meetings. **Denominator:** • Denominator is the count of all CME enrollees. See recommendations below for potential update. **Overall Findings**: • While this is not a finding representative of an error or oversight, WDH may determine if it is important to understand if a meeting was held with no participants, or a meeting was not held, and modify the CDF display accordingly.	**Yes**	**Yes**	**Yes**

E. Outcome Measures Performance Findings

Guidehouse assessed data provided by Magellan to evaluate compliance with 10 outcome measures. **Figure 24** provides a summary of the outcome measure results based on performance throughout SFY 2025. 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.

Figure 24. Status of Outcome Measures

Outcome Measure	Guidehouse Determination
OUT 13-1: OOH Placements The Contractor shall report the number of OOH placements of Contractor youth (anything other than a family or adoptive placement).	**Meets Requirements**
OUT 13-2: Decreased LOS for Inpatient and Residential Treatment admissions The Contractor shall report the overall LOS for inpatient and residential treatment for youth enrolled in the CME.	**Meets Requirements**

Outcome Measure	Guidehouse Determination
OUT 13-3: Recidivism The Contractor shall decrease the recidivism of youth served by the Contractor moving from a lower level of care (LOC) to a higher LOC.	**Meets Requirements**
OUT 13-4: Recidivism LOC at six (6) months post CME graduation The Contractor shall report recidivism of youth served by the Contractor and who graduated from the CME Program who are moving from a lower LOC to a higher LOC within six (6) months of graduation from the CME.	**Meets Requirement**
OUT 13-5: Primary Care Practitioner Access (EPSDT) The Contractor must report the number of CME enrolled youth who have an identified Primary Care Practitioner.	**Meets Requirement**
OUT 13-6: Cost Savings (Healthcare Costs) The Contractor shall report healthcare costs to Medicaid for the CME enrolled youth.	**Meets Requirement**
OUT 13-7, 13-8: Fidelity to the HFWA Model • The Contractor shall report fidelity to the HFWA model as measured by the WFI-EZ • The Contractor shall report the number of WFI-EZ surveys administered to capture a valid and representative sample of the experiences of members served.	**Meets Requirement**
OUT 13-9: Family and Youth Participation at State-level Steering Committees The Contractor shall report family and youth participation on State-level Steering Committees.	**Meet Requirements**
OUT 13-10: Family and Youth Participation in Communities The Contractor shall report family and youth participation on the CME's community advisory boards, support groups and other stakeholder meetings facilitated by the Contractor.	**Meet Requirements**

F. Protocol 2 Strengths, Opportunities for Improvement, and Recommendations

Magellan's SOW operational requirements, outcome measures, and associated processes demonstrate several strengths and areas for improvement, described below. Many of the strengths are consistent with strengths identified in the previous measurement years.

- Project team is comprised of knowledgeable staff with years of experience with the CME Program, the measure, and the EQR process.
- The measure creator demonstrated the data extraction and measure calculation processes for OUT 13-2 in both Cognos and SQLServer. For Measures 13-9 and 13-10, the clinical owner explained meeting attendance as the data source. 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 queries, and complete calculation(s) reported in the CDF.
- For OUT 13-2, some previous EQR recommendations were implemented, and measure creation documentation updated to reflect conversations surrounding intent of measure.
- Measure creator could successfully explain prior run results, and the team could perform manual tasks, and match counts across systems.
- Quality team could locate and extract samples to display confirmation.
- QIC remains a key part of the CME Program.

S4. 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, 2023, and 2024).

S5. Strength: Documentation describing measure result creation is detailed and robust.

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 and 2024).

S6. 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.

N3. Needed Improvement: Reporting Metric documentation is inaccurate.

R3. Recommendation for Magellan: Correct the definition of numerator.

- Documentation for OUT 13-2 incorrectly states “Average LOS is equal to the number of PRTF hospitalization stays / Distinct # of youth enrolled 6 months or greater within the reporting period”. In this case, “stays” should be “days”.
- Documentation for OUT 13-9 describes numerator as “Member Advisory Group attendees + Providers that attend External QIC + Coaches Advisory attendees + Referral Summit calls” in the CDF and SOW, but just “Member Advisory Group attendees” in the Metric Review Document.

N4. Needed Improvement: Manual process calculation is needed for LOS and reporting days.

The Global report is miscalculating LOS and reporting days and youth that the Quality team later removes.

R4. Recommendation for Magellan: Correct the Cognos extract for PRTF days.

The Global report should (1) include Patient Status; and (2) provide the correct values so that post-review manual reductions are made only where Clinical Notes override claims because the youth was not in PRTF. In one case, the Case Note review indicated the PRTF stay began before the youth was enrolled at least 6 months, but the youth and days were included in the Global report results.

Note: This may be the result of misunderstanding the definition of the numerator and denominator including youth enrolled in the CME Program 6+ months versus youth enrolled in the CME Program 6+ months *before the PRTF stay*.

R5. Recommendation for Magellan: Correct the calculation of PRTF days.

The manual calculation where the Patient Status = 30 (Still a Patient). For each full week billed, the count is reflected as only 6 days but should be 7 days. The =DAYS() function is sufficient only when the Patient Status indicates the last day is a discharge.

For each non-discharge claim billed for a youth, we are missing 1 day in the Average Length of Stay (ALOS) calculation. For a 3-month stay billed weekly, the value is understated by 12-14 days.

R6. Recommendation for Magellan: Work with WDH to determine process for reporting Case Note / Cognos discrepancies.

A Case Note reflecting a youth was not in PRTF on the same day the state paid a claim for a PRTF stay is the result of erroneous data; either the Case Note is mistaken or the PRTF billed for a day where the youth was not present. Before removing the days and youth from the Measure OUT 13-2 results, work with WDH to determine which data is correct.

N5. Needed Improvement: Contract and business requirements documents (BRD) require more clarity to accurately perform calculations.

To ensure the technical staff authors the extract and calculation scripts correctly, and post-report manual updates are correct, provide more clarity in the business requirements. This will also serve the reconciliation team and QIC as they validate the results.

R7. Recommendation for WDH: Include more details in the contract and subsequently the BRDs.

To avoid assumptions which may lead to under- or over-reporting of enrollees, days of stay, etc., consider more specific documentation describing the exact inclusions and exclusions required for each measure.

Consider updating the following for Measure OUT 13-2:

Intent of Measure

- Determine if the ">= 6 months" is as of the quarter in which the report is executed or as of the report run date. As currently coded, the denominator keeps growing because more youth are enrolled >= 6 months.
- From SFY 2024 review, based on the measure name "Decreased LOS", WDH believes each quarter should be compared to the same quarter in the prior year to see if ALOS is decreasing.

Numerator

- By stating the average days as the numerator in the CDF, there is no way to verify creation of ALOS.
- Consider the numerator being "Total number of days for PRTF admission for youth enrolled greater than or equal to 6 months in the reporting period, or prior to PRTF admission".

Denominator

- Should denominator be "Youth enrolled greater than or equal to 6 months in the reporting period before having at least one day in PRTF"? It does not seem the days or ALOS should be compared to all youth in CME >=6 months when this measure is only applicable to the subset who had a PRTF stay. It is also unclear if the youth must be in CME for 6 months prior to the first day of PRTF stay.

Define Process for Researching Discrepancies

- A Case Note reflecting a youth was not in PRTF on the same day the state paid a claim for a PRTF stay is the result of erroneous data; either the Case Note is mistaken or the PRTF billed for a day where the youth was not present. WDH should provide for Magellan an explanation of how, and to whom, the Case Note

reviewer should report such discrepancies before removing the days and youth from the Measure OUT 13-2 results.

Define Manual Process Calculation

- The Case Note Manual Review process is miscalculating the number of days per stay (typically 1-2 weeks of each stay) by using the =DAYS() function without adding 1 to each span where the Patient Status = 30 (Still a Patient). For each full week billed, the count is only 6 days and should be 7 days. The =DAYS() function is sufficient only when the Patient Status indicates the last day is a discharge.
- For each non-discharge claim billed for a youth, we are missing 1 day in the ALOS calculation. For a 3-month stay billed weekly, the value is understated by 12-14 days.

Define Day/Youth Count Discrepancy Process

- The Case Note Manual Review process is miscalculating the number of days per stay (typically 1-2 weeks of each stay) by using the =DAYS() function without adding 1 to each span where the Patient Status = 30 (Still a Patient). For each full week billed, the count is only 6 days and should be 7 days. The =DAYS() function is sufficient only when the Patient Status indicates the last day is a discharge.

Consider updating the following for Measure OUT 13-9:

Denominator

- Consider defining the denominator as “Total Number of People eligible/assigned/invited to participate in the State-level Advisory Committees (SLAC) meetings rather than the sum of all CME enrollees.
- For months when there is no SLAC meeting, consider displaying the denominator as 0 to provide a visual indicator that no meeting was held. A month reflecting 0/0 would indicate no meeting was held while a month with 0/23 would indicate a meeting was held but none of the 23 eligible participants attended.

Consider updating the following for Measure OUT 13-10:

Committee Data File

- The CDF could display a result (the num/den % calculation) as this metric captures Family and Youth Participation in Communities. It would be appropriate to displaying the % of people participating out of those eligible to participate.

Denominator

- Consider changing the denominator as “Total Number of People eligible/assigned/invited to participate in the MAG meetings” rather than the sum of all CME enrollees.
- For months where there is no MAG meeting, consider displaying the denominator as 0 to provide visual indicator that no meeting was held. A month with 0/0 would indicate no meeting was held while a month with 0/46 would indicate a meeting was held but none of the 46 members of the MAG attended.

5. Protocol 3: Compliance with Medicaid Managed Care Regulations

A. Protocol 3 Overview

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. This protocol assesses whether Magellan has established and implemented policies, procedures, and operational practices that align with requirements set forth in 42 CFR § 438, as well as State-specific expectations applicable to the Wyoming CME Program.

The review also assesses the consistency of compliance practices across functional areas, including enrollee rights and protections, access to services, care coordination, provider network oversight, grievance and appeal processes, and information systems. Findings from this protocol inform State oversight activities and support identification of strengths, areas of needed improvement, and recommendations related to regulatory compliance and program accountability.

B. Review Methodology

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 12 elements applicable to the CME Program.[5] This compliance review encompassed the standards listed in **Figure 25.**

Figure 25. MCP Compliance Standards Reviewed by the EQRO in SFY 2025

Standard Reviewed by Guidehouse	Subpart D Standard	CFR #	Last Reviewed
MCP Standards, including Enrollee Rights and Protections: Includes standards for content and distribution of member materials and State laws on member rights.	Disenrollment: Requirements and limitations	**42 CFR § 438.56**	SFY 2022
	General compliance, including enrollee rights and protections; information requirements for all enrollees	**42 CFR § 438.100**	SFY 2022
	Emergency and post-stabilization services	**42 CFR § 438.114**	SFY 2022
	Availability of services; access and cultural considerations; furnishing of services and timely access	**42 CFR § 438.206**	SFY 2022
	Assurances of adequate capacity and services	**42 CFR § 438.207**	SFY 2022
	Coordination and continuity of care	**42 CFR § 438.208**	SFY 2022

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

Standard Reviewed by Guidehouse	Subpart D Standard	CFR #	Last Reviewed
	Coverage and authorization of services	**42 CFR § 438.210**	SFY 2022
	Provider selection	**42 CFR § 438.214**	SFY 2022
	Confidentiality	**42 CFR § 438.224**	SFY 2022
	Sub-contractual relationships and delegation	**42 CFR § 438.230**	SFY 2022
	Practice guidelines	**42 CFR § 438.236**	SFY 2022
	Health information systems	**42 CFR § 438.242**	SFY 2022

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, was present; and Magellan staff provided responses to Guidehouse reviewers that were consistent with each other and with the documentation.
- **Partially Met** – Magellan staff described and verified existence of compliance practices during interview(s) and/or discussion(s) with Guidehouse reviewers, but required documentation was unavailable, incomplete, or inconsistent with practice; or all documentation listed under a regulatory provision, or component thereof, was present, but Magellan staff were unable to consistently articulate evidence of compliance.
- **Not Met** – Submitted documentation did not meet federal or State standards; or no documentation was present and Magellan staff had little to no knowledge of processes or issues that comply with regulatory provisions.

C. Performance Findings

Since full compliance reviews are only required once every three years, Guidehouse conducted a full review in SFY 2023. During the three-year timeframe, targeted reviews are conducted in smaller sections. Last year, review focused on QAPI and this year on enrollee rights, provision of services, and provider network. **Appendix G** includes Guidehouse's review tool for EQR Protocol 3.

Figure 26 provides an overview of Magellan's compliance by topic. Magellan fully met 100% of applicable elements in SFY 2025. None of applicable elements were considered "partially met" or "not met" in SFY 2025.

Figure 26. Extent of Compliance with EQR Protocol 3 Elements, by MCP Requirement Section

Compliance Level	*MCP Standards: Enrollee Rights and Protections*	
	No.	**Percent**
Fully Met	**56**	**100%**
Partially Met	**0**	**0%**
Not Met	**0**	**0%**
Total Applicable	**56**	**100%**

Compliance Level	*MCP Standards: Enrollee Rights and Protections*	
	No.	Percent
Not Applicable[6]	**4**	--

There are four (4) total elements of the compliance review worksheet that were not applicable to the CME Program and were excluded from review. The excluded compliance elements are summarized in **Figure 27.**

Figure 27. Compliance Review Elements Not Applicable to the CME Program

Elements Not Applicable to the CME Program	Relevant CFR
Additional coordination and continuity of care requirements for Long-Term Services and Supports (LTSS): LTSS does not apply to the CME Program population; CME Program delivers care coordination to children aged 4-20 years old.	**42 CFR 438.208.** Coordination and continuity of care
Additional coordination and continuity of care requirements Special Health Care Needs (SCHN): Dually-enrolled beneficiaries are not eligible for the CME Program.	**42 CFR 438.208.** Coordination and continuity of care
Coverage and authorization of pharmacy services: Approval of outpatient drugs before dispensing is not applicable, as pharmacy is not a covered service under this program.	**42 CFR 438.210(a–e).** Coverage and authorization of services, including **42 CFR 440.230**. Sufficiency of amount, duration, and scope; **42 CFR Part 441, Subpart B.** EPSDT of Individuals Under Age 21;* and **42 CFR 438.114.** Emergency and post-stabilization services **CHIP: 42 CFR 457.1230(d).** Coverage and authorization of services **42 CFR 457.1228.** Emergency and post-stabilization services
Enrollee right to participate in decisions regarding his or her care and be free from any form of restraint through an advance directive: The CME does not request advance directives from enrollees and provides coverage only to minors.	**42 CFR 438.100(b)(2)(iv) and (v):** Enrollee right to: • Participate in decisions regarding his or her care, including the right to refuse treatment;

[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	Relevant CFR
	• Be free from any form of restraint... as specified in other Federal regulations

Within each topic, Magellan's policies indicated compliance with most 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 HFWA (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.
- Grievance and Appeals System
  - Standards for handling 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.

D. Protocol 3 Strengths, Opportunities for Improvement, and Recommendations

S7. Strength: Magellan exhibited strong adherence to enrollee rights and protections.

Magellan demonstrated strong compliance with Medicaid managed care requirements related to enrollee rights, privacy, accessibility, and procedural protections. The MCP has established processes to inform enrollees and families of their rights and program options through enrollment letters, orientation activities, member handbooks, and ongoing FCC engagement. These processes supported enrollee understanding of provider choice, care coordination roles, and access to services.

Magellan demonstrated that grievance and appeal protections are operationalized through defined workflows that ensure enrollees have access to resolution processes, with escalation to the State when applicable. The review confirmed that Magellan ensures continuation of services during grievance and appeal processes, as required, and maintains procedures to route grievances appropriately to support consistent and timely resolution.

S8. Strength: Magellan demonstrated effective service provision and care coordination.

Magellan also demonstrated strong performance in service provision and care coordination. Initial outreach, enrollee screenings, and development of POCs were monitored through system tracking and reinforced through FCC oversight and provider training. These processes supported timely engagement and continuity of care across the enrollee lifecycle.

The MCP implemented robust transition planning practices, including proactive monitoring of provider capacity changes and youth aging out of services. Transition activities include family engagement,

provider choice, warm handoffs, documented discharge planning, and follow-up supports, which collectively support continuity of care and minimize service disruptions.

S9. Strength: Magellan fostered strong processes for provider network management.

Magellan maintained defined processes for provider credentialing, recertification, onboarding, coaching, and ongoing monitoring. Provider oversight was supported through structured documentation review, regular provider engagement, and ongoing training. These activities supported network stability, provider readiness, and adherence to program requirements.

Magellan also conducted internal meetings, quarterly reporting, and oversight activities to monitor network performance and access. These processes supported proactive identification of network issues and timely response to access or capacity challenges.

S10. Strength: Magellan utilized a mature health information system infrastructure.

Magellan's health information system infrastructure, including the Fidelity EHR, supported comprehensive documentation, monitoring, and reporting of care coordination activities. The system allowed tracking of enrollee interactions, assessments, plans of care, provider engagement, and team composition. It also supported differentiation between formal and informal supports and facilitated oversight of service delivery and quality monitoring activities.

Regular system monitoring, reporting, and security processes further supported data integrity and operational accountability within the CME Program.

N6. Needed Improvement: Policies, manuals, and enrollee-facing materials do not consistently align with operations supporting enrollee protections.

> ***R8. Recommendation for Magellan:*** Align written documentation with actual operations.
>
> Certain requirements related to enrollee protections, such as prior authorization processes, provider directory access, EHR management, enrollee appeals, denial tracking, and continuity of care safeguards, are described at a high level or inconsistently across documents.
>
> Magellan may enhance documentation describing PA processes, denial or pending decision tracking, and utilization monitoring to ensure enrollee protections are clearly articulated following recent process changes. Clear written guidance will support consistent implementation, reduce reliance on interpretation, and reinforce enrollee protections.

N7. Needed Improvement: Documentation includes definitions of applicable Medicaid Managed Care terms, though they are not consistently presented across all materials.

> ***R9. Recommendation for Magellan:*** Ensure Medicaid Managed Care definitions are consistently presented and easily accessible across enrollee-facing documentation.
>
> Magellan's documentation reviewed under Protocol 3 included required definitions for applicable Medicaid Managed Care terms. However, these definitions were not consistently presented or referenced across all enrollee-facing materials, such as member handbooks, notices, and related communications. In some instances, defined terms appeared in one document without corresponding definitions or cross-references in other materials where the terms were also used.
>
> While this did not result in missing required content, greater consistency in how and where definitions are presented would strengthen clarity and ease of reference for enrollees and families. Clear, uniform presentation of managed care terminology supports understanding of enrollee rights, benefits, and procedural protections.
>
> To enhance consistency, Magellan may consider consolidating required Medicaid Managed Care definitions into a single, centralized definitions section or clearly referencing an authoritative external source, such as the Wyoming Medicaid website, where standardized definitions are

maintained. A centralized or clearly referenced approach would reduce duplication, minimize the risk of inconsistent language, and support a clearer, more user-friendly experience for enrollees.

Ensuring consistent, regulatory-aligned definitions across enrollee-facing materials will further strengthen Magellan's demonstration of compliance with Medicaid Managed Care requirements and support enrollee understanding.

6. Protocol 4: Validation of Network Adequacy

A. Protocol 4 Overview

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 2025 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 2025 SOW.
- Criteria outlined in CMS EQR Protocol 4 Guidelines.

B. Review Methodology

The Protocol 4 review process follows a logical and stepwise process based on network adequacy standards and reporting practices that a state requires contracted MCPs to adhere to.

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

The Protocol 4 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.

C. Performance Findings

Magellan demonstrated active and consistent oversight of network adequacy requirements established in Wyoming's SFY 2025 CME contract. Documentation submitted for review showed that Magellan regularly monitored provider availability and capacity through multiple mechanisms, including weekly caseload reviews, provider rosters, referral tracking, network development plans, and the use of geomapping to identify potential service gaps.

For SFY 2025, Magellan's network adequacy activities were appropriately assessed against the requirements of the existing SOW, as the updated CMS Medicaid Managed Care Network Adequacy standards are not effective until the SFY 2026 measurement period, will be evaluated in the subsequent EQR cycle. Accordingly, this review does not reflect an evaluation against those future contractual monitoring requirements.

However, CMS EQR Protocol 4 requires that network adequacy monitoring be supported by clearly defined, quantitative, and independently verifiable indicators to allow standardized validation. While Magellan maintains documented procedures for monitoring provider availability, capacity, training compliance, and geographic access (e.g., outline caseload monitoring, provider roster reviews, quarterly

geomapping, and network development planning) these activities are not consistently translated into discrete, reportable quantitative indicators with explicit numerators, denominators, thresholds, or calculation methodologies that can be independently replicated.

While Magellan relied on internal monitoring processes and manual reviews to assess provider capacity and availability, these approaches were not consistently translated into quantitative measures with explicit numerators, denominators, thresholds, or calculation methodologies that could be independently replicated by the EQRO.

As documented in the Protocol 4 worksheets, evidence of network monitoring was often presented through narrative descriptions, provider listings, geomapping, or manual attestations rather than standardized quantitative indicators. As a result, although monitoring activity was occurring, the EQRO's ability to validate network adequacy outcomes was constrained by how performance information was structured and reported. This limitation affected the EQRO's ability to assess rigor, reliability, and reproducibility of reported information as required under CMS Protocol 4, rather than indicating an absence of network oversight.

Figure 28 presents the validation scores and confidence ratings assigned for each Network Adequacy indicator reviewed. The scores and ratings reflect a composite assessment derived from the CMS EQR Protocol 4 worksheet (**Appendix H**) responses. Criteria not applicable to the CME program were excluded from the scoring and rating.

Figure 28. 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.	**11.76%**	**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.	**27.3%**	**Low 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.	**21.4%**	**Low Confidence**
(PM 10-11) Magellan must implement a regional approach to	8 regions with associated counties and Geomaps with	**30.8%**	**Low Confidence**

its provider network as approved by WDH.	provider counts.		
(PM 10-13) Maximum caseload of 10 members for each FCC provider.	List of members and their assigned provider(s) (intended to demonstrate caseload ratios).	**5.9%**	**Low Confidence**

D. Protocol 4 Strengths, Opportunities for Improvement, and Recommendations

The contract between WDH and Magellan does not yet align with the network adequacy reporting system required in the EQR Protocol 4 assessment worksheets as it lacks clearly identified network standards and indicators from WDH that Magellan should meet. WDH still delegates setting most network adequacy standards and reporting indicators to Magellan. The updated SFY 2026 SOW will address the need for more stringent network adequacy standards and indicators. 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.

S11. Strength: Magellan has already made significant progress to report on and meet the new network adequacy standards and indicators for SFY 2026.

Although the State's SOW for the past two years of review did not meet the CMS expectations for network adequacy standards and indicators, the requirements for SFY 2026 incorporate the expectations. Magellan shared the new standards and how they are already tracking and evaluating their provider networks in preparation for the new requirements. Magellan has worked with the State on clarifying data sources and reporting expectations while also evaluating their internal processes to ensure they meet the new requirements. This proactive approach should be commended and will set them up for early success next year as the shift in network adequacy expectations are not an easy adjustment.

S12. Strength: Magellan has made significant improvements in developing and documenting their targeted provider outreach and recruitment efforts.

Magellan's SFY 2025 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 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 which was also an improvement in previous years. Their focus on the tribal population and outreach to educate tribal providers have benefited the State and aligned with recent goals to further engage tribal communities. Magellan's continued efforts have shown to be successful again this year in driving positive change in a targeted population.

S13. 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. They also made significant strides in outreach to the tribal population and enrolling new tribal providers. The focus on ongoing education and responsiveness to provider feedback has also

been successful with the increased number of new providers, along with continued engagement with current providers.

N8. Needed Improvement: Caseload monitoring reports do not consistently demonstrate compliance with contractual caseload requirements in a standardized, externally verifiable format.

Magellan's contract with WDH requires that FCCs that have only completed "Tier 1 trainings" are limited to a client ratio of 1 provider per 10 members. FCCs 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. During the intensive review sessions, Magellan did discuss their interpretation of the requirements and how they operationalize the requirements by requiring all FCC providers to be Tier 2, which was the first time that Guidehouse had been notified as it is not discussed in the submitted policies or procedures.

Magellan noted that they assess provider caseloads through weekly meetings regarding members, their assigned providers, and provider caseload. Magellan also produces weekly caseload reports that demonstrate active oversight of provider assignments and capacity. However, the caseload reports submitted for EQR review did not consistently include standardized, quantitative elements sufficient to independently validate compliance with contractual caseload ratio requirements.

Specifically, the caseload reports reviewed:

- Did not consistently identify the provider role or type of service delivered;
- Did not present caseload ratios or other quantitative calculations that demonstrate compliance with applicable maximum caseload standards; and
- Did not consistently identify the provider training tier associated with each provider.

Magellan also did not provide any aggregate statistics regarding provider caseloads or caseload reports from periods beyond one week.

> ***R10. Recommendation for Magellan:*** Incorporate caseload ratio calculations as regular measures reported to WDH to demonstrate compliance with contractual requirements.
>
> To strengthen the ability to demonstrate compliance with caseload requirements, Magellan should enhance its caseload reports to include standardized quantitative indicators that clearly reflect individual provider caseloads relative to applicable contractual limits. This may include reporting caseload ratios (e.g., members per provider), identification of provider role and training tier, and clear comparison to contractual thresholds. It is also recommended that the average acuity and the number of services provided to a youth be considered when evaluating provider caseloads as youth with an increased acuity or services will require more of a provider's attention.
>
> ***R11. Recommendation for Magellan:*** Provide caseload measures for additional periods beyond weekly.
>
> While weekly caseload reports support real-time operational oversight, Magellan could further strengthen network adequacy monitoring by supplementing these reports with aggregated caseload measures across additional timeframes (e.g., monthly, quarterly, or annually). Period-based summaries would support evaluation of trends, seasonal variation, and sustained compliance with caseload standards over time. Given the youth population served and the potential influence of family availability and seasonal factors on service delivery, reporting caseload measures across multiple time horizons would improve interpretability and provide additional assurance of ongoing compliance with contractual requirements.

N9. Needed Improvement: Magellan and WDH do not have a definition or formal measures to determine what constitutes adequate access to services.

While Magellan conducts ongoing monitoring of provider availability, referrals, and service access, and reports that all enrolled members are assigned a Family Care Coordinator, neither the contract nor supporting documentation establishes a formal, quantitative definition of what constitutes "adequate access" to CME services. The absence of clearly defined access thresholds or measurable standards limits the State's ability to independently assess whether access expectations are consistently met across regions and over time.

R12. 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. One example of a possible collaboration was brought up during the intensive review sessions when the evaluation of a youth's acuity and frequency of services delivered were discussed and mentioned as a topic the State would like to evaluate in more detail with Magellan.

N10. 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 analytical 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.

R13. Recommendation for Magellan: Develop a process and measures to assess and define current and potential members' demand for services / providers.

To strengthen network adequacy planning and support measurable access oversight, Magellan should establish and document a consistent approach for assessing current and anticipated demand for CME services and use that assessment to define target capacity benchmarks for the provider network. While Magellan actively monitors provider availability, caseloads, referrals, enrollment trends, and service delivery, these activities are not currently synthesized into a documented framework that identifies how much provider capacity is needed to meet program demand or how close the existing network is to that desired level. As a result, network development goals are not tied to clearly articulated targets that define what constitutes adequate or optimal network capacity. Identifying target capacity benchmarks would improve transparency for WDH oversight, provide clearer context for evaluating network performance over time, and strengthen alignment with CMS network adequacy expectations

7. Quality Strategy

A. Quality Strategy Overview

In addition to the federally required EQR activities, Guidehouse conducted a review of Magellan's compliance with and implementation of the Wyoming CME Quality Strategy as an additional component of the SFY 2025 EQR. While review of the Quality Strategy is not a mandatory EQR activity, this assessment was performed to provide additional insight into how Magellan aligns program operations with the State's quality goals and performance priorities. The review assessed how Magellan operationalizes the Quality Strategy through program design, service delivery oversight, monitoring activities, and performance improvement efforts. Insights reflect that Magellan has established structures and processes intended to support the State's quality priorities and to promote outcomes consistent with the goals of the Wyoming CME Program.

B. Review Methodology

Guidehouse reviewed documentation submitted by Magellan and WDH, including the Network Development Plan**,** HealthStat materials, performance trend and demographic reports, and materials from advisory bodies and interagency initiatives. Guidehouse also reviewed prior EQR feedback and reports from conferences and advisory forums to understand how program performance and stakeholder experience inform quality oversight and improvement.

Guidehouse supplemented document review with discussions held during intensive review sessions and ongoing coordination meetings to clarify implementation approaches and use of quality-related data. Findings reflect evidence available during the SFY 2025 review period and are summarized in Section 7.C, with supporting detail provided in **Appendix I**.

C. Performance Findings

Magellan's documentation and responses demonstrated an understanding of, and alignment with, the Wyoming CME Quality Strategy and its six program goals. These goals emphasize reducing inpatient psychiatric utilization, including admissions, readmissions, and LOS, containing overall Medicaid cost of care, and strengthening service delivery through enhanced home and community-based integration and increased reliance on family and natural supports. See **Figure 29** for detailed Quality Strategy goals, objectives, and evidence of alignment.

Figure 29. Quality Strategy Goals, Objectives, and Alignment Observations

Quality Strategy Goal	Associated Quality Strategy Objective(s)	Quality Strategy Alignment Observations
Goals 1-3: Admission, Readmission, and LOS	• Decrease OOH placements of CME youth. • Decrease recidivism of CME youth moving from a lower LOC to a higher LOC. • Decrease recidivism of youth who graduated from the CME Program having met their goals and who are moving from a lower LOC to a higher LOC within six months of graduation from the CME Program.	Magellan's Network Development Plan aligned with the State's Quality Strategy by documenting provider coverage, geographic access, and targeted recruitment to support community-based services. Network planning and continuity safeguards further promote timely transitions and family-based care, supporting goals to reduce avoidable inpatient utilization, readmissions, and LOS.
Goal 4: Cost of Care	• Decrease Medicaid costs compared to the target eligible population of non-CME enrolled youth with PRTF stays.	Routine performance monitoring and trend reporting supported oversight of utilization patterns and cost drivers, including analysis of PRTF stays. Existing monitoring infrastructure enabled ongoing assessment of utilization trends and supported alignment between cost containment efforts and quality and access oversight.

Quality Strategy Goal	Associated Quality Strategy Objective(s)	Quality Strategy Alignment Observations
Goals 5-6: Integration, Family Partnerships, and Natural Supports	• Increase compliance with EPSDT/increase number of CME youth who have an identified primary care practitioner. • Increase participation in the WFI-EZ, as measured by the number of WFI-EZ surveys received. • Increase family and youth participation at State-level Advisory Committees. • Increase family and youth participation in communities (e.g., community advisory boards, support groups, and other stakeholder meetings).	Year-end program reviews and annual reports demonstrated that Magellan monitors key outcomes related to integration and natural supports, including fidelity to the HFWA model and family and youth experience measures. Data systems, provider onboarding, and ongoing performance reporting supported culturally competent, family-driven care and continuous quality improvement aligned with the State's Quality Strategy.

8. Conclusion

Guidehouse identified ***13*** areas of strength, ***10*** areas of needed improvement, and ***13*** recommendations. Strengths of the CME Program include:

- **Sustained engagement with providers, families, and stakeholders** to identify opportunities for program improvement and respond to emerging operational and access challenges;
- **Continued improvement in program documentation and reporting**, demonstrating increased alignment with WDH requirements and CMS EQR protocols across multiple review areas; and
- **Advancement in PIP design and implementation**, including clearer articulation of program goals, targeted interventions, and alignment with access-focused CMS priorities.

Areas needing improvement include but are not limited to the following:

- **Strengthening PIP data analysis and evaluation methodologies**, including clearer analysis plans, consideration of secondary drivers, and stronger linkage between interventions and outcomes;
- **Improving consistency and transparency in data collection**, validation, and reporting processes, particularly where manual processes or unclear documentation contribute to data discrepancies; and
- **Enhancing the clarity, standardization, and reportability of network adequacy measures and documentation** to support consistent external validation and alignment with CMS' updated EQR Protocol 4 expectations and applicable contractual requirements.

Appendix J provides a consolidated list of EQRO findings for the CME Program organized by 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 determine which opportunities for improvement they anticipate prioritizing to support continued operation and oversight of the CME Program.

III. Appendices (Attached Separately)

Appendix A: Abbreviations and Acronyms

Appendix B: Status of SFY 2024 Recommendations

Appendix C: Protocol 1 - PIP Worksheets Combined

Appendix D: Protocol 2 - Additional Methodology

Appendix E: Protocol 2 - Operational Requirements Review Tool

Appendix F: Protocol 2 - Outcome Measures Review Tool

Appendix G: Protocol 3 - Compliance Review Tool

Appendix H: Protocol 4 - Network Adequacy Review Tool

Appendix I: Quality Strategy Findings

Appendix J: Plan Level Strengths, Areas of Needed Improvement, and Associated Domains