EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

RESPONDENT NAME: Florida MHS, Inc., dba Magellan Complete Care

A. RESPONDENT BACKGROUND / EXPERIENCE

SRC# 1 – Managed Care Experience (Statewide):

The respondent, including respondent’s parent, affiliate(s) and subsidiary(ies), shall provide a list of all current and/or recent (within five (5) years of the issue date of this solicitation (since July 14, 2012) contracts for managed care services (e.g. medical care, integrated medical and behavioral health services, transportation services and/or long-term services and support).

The respondent shall provide the following information for each identified contract:

a. The Medicaid population served (such as TANF, ABD, dual eligible);
b. The name and address of the client;
c. The name of the contract;
d. The specific start and end dates of the contract;
e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services;
f. The use of administrative and/or delegated subcontractor(s) and their scope of work;
g. The annual contract amount (payment to the respondent) and annual claims payment amount;
h. The scheduled and actual completion dates for contract implementation;
i. The barriers encountered that hindered implementation (if applicable) and the resolutions;
j. Accomplishments and achievements;
k. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid); and
l. Whether the contract was capitated, FFS or other payment method.

In addition, the respondent shall describe its experience in delivering managed care services (e.g. medical care, integrated medical and behavioral health services, transportation services and/or long-term services and support), to Medicaid populations similar to the target population (such as TANF, ABD, dual eligible) identified in this solicitation.

For this SRC, the respondent may include experience provided by subcontractors for which the respondent was contractually responsible, if the respondent plans to use those same subcontractors for the SMMC program.

Response:

OVERVIEW
Magellan Health has been a committed partner to AHCA, and by extension all Floridians, for over twenty years. We bring significant experience serving Floridians from the Panhandle and urban areas, to south Florida and the Florida Keys. Florida is diverse in its culture, and we have demonstrated that we have built a model that speaks to that diversity. We are pleased to have an opportunity, through the current procurement, to continue to evolve and transform health care delivery within a managed care model, and believe that our work is, in fact, changing the lives of the most vulnerable Floridians across the State. While our fully integrated Specialty Plan has only
been operating since 2014, our work, and the partnership with AHCA it represents the culmination of decades of specialized experience. The best practices embedded in every aspect of our Florida operation evolved as the result of numerous lessons learned in the field, working directly with enrollees, and addressing their often complex and challenging needs. We view the current procurement as an opportunity to continue to build on lessons learned, and accelerate the productive partnership with AHCA which has allowed us to overcome multiple barriers and engage Floridians with Serious Mental Illness (SMI) in a progressive, innovative health plan that is unique in the country. Working closely with the State, over the past four years Magellan has implemented a person-centered, evidence-based system of care for individuals with multiple behavioral and physical challenges. In the process, we have addressed significant access barriers, and personally reached out to, and successfully engaged, individuals who in many cases have spent most of their lives outside the healthcare system. Our mission is to build upon what we have done to date with AHCA and our enrollees, so as to truly lead more Floridians to healthy and vibrant lives, our company mission.

As noted above, a detailed list of Magellan managed care contracts covering the past five years, and providing all of the data elements requested in items a. through l. is included in [General SRC #01, Attachment 1: Magellan Complete Care Contract Listing]. On the following pages, we specifically address each of the five scoring criteria included in this question.

CRITERIA 1: THE EXTENT OF THE RESPONDENT’S EXPERIENCE...
[General SRC #01, Attachment 1: Magellan Complete Care Contract Listing] provides a complete listing of Magellan programs implemented in the last five years that delivered integrated medical and behavioral health services as either a prime contractor or as a collaborating partner with the Medicaid MCOs in a particular state.

For each contract, we have included the population served (Column A), term (Column B), scope (Column C) and accomplishments (Column J), together with implementation barriers and timelines (Columns H and I). Counting programs where Magellan was the behavioral health partner in a State or local government Medicaid program, we have implemented more than 30 programs in 11 states on behalf of 4.3 million Medicaid, Medicare and CHIP members.

Magellan’s Specialty plan in Florida, Magellan Complete Care, provides integrated medical and behavioral health services. Additionally, it delivers fully integrated, in-house PBM and specialty pharmacy services through Magellan Rx (MRx), our wholly owned PBM. In this regard, Magellan Complete Care is different from other managed care plans in the State, most of which outsource PBM services and therefore lack true coordination. Magellan brings intense oversight to both our health care and pharmacy services. The synergy between Magellan Complete Care and our MRx pharmacy company was demonstrated most recently in September, when Hurricane Irma made landfall in Florida, affecting several parts of the State where our enrollees and their families reside. As part of our comprehensive emergency response, Care Managers contacted all High Risk enrollees to ensure medications were filled and any critical needs were addressed, including O2, Vents, Bipaps, Suction Pumps, and Apnea monitors. Our ability to quickly meet enrollee needs during Hurricane Irma was enhanced by the high degree of coordination and alignment between Magellan Complete Care and MRx.

The Magellan Complete Care integrated specialty plan leverages numerous best practices developed on the ground in Florida by Magellan during the years when we managed the PMHP.
Our stewardship of PMHP began with the general Medicaid membership in 2006, and expanded in 2007 when we began administering the child welfare program. Managing PMHP services for many years in several AHCA regions allowed the Magellan Complete Care team to gain a deep understanding of the needs of Floridians with serious mental health conditions, as well as the multi-system needs of children in the child welfare system. As a result, we were well prepared to expand our program to include physical health, dental and vision services under the Specialty plan contract. Among the key learnings from our time as PMHP administrator are the following:

> Diversity: Florida is a diverse state, and the most effective health services programs speak the language of enrollees and employ staff who live in the neighborhoods where enrollees themselves live. A high percentage of Magellan Complete Care’s customer service team is fluent in Spanish, and our enrollee materials are available in French Creole as well as English and Spanish. When we are engaging a care coordination team on behalf of a particular enrollee, cultural, social and linguistic considerations are always taken into account.

> Coordination Is Key: Traditional health systems in Florida have often been fragmented, with services provided in siloes. Programs that systematically bring different providers and agencies together through a thoughtful care coordination process, such as PCPs and child welfare administrators, will generate better enrollee outcomes. Magellan Complete Care has entered into collaborative, productive agreements with many provider groups and agencies in the state. We work on behalf of our enrollees, irrespective of traditional barriers. We focus on the enrollee and the result is a community-based team. For example, in Area 9, we partnered with Chrysalis Mental health substance abuse and child welfare agency, as well as with a large hospital to develop a fast track for post discharge appointments.

> Health Homes: Partly as a result of our local engagement through the legacy PMHP plans, Magellan Complete Care has been able to implement a Provider Partnership Project— an Integrated Health Home (IHH) initiative, which exemplifies our approach to integrated care. The Integrated Health Home actively engages individuals and their families in managing their illnesses, aiding them on the journey to recovery. While peer support specialists, community services and individual service plans have been common component of behavioral health care, they have not been widely used for physical health. Magellan has expanded the use of these tools and services to meet all of the enrollee’s needs. Enrollees and their families receive support from peers and care coordinators to:

> Participate in self-management of their condition including follow-up care and medication adherence
> Maintain healthy habits (e.g., healthy eating and sleeping, exercise) and other wellness issues
> Access timely care at the appropriate level and treatment setting.

In Florida, as part of the Provider Partnership Project, we worked with nine PCP and FQHC providers to transform their practices to assist in integrated medical and behavioral care for more than 300 high and ultra high-risk enrollees. We assisted these providers in co-location, information sharing arrangements, and building internal capacity to include behavioral health services.

Magellan also implemented IHH programs in Iowa and Arizona. The Iowa program is of particular relevance because it featured a targeted model for children, the Pediatric Health Home. In this program, we deployed a Quality Caregiver Survey (QCS) analysis of flagged domains, which
reflected improvements for both members and caregivers across multiple domains including medical, school, familial, economic, psychological and legal issues. The outcomes were extremely positive. Children and youth reporting to have shown self harm behaviors between intake and three months of IHH dropped from 17 percent to 10 percent; and of those currently employed, the number of caregivers who reported missing at least one day of work per month due to a child’s emotional or behavioral problem dropped 58 percent from 31 percent at intake to 18 percent at three months.

In Arizona, we used two methods to integrate our enrollees’ physical and behavioral health, an Integrated Health Home program, as well as a joint venture with a local Medicaid health plan through which we delivered co-located services, allowing us to quickly address the needs of members who had both a physical condition and a behavioral health diagnosis (typically serious illness). Through these initiatives, Magellan enhanced its medical capabilities to serve those challenged with a serious mental illness and accomplished significant behavioral and physical health integration. By the time the program ended in 2014 we had:

> Managed the medical and behavioral health needs of 1,850 enrollees with SMI
> Increased enrollee contact with PCPs resulting in 1,300 visits on-site at our Integrated Health Homes, leading to the discovery and treatment of tumors, hypertension, thyroid nodules, polyps, diabetes, heart disease, and many other physical health disorders
> Doubled the rates of mammograms
> Improved annual screening for high blood pressure and diabetes
> Implemented evidence-based screening tools and proprietary assessments to determine this vulnerable population’s comprehensive needs
> Implemented our Comprehensive Enrollee Risk Profile, a robust, 360-degree assessment that identifies how the enrollee is functioning, and helps our Interdisciplinary Care Team (ICT) develop the enrollee’s integrated plan of care.

Magellan’s approach to integrating care also builds on our 20 years in the Pennsylvania HealthChoices program, where we deployed an integrated healthcare portal that allowed providers from different disciplines, including medical providers, to collaborate on individualized care plans for members with both behavioral and medical diagnoses. The HealthChoices HealthConnections program was designed in partnership with local behavioral health systems, county departments, and a regional Medicaid health plan as a model of coordination of behavioral health care with physical health care for an identified population of enrollees with SMI and co-morbid medical condition(s). HealthChoices HealthConnections was part of a Center for Health Care Strategies multi-state national effort to improve quality and reduce expenditures for Medicaid beneficiaries with complex medical and behavioral health needs. As a result of this program, ER visits decreased by 11 percent, and medical facility admissions decreased by 56 percent.

CRITERIA 2: THE EXTENT OF THE RESPONDENT’S SUBCONTRACTORS’ EXPERIENCE...
Included in Column F in the attachment are specifics about the subcontractors employed by Magellan for each of our Medicaid contracts. In every case, Magellan’s implementation team identifies companies that are leaders in their area of expertise, with proven experience demonstrating that expertise with Medicaid members. For some of our sub-contracted partners, such as the DentaQuest managed dental services provider, Medicaid and CHIP contracts are literally 100% of their business. For complex, geographically dispersed, multi-system programs such as Magellan Complete Care and our other fully-integrated Medicaid programs, we selectively
enter into delegated sub-contracts with organizations that provide specific niche expertise that Magellan does not currently offer, such as transportation, dental and vision services. Magellan engages in a rigorous selection process for all delegated vendors and sub-contractors, and we have confidence in their ability to deliver consistent, high-quality services. However, it is important to emphasize that Magellan remains ultimately accountable for performance in every aspect of our contracts. We take our responsibilities as prime contractor extremely seriously. We manage our sub-contractors diligently, and take action quickly if performance issues arise. As an illustration of our subcontractors’ experience, we have highlighted below the experiences and accomplishments of Magellan’s delegated sub-contractors in Florida, all of whom will continue to work with us moving forward.

2.1 Magellan’s Sub-Contractor Partners in Florida Enrich Our Program
We work to identify the best experts and manage them to high standards. We engage Magellan's leadership in key program areas, including operations and quality management, to interact with sub-contractors and monitor and manage their performance on a routine day-to-day basis. Feedback on vendor performance is centralized through our formal Vendor Oversight Committee, which meets quarterly, and more often should specific performance issues arise with a sub-contractor, to review performance against program standards. We regard our sub-contracted organizations as an integral part of the Magellan Complete Care team, and extension of the Magellan family. We ensure their performance, commitment to our mission and our enrollees meet our standards. If we find they do not, we move swiftly to address issues.

2.1.a Non-emergent transportation services (Veyo):
Non-emergency transportation is a critical component of any public sector integrated or specialty health plan. Transportation should never prove a barrier to getting the right care, at the right place, at the right time. To that end, we entered into a contract with non-emergency transportation vendor Veyo, an end-to-end non-emergency transportation (NEMT) services provider. We selected Veyo as a result of Magellan Complete Care’s desire to improve performance and further enhance transportation services and capabilities. In addition to a jointly prepared and integrated transition plan, we established daily internal calls as well as daily calls with Veyo to address any transition issues. Veyo and Magellan Complete Care have worked, in collaboration with AHCA, to address those issues and deliver significantly enhanced results.

As with any new vendor to our Magellan team, we devote tremendous amount of time ensuring that any barriers and issues are managed in “real time” as they occur. We selected Veyo because we believe they are the best-qualified Medicaid transportation vendor in Florida. Veyo’s technology-driven delivery system has the potential to increase efficiency and decrease scheduling bottlenecks that can delay needed care. Veyo offers enrollee and provider Smartphone apps; an expanded fleet that includes both traditional and ‘virtual’ rideshare networks; and real time data facilitated by GPS-tracking and predictive analytics.

Veyo’s flexibility and capabilities were put to the test in September during Hurricane Irma, when the company was called upon both by AHCA and by Magellan Complete Care to exceed routine transportation service delivery, and help enrollees in emergency situations who had been impacted by the hurricane and needed urgent medical assistance. Early on, Veyo was contacted by AHCA to assist in evacuations of ALFs, nursing facilities, and hospitals. Veyo quickly assessed its network capabilities and stepped up, eager to assist in any way. Magellan Complete Care asked Veyo to assist in transporting enrollees to shelters, which they were happy to do. In one case, a Veyo transportation provider drove an enrollee in an evacuation zone to at least 4 shelters,
only to be turned away because the shelters had reached maximum capacity. Magellan Complete Care’s care coordination team monitored capacity area-wide, and was able to direct the Veyo driver to a shelter where the enrollee could be safely accommodated.

On a more routine basis, Veyo is responsible for:

> Taking reservations from enrollees, healthcare facilities, medical providers, caregivers, and caseworkers for NEMT trips
> Contracting with third-party transportation providers including shuttle vans and taxis
> Providing payment for NEMT claims

Prior to providing transportation services to any enrollee, all of Veyo’s drivers go through extensive onboarding which includes, but is not limited to:

> ADA and HIPAA regulation training
> Sensitivity and professionalism training
> Customer service expectations
> Compliance with Veyo protocols and contractual obligations
> CPR and first aid certification
> State Level 1 background check
> Rigorous vehicle inspection.

2.1.b Dental Services
Magellan Complete Care provides dental services, including enhanced prevention and treatment services, through DentaQuest and the College of Dental Medicine at Nova Southeastern University.

DentaQuest serves more than 20 million members in state Medicaid and CHIP programs across the US, providing experienced network development, specialized Medicaid underwriting, accurate claims processing, culturally appropriate member services and dental management services.

In addition to our contract with DentaQuest for routine adult and children’s care, Magellan recently entered into an innovative person-centered partnership with the College of Dental Medicine at Nova Southeastern University. Nova has been a provider with DentaQuest, serving individuals enrolled in Medicaid for a number of years, and was recently awarded a grant by DentaQuest to improve dental health delivery for Medicaid-enrolled children. Through the grant, Nova has collaborated with Magellan to offer dedicated slots to children in the Magellan Complete Care Specialty Health plan. Our customer service team makes outbound calls to identified youth to assign the slots.

We have been deeply impressed by Nova’s commitment to children’s dental health, as evidenced by the fact that Dr. Linda C. Nyssen, Dean of the College of Dental Medicine, participated in bi-weekly calls with Magellan’s Chief Operating Officer and other members of the management team to build on best practices. For example, we have worked collaboratively on an integrated medication management protocol to ensure that there are no potential adverse interactions between existing medications that grant participants may be taking, and medications such as Novocain that these children may be exposed to as a direct result of receiving dental care through the Nova program. Magellan is the only managed care company that Nova collaborates with in this manner; we consider our partnership a best practice in public-private dental health collaboration.
2.1.c Routine and Preventive Vision Care (Premier Eye Care and Florida Eye Care):
Magellan currently contracts with two vision care sub-contractors in Florida. We contract with Premier Eye Care, to provide vision care to eligible enrollees in Areas 2, 4, 5, 6, 7, 9, 10 and 11. In addition, in Areas 10 and 11, where there is a high density of Magellan Complete Care enrollees, we contract with Florida Eye Care CORPORATION as a supplementary vendor, to ensure that all of our enrollees have ready access to high quality vision care and do not have to wait to receive needed services. Each of these organizations is profiled briefly below.

Premier Eye Care is a leader in managed eye care services, and provides optometric, ophthalmologic and full administrative services to health plans and their members. In Florida, Premier works with several public and private sector health plans, including Medicaid and Medicare. The company has won many awards for its customer service and employee relations. For enrollees of our Specialty plan in this situation, Florida Eye Care offers an invaluable service, providing exams and eyeglasses to individuals who might otherwise face significant barriers to receiving high quality eye care because of their geographic location, mobility challenges or income level.

Premier has consistently exceeded quality metrics in all key areas. For example, in the most recent annual report for the reporting period through December 2016, Premier served 11,386 Magellan Complete Care enrollees in 8 Medicaid regions, achieving excellent results: Average speed of answering enrollee calls averaged 6 seconds (compared to a performance goal of under 30 seconds); 98.6 percent of all clean claims were submitted within 20 calendar days (performance goal: 90 percent); and network accessibility goals were met 100 percent for all Medicaid enrollees, for all specialties, in all regions. During the same reporting period, there was not a single complaint about enrollee services.

Florida Eye Care provides bi-lingual eye care to Medicaid and Medicare recipients enrolled in several Florida health plans, as well as to commercial health plan members and those with individual plans. One of the primary reasons that Magellan Complete Care selected Florida Eye Care is because the company has extensive experience working specifically with Medicaid and Medicare enrollees, and understands the unique challenges they face.

Florida Eye Care is also familiar with the Medicaid reimbursement system in the state, and comfortable with the regulations governing the eye care benefit in Medicaid and other public sector programs. In addition, Florida Eye Care specializes in services provided to enrollees with mobility challenges, such as older adults or other individuals with physical constraints by providing on-site service in medical centers, assisted living facilities and nursing homes. For Magellan Complete Care, Florida Eye Corporation Inc. provides a range of delegated services, including claims processing, provider services, credentialing/re-credentialing, reporting, quality management, provider contracting, provider directory, and access and availability monitoring. In the last annual reporting period ending December 2016, Florida Eye Care provided vision care to 2,246 Magellan Complete Care enrollees in Regions 10 and 11, achieving strong performance throughout the reporting period.

2.1.d Hearing Evaluations: HearUSA (Sivantos):
Magellan Complete Care contracted with HearUSA to administer the Medicaid hearing benefit on behalf of our Specialty plan enrollees. We selected HearUSA because of their specific experience with publicly-funded programs, including Medicaid, as well as their longstanding presence in the state of Florida. HearUSA includes private plans in their client portfolio, but they are especially
well versed in Medicaid benefit administration, as they have proven in the years they have worked successfully with Magellan Complete Care.

One of the advantages brought by HearUSA is that their parent company, Sivantos, manufactures a wide range of hearing aids and other auditory devices, which provides excellent synergy for Specialty plan enrollees with complex needs. HearUSA is proud of the fact that the company has helped people with hearing loss for far more than 25 years, and in fact, opened its very first hearing care center in Florida in 1987. The company knows the State of Florida better than any other hearing care specialist in the country, and the company prides itself on its track record advocating for the medical necessity of hearing care for some of Florida’s most vulnerable residents.

Nationally, HearUSA has a network of nearly 4,000 independently practicing audiologists and more than 220 company owned hearing centers, HearUSA administers hearing benefits and provides comprehensive testing and hearing equipment, including hearing aids, to both publicly and privately funded clients. On behalf of Magellan Complete Care, HearUSA provides claims processing, provider services, credentialing/re-credentialing, reporting, quality management, provider contracting, provider directory, and access and availability monitoring.

2.1.e Podiatry, Dermatology, and Orthopedic Services: Provider Network Solutions (PNS) Management

PNS Management is a specialty network management company that works with specialty physicians to provide highly targeted services. PNS Management holds contracts with the majority of Medicaid MCOs in Florida. Magellan Complete Care has contracted with PNS management to provide network management, network development, credentialing intake, provider services, claims management, and claims adjudication in the specialty areas of podiatry, dermatology and orthopedic services. Using this vendor extends our network, and the expertise provided to our enrollees in these highly specialized areas.

In addition to the fully-delegated contractors profiled above, all of whom have a solid track record providing specialized services to Medicaid enrollees, Magellan Complete Care also contracts with select organizations to provide non-delegated services in very specific niche areas. These include, for example, interpreter services, enrollee outreach and in-person contact services (for enrollees who do not have a fixed address or telephone number).

Each of these subcontractors has been approved by AHCA, is well versed in the obligations that Magellan Complete Care has directly to AHCA, is performing the services that Magellan Complete Care has delegated to it in good standing, and more particularly, is in compliance with the requirements included in the Contract between Magellan Complete Care and AHCA. Assuming that Magellan Complete Care enters into a new agreement equivalent to the current Statewide Medicaid Contract with AHCA, our plan would be to again seek required written approval to delegate the described services to these subcontractors.

CRITERIA 3: THE EXTENT TO WHICH THE BARRIERS TO IMPLEMENTATION...

Column I in [General SRC #01, Attachment 1: Magellan Complete Care Contract Listing] lists implementation barriers and resolutions achieved by Magellan for every Medicaid contract we have operationalized in the last five years. Highlighted barriers reflect the unique demographics, managed care environment and service array of each contract; resolutions are customized
accordingly, and demonstrate Magellan’s flexibility in reacting quickly and decisively to address issues as they occur.

While each Medicaid program is unique, and presents its own specific challenges, Magellan has nevertheless encountered broadly similar – and therefore to some extent, predictable - barriers across several implementations. With more than 30 successful (direct to state contract) Medicaid implementations, and hundreds of successful implementations with our own Medicaid customers in the behavioral health and PBM spaces, Magellan has the bench strength and tactical expertise to address any operational challenge that we encounter. Below, we highlight five examples of how we have put our philosophy to ‘maximize a positive member experience and minimize transition noise’ into practice.

Example 1. Accommodating Regional and Cultural Differences in Enrollees and Providers
Barrier: In our Virginia Medicaid behavioral health program, Magellan quickly identified significant regional differences in member and provider needs. Our implementation team realized that a ‘one size fits all’ approach to member and provider outreach would not be effective. Providers had vastly different levels of knowledge and sophistication regarding the new managed care program, depending on factors such as which part of the Commonwealth they served, what kind of provider they were (large practice or individual practitioner) and how much previous experience they had with managed care programs.

Resolution: Magellan’s leadership team in Richmond convened local and regional town halls with members and providers to learn more about their specific needs. This allowed us to customize and adjust aspects of our standard operating procedure, and adapt our clinical, network and care coordination protocols to reflect local needs. Following implementation, Magellan continues to hold regular, ongoing technical assistance calls for providers related primarily to the care authorization and claims submission processes. Initially the leadership team held the calls daily and then moved to weekly calls as providers became comfortable with systems and processes. As a result, Magellan was able to implement a specialized managed care program Commonwealth-wide in partnership with providers across Virginia, not in conflict with them.

Example 2. Transition from a Behavioral Health Carve-out to a Fully-integrated Specialty SMI Plan
Barrier: In Florida, Magellan Complete Care’s legacy infrastructure and network had been customized to meet behavioral challenges and needs, as our predecessor contracts to the SMI Specialty plan were PMHPs. While we learned numerous valuable lessons from the PMHPs, and developed many best practices based on our experience managing them, we nevertheless had to transition from a specialty plan to a full-service integrated medical/behavioral plan in order to operationalize Magellan Complete Care.

Resolution: During the application and ramp-up period we worked decisively and successfully to expand our service array and infrastructure to include physical, dental, vision care. We deployed subject matter experts and experienced operations professionals from across the entire Magellan organization. We worked with an experienced local network consultant that helped us expand our Medicaid network to include all required disciplines and specialties. Our implementation SWAT team was drawn from national centers of excellence, as well as numerous new staff hires, brought on board to achieve AHCA’s vision of integrated care; this carried over directly into the specialty plan implementation.
Example 3. Transitioning Members to Magellan from Another Health Plan When We Entered the Market through Competitive Procurement
Barrier: Magellan recently completed transition of Cambria County HealthChoices Medicaid behavioral health program from another managed care company, and began providing services 07/01/2017. Magellan anticipated possible delays obtaining utilization data and clinical history relevant to transition of care from the incumbent.

Resolution: To address this, we established calls (several per week) in the weeks prior to go-live to work through obtaining the expected deliverables. Magellan led the calls, with the customer present/supporting our requests. The State and outgoing BH-MCO also participated in the calls. As a result, transition proceeded smoothly and there were no gaps in care or issues with transition of members already in acute settings and in community based services.

Example 4: Significant IT and Systems Buildout in a Short Timeframe
Barrier: Magellan committed to a major system configuration for Virginia-specific requirements for our new managed long term services and supports (LTSS) program.

Resolution: Magellan recognized that with all of the priority initiatives associated with the implementation, we needed expert help to accomplish a timeline and robust systems transition. Therefore, we engaged consultant firm, Optimity, to support the systems build out effort. As a result of this partnership, our Virginia MLTSS implementation proceeded smoothly and all key readiness review deliverables were accomplished on time, with no major issues.

Example 5: Resistance to Managed Care among Some Stakeholders
Barrier: Also in the Virginia MLTSS implementation, Magellan faced some opposition to managed care by provider associations and advocacy groups (particularly I/DD). They were concerned about the impact of managed care on access to care for their family members.

Resolution: Magellan conducted significant outreach and engagement at all levels of the stakeholder community in the weeks leading up to program start and afterwards. We made successful efforts to have stakeholder participation in the Advisory Committee and other structural feedback loops within the new program. As a result, stakeholder concerns were allayed; Magellan continues to meet with stakeholders on a regular basis, and to encourage them to participate in ongoing discussions around program design and service delivery.

These are just a few representative samples of our approach, in categories such as network access that present challenges for most implementations, however well-planned. We encourage reviewers to scan Column I of the comprehensive contract list to fully assess Magellan’s ability to remove barriers and minimize disruption for our members and provider partners.

CRITERIA 4: THE EXTENT TO WHICH THE RESPONDENT HAS LISTED ACCOMPLISHMENTS...
In the past five years alone, this Magellan team has managed a cumulative total of 31 Medicaid contracts held directly with State and local government customers in 11 states, and covering approximately 4.3 million members. What’s more, Magellan has a solid record renewing our Medicaid contracts, in some cases, multiple times. In Pennsylvania, for example, we recently celebrated the 20th anniversary of our Delaware County Medicaid behavioral health program with a series of events attended by our County customer, beneficiaries of our program, and other
community members. Accordingly, the accomplishments and achievements listed for each Magellan public sector program in column "j" of the attachment have been selected because they impact members similar to those in the FL ITN, reflect AHCA’s priorities for the program and/or demonstrate program resolutions that informed our approach to implementation of our Specialty plan in Florida.

Below, we have summarized highlights of our accomplishments in several program areas relevant to this solicitation, specifically our accomplishments in general Medicaid programs; our approach to members with SMI; and our experience meeting the special needs of children and adolescents in Medicaid.

4.1. Increasing Access, Improving Outcomes for Enrollees in the General Medicaid Population

While the focus of our Magellan Complete Care program is individuals with SMI, the majority of enrollees in Magellan’s Medicaid programs do not have complex multi-system needs. Magellan Complete Care’s parent company, Magellan Health, has a deep understanding of TANF, CHIP and ABD programs through our many health plan relationships across all lines of business throughout the United States. As of July 2017, Magellan was actively providing behavioral health and/or specialty health – imaging, cardiac management, pain management, PT/OT and similar services – to more than 11 million Medicaid and dual Medicaid/Medicare members; and approximately 1.7 million Medicare only members on behalf of close to 50 health plan customers. For individuals in these programs, the most important services are access to good primary care, prevention and wellness services, accessible pharmacy options, and availability of specialized services when they need it.

Four other examples are summarized below.

Example 1. Integrated Medical, Behavioral and Pharmacy Services

Through our in-house PBM, Magellan offers an integrated Medicaid program that leverages the benefits of fully coordinated care coordination, network management and medication adherence initiatives. In Florida, this synergistic partnership between Magellan Complete Care and our MRx PBM is exemplified by our WholeHealthRx initiative, which focuses on prescriber outreach and education as a tool in facilitating best practice medication management for complex cases. During the most recent annual outcomes reporting period in 2016, the WholeHealthRx team conducted an average of 125 face-to-face prescriber visits per quarter, impacting 877 beneficiaries, and resulting in positive outcomes in several key areas: Utilization of antipsychotics decreased by 10.6 percent and 26.7 percent of eligible beneficiaries were no longer receiving two or more antipsychotics; medication persistence for antipsychotics increased by 32.8 percent; and there was a 25.3 percent increase in the number of members who received one or more of the recommended lab tests for second generation anti-psychotics.

Example 2. Peer Support

All of Magellan’s Medicaid programs feature peer support resources. In Florida, for example, Magellan helped 14 CMHCs implement peer support as a billable service; a total of 355 enrollees participated in peer support in 2016, with overall resulting decrease in inpatient readmissions for peer support enrollees.

Our commitment to peer support goes well beyond our enrollees. We are national experts and host empowerment initiatives across the country to promote the concepts of independence, advocacy and skill-building. We also introduced the MyLife youth empowerment initiative in
Example 3. Addressing the Opioid Crisis
In 2015, Magellan implemented an innovative Medication Assisted Treatment (MAT) initiative across six Pennsylvania counties in the eastern part of the state. Ours is a multi-pronged approach that increases access to MAT services for members with alcohol and/or Opioid Use Disorder. As part of the initiative, we sponsored an Addictions conference in June 2016 attended by more than 300 people. Through the MAT initiative, we collaborated with local providers to add approximately 70 withdrawal beds, 120 rehabilitation beds, and increased methadone maintenance capacity for 240 individuals across our Pennsylvania programs. We are also in discussions to contract with a new, 10-bed halfway house. The variety of services this initiative brings to our members is critical to our prevention efforts and addressing active opioid addiction.

4. Reducing Administrative Burden for Providers
In our Virginia Medicaid program, Magellan implemented an innovative Total Web Solution, an “Authorization Request Tool” for Providers. Beginning in 2013, while we were contracted as the BHSA, we transitioned utilization management (UM) services from an incumbent and have worked with the Commonwealth since that time on service expansions while containing cost for nearly 900,000 Members. The Authorization Request tool has significantly reduced the amount of time that providers have to spend on the administrative tasks associated with the BHSA program, allowing them to allocate additional timeslots to members.

4.2 Supporting Those Living with Serious Mental Illness
Analysis of utilization data in the Magellan Complete Care program indicates that approximately 5 percent of super high-utilizing enrollees generate more than 50 percent of cost of care expenditures. As a result of this medical complexity, individuals living with SMI require support from a team with significant clinical expertise, combined with a comprehensive, tailored model of care, to reduce short- and long-term costs and health risks, and to provide the best chance for our enrollees to lead a healthy and vibrant life.

We also understand that an effective approach to improving the lives of individuals living with SMI requires connecting behavioral, physical, pharmacy and social needs—including permanent supportive housing (PSH), supported employment services, and peer support services—into a plan of care that is individualized, coordinated and cost effective. We recognize the value and effectiveness of peer support services, and incorporate evidence-based practices in all of our peer support programs, including in Florida and Virginia.

A key challenge in serving beneficiaries living with SMI is addressing their housing needs. In January 2016, one in five people experiencing homelessness was living with SMI and a similar percentage had a chronic SUD. This issues are particularly acute among veterans. In Florida, Pennsylvania and Virginia where we support the local behavioral healthcare systems (or, in the case of Maricopa County, Arizona and Louisiana, have supported these systems in the past), Magellan has spearheaded efforts to ensure support services for individuals experiencing or at
high risk of homelessness in conformance with the Housing First approach and the SAMHSA’s PSH evidence-based practice.

As a result of these efforts, we have secured permanent housing for many previously homeless veterans and other individuals. In Florida in particular, we have successfully implemented the Housing First approach under the leadership of the Magellan Complete Care housing specialist. Through his efforts, and those of the local Community Outreach Specialists (COS) with whom he coordinates in local communities across Florida to develop regional community housing resource guides, Magellan Complete Care has successfully placed over 100 individuals in supportive housing since December 2015.

To accomplish this, the COS developed regional housing work flows that outlined each region’s homeless housing access process. They then coordinated with the regional lead agencies designated by HUD to administer homeless housing funds, and, at monthly regional housing meetings, discussed available housing opportunities with Magellan Complete Care care coordination clinicians. Further, Magellan Complete Care developed relationships with housing agencies such as the Florida Housing Finance Corp and Goodwill Industries to fast track placements into permanent supported housing; and contracted with Integra Service Connect in the Tampa and Miami areas to help locate and build relationships with our hardest-to-find, hardest-to-engage enrollees.

4.3 Providing Services to Children and Youth, Including Those with Serious Emotional Disturbance
Magellan understands the unique issues that impact the daily lives of children in the Medicaid program. Because these young people are also affected by issues associated with living in poverty, they often have less robust support systems and a less stable home environment. Compared with children who do not face these challenges, they disproportionately experience complex behavioral health and medical issues that, if not addressed quickly, can escalate and cause significant stress to the young person and his or her family. Our success in other states shows Magellan’s commitment to improving the quality of life for the children, youth, and families within the communities we serve, examples include:

> Magellan’s PMHP for Child Welfare in Florida, which we administered between 2007 and 2015, increased adoptions and reunifications of children with their families through integrating psychiatric and medical care; expanding specialized therapeutic foster care; unifying our concurrent review and child welfare teams; and ensuring that a child’s mental health services are integrated into a child’s permanency plan.
> In Arizona, we developed the Child and Family Teams (CFT) initiative, which has since become an integral component in all Magellan programs for youth and families. The Arizona CFT program, included family members, natural supports, providers and system partners involved with the family. The CFT works to establish and maintain a coordinated network of support around the family. The CFT identifies a coordinated network of support around the family. All activities are consistent with Systems of Care principles and child welfare best practice. Meetings are family driven, youth guided, inclusive family centered, strengths-based and solution focused. Crisis planning is an integral component of the program, allowing us to anticipate potential obstacles, and manage them before a crisis occurs.
> In Louisiana, in 2012, Magellan implemented a Coordinated System of Care (CSoC) for youth in imminent danger of out-of-home placement. The CSoC was governed by two CMS Medicaid
waivers, through which eligible youth had access to five supplementary wraparound services: Parent Support and Training, Youth Support and Training, Crisis Stabilization, Short-term Respite, and Independent Living/Skills Building. After two years of managing youth, we experienced very positive outcomes, including a 50 percent decline in in-patient readmission rates for youth engaged in CSoC, a reduction in inpatient admissions once enrolled in CSoC by an average of 82 percent, and in number of total days spent in an inpatient hospital once enrolled by an average of 79 percent. We continue to manage this program today, and have seen an extraordinary amount of success, so much so, that the state continues to have Magellan manage these services outside of their traditional managed care model.

> In Wyoming, Magellan has served since 2015 as the Care Management Entity (CME), implementing a High-Fidelity Wraparound Program on behalf of children and their families eligible for the State’s children’s mental health waiver. Through the program, we offer access to flex funds, respite services, family care coordinator support, youth support, parent support and youth and family training. Partnering with service providers and organizations across the State, Magellan implemented a streamlined application process, shortened the length of time it took for children to be fully-enrolled and active in the program, and increased the total number of families served by the program.

> In our HealthChoices county-based programs in Pennsylvania, we identified a need for transition age youth (TAY) focused services for youth who experienced difficulty transitioning from the child BH system to the adult BH system. In an average year, Magellan serves about 150,000 TAY Members across our six PA counties. In 2013, we implemented the Transition to Independence (TIP) model in Bucks County. TIP engages and supports youth in their own future planning process across five transition domains: educational opportunities; living situation; employment and career; community life functioning; and personal effectiveness and well-being. TIP assists youth as they transition from a Residential Treatment Facility (RTF) or behavioral health rehabilitation services (BHRS). This program has been instrumental in assisting youth with long-standing BH issues in transitioning them into education, stable housing, and employment. We are truly assisting our members in learning to live independent lives. To that end, we implemented TIP in the remaining four PA counties we serve in 2015.

In summary, Magellan Complete Care is an expert with established and demonstrated experience in effectively and efficiently serving Medicaid managed care members, and in particular, the highly specialized and complex group of individuals with SMI. The examples above highlight our accomplishments on behalf of some of the most notable sub-groups in our overall Medicaid membership. As noted previously, a full list of accomplishments can be found in Column J of [General SRC #01, Attachment 1: Magellan Complete Care Contract Listing].

CRITERIA 5: THE EXTENT TO WHICH THE RESPONDENT’S MEDICAID POPULATIONS...
Each of the contracts summarized in the attachment includes a description of the membership served, highlighting similarities between the contract population and individuals served in the SMMC program. Magellan has been a Specialty MCO since 2013 and today partners with AHCA to serve SMMC enrollees. Nationwide, we also cover Medicaid, Medicare and other public sector adults, older adults and youth. Magellan Complete Care’s parent company, Magellan Health, actively provides behavioral health and/or specialty health services to over 11 million Medicaid and dual Medicaid/Medicare members; and approximately 1.7 million Medicare only members on behalf of close to 50 health plan customers.
Magellan also serves as direct contractor to state and local governments for integrated and specialty (primarily behavioral health) programs delivered to almost 1.5 million Medicaid enrollees across the country. Of these, we estimate that approximately 60 percent are aged 18 or younger, and a substantial sub-set have a diagnosis of serious emotional disturbance. Further, an estimated 20 percent of our public markets membership is eligible for ABD benefits. (This figure excludes individuals served through our Medicaid PBM contracts, which are not reimbursed on a capitated basis.). In order to serve these members effectively, Magellan has prioritized building teams that have a significant percentage of clinicians working directly with members. We are proud that more than 40 percent of Magellan employees and staff are clinicians or other individuals who require a professional credential to fulfill their daily work requirements. We believe our commitment to excellence in the workforce translates to superior interactions with, and outcomes for, our members.

For ease of review, we have listed Magellan’s experience working directly with Medicaid enrollees in Florida in a number of integrated and specialty programs over many years. We provide a listing of Magellan programs in other states, held within the last five years that cover a similar membership (and by extension, address similar challenges):

**Florida Medicaid** –
- Magellan Complete Care Medicaid Specialty Plan for Persons with SMI
- Magellan Complete Care Integrated Medicaid Program, AHCA Area 10
- AHCA Medicaid Qualified Evaluator Network (QEN) Contract
- Department of Children and Families Care Coordination program for youth
- AHCA Utilization Management Program for Adults
- Prepaid Mental Health Program (PMHP) – AHCA Areas 2, 4, 9, 11 and child welfare

**TANF/ABD Membership**–
- Magellan Complete Care Integrated Medical Program, AHCA Area 10
- Pennsylvania HealthChoices Program
- Prepaid Mental Health Program (PMHP) – AHCA Areas 2, 4, 9, 11 and child welfare
- AHCA Medicaid Qualified Evaluator Network (QEN) Contract
- Department of Children and Families Care Coordination program for youth
- AHCA Utilization Management Program for Adults
- Nevada Health Care Utilization and Program Management
- Montana Utilization Management Program

**Other Programs for Medicaid-eligible children and adolescents**
- Louisiana Coordinated System of Care for Children (CSoC)
- Wyoming Care Management Entity Program

Behavioral Health Specialty Programs, including members with Serious Mental Illness (SMI) and/or Serious Emotional Disturbance (SED) -
- Pennsylvania HealthChoices Program
- Arizona Regional Behavioral Health Authority
- Iowa Plan for Behavioral Health
- Louisiana Behavioral Health Partnership
- Nebraska Comprehensive Medicaid Managed Behavioral Health Program
- Montana Behavioral Health Utilization Management Program
Medicaid Long Term Care and/or Programs for Dual Medicaid/Medicare eligible members -
> Magellan Complete Care Medicaid Specialty Plan for Persons with Serious Mental Illness
> Commonwealth of Virginia MLTSS Program
> New York AlphaCare MLTSS Program
> New York AlphaCare D-SNP Program
> Wisconsin ‘Include, Respect, I Self-Direct’ (IRIS) Program

We are excited about the opportunity to build on positive accomplishments in Florida to date by contracting with AHCA for the next generation of managed care across Florida. The programmatic building blocks in place today, created by partnering with AHCA to meet significant challenges associated with an SMI plan, are the foundation for ongoing, continuous improvement in services and outcomes. We look forward to having the opportunity to continue our contract with AHCA and that our work to date will continue to evolve and mature across an expanded service area.

**Evaluation Criteria:**

1. The extent of the respondent’s experience with providing integrated medical and behavioral health services.

2. The extent of the respondent’s subcontractors’ experience in coordinating or providing services to Medicaid recipients.

3. The extent to which the barriers to implementation experienced by the respondent have clear resolutions outlined.

4. The extent to which the respondent has listed accomplishments and achievements that are relevant to this solicitation.

5. The extent to which the respondent’s Medicaid populations served are similar to the populations served by the SMMC program.

**Score:** This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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SRC# 2 – Florida Experience (Regional):

The respondent shall provide documentation of the extent to which it has experience operating as a Florida Medicaid health plan in the region in which it plans to provide services or in any other region in the State of Florida. If applicable, the respondent shall provide the Agency Contract number and the regions of operation to show it has experience providing managed care services and/or LTC services in Florida. The respondent shall provide documentation of any Medicare Advantage Plan contracts for counties in the State of Florida.

Response:

Florida MHS, Inc., d/b/a as Magellan Complete Care (FEIN 45-4229574), is the only Medicaid Specialty Plan dedicated to serving individuals with Serious Mental Illness (SMI) in the State of Florida through a Standard Contract with the Agency for Health Care Administration (AHCA) effective on February 4, 2014 (Contract Number: FP-028).

As indicated in the attached June 22, 2016, correspondence from AHCA’s Bureau of Health Facility Regulation and in the aforementioned Standard SMMC Contract, we currently serve SMI populations in most areas of the state. Please see [General SRC #02, Attachment 1: AHCA Contract No FP028], and [General SRC #02, Attachment 2: MCC HCPC Renewed Certificate].

As part of this ITN, Magellan Complete Care intends to expand the value and benefit to those with SMI across the entire state. To that end, we have submitted our service area expansion documentation; a copy of that application is provided as [General SRC #02, Attachment 3: Affidavit for Expansion of Service Area].

On a FL MMA region-specific basis, Magellan Complete Care’s experience operating as a Florida Medicaid health plan is as follows:

Region 1 – Service area expansion**
Region 2 – Existing SMMC Contract*
Region 3 – Service area expansion**
Region 4 – Existing SMMC Contract*
Region 5 – Existing SMMC Contract*
Region 6 – Existing SMMC Contract*
Region 7 – Existing SMMC Contract*
Region 8 – Service area expansion**
Region 9 – Existing SMMC Contract*
Region 10 – Existing SMMC Contract*
Region 11 – Existing SMMC Contract*

*see [General SRC #02, Attachments 1 and 2]
**see [General SRC #02, Attachment 3]

Evaluation Criteria:
For the Managed Care Plan that is proposing to provide services under this solicitation, whether the respondent has:

- An existing SMMC Contract in that region;
- An existing SMMC Contract in another region in the State of Florida; or
- A Medicare Advantage Plan contract in that region.

**Score:** This section is worth a maximum of 30 raw points as outlined below.

1. 20 points if the respondent already has an SMMC Contract in the region that it plans to provide services (MMA, LTC and/or Specialty).
2. 10 points if the respondent has an SMMC Contract in other regions in the State.
3. 5 additional points will be awarded if the respondent has a comprehensive (MMA & LTC) SMMC Contract in the region that it plans to provide Medicaid services.
4. 5 additional points will be awarded if the plan has a Medicare Advantage Plan in the region that it plans to provide services.
5. 0 points will be awarded if the plan does not have an SMMC Contract in Florida or a Medicare Advantage Plan contract in the region.
SRC# 3 – Statutorily Required Florida Presence (Statewide):

The respondent shall provide information regarding whether each operational function, as defined in Section 409.966(3)(c)3, Florida Statutes, will be based in the State of Florida, and the extent to which operational functions will be conducted by staff in-house or through contracted arrangements, located in the State of Florida. This includes:

a. Specifying the location of where the respondent’s corporate headquarters will be located (as defined by Section 409.966(3)(c)3, Florida Statutes);

b. Indicating whether the respondent is a subsidiary of, or a joint venture with, any other entity whose principal office will not be located in the State of Florida; and

c. Identifying the number of full-time staff, by operational function (as defined in Section 409.966(3)(c)3, Florida Statutes), that will be located in the State of Florida and out of state.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

Response:

CRITERIA 1: WHETHER THE RESPONDENT’S CORPORATE HEADQUARTERS WILL BE LOCATED IN FLORIDA...

a. Specifying the location of where the respondent’s corporate headquarters will be located…

As the current Serious Mental Illness (SMI) Specialty Plan, Magellan Complete Care’s operational functions are primarily based in the State of Florida in Miami and Orlando. In 2014, following successful negotiations with AHCA, Magellan Complete Care began providing services to enrollees of the Florida Managed Medicaid Program.

Magellan Complete Care’s corporate headquarters/principal office is located at:
>7600 NW 19th Street, Suite 400, Miami, Florida, 33126

Magellan Complete Care’s satellite offices are located at:
>6870 Shadowridge Drive, Orlando, Florida 32812 (office for Region 7 Care Management Team, Provider Support Specialists, Pharmacy Team)

>1200 South Park Center, Suite 250, Orlando, Florida 32819 (2nd operational office in central Florida that enables Magellan Complete Care to efficiently manage central and north Florida membership, as well as duplicating enrollee/member services, UM, and CM in-state operations which further enhance business continuity and disaster recovery plans)

In addition to the staff located at the locations above, we also employ a number of work-from-home staff throughout the state. Staff work closely with enrollees and providers in various communities to develop and maintain close working relationships and a greater understanding of the culture, resources, and community supports specific to each Region.
b. Indicating whether the respondent is a subsidiary of, or a joint venture with, any other entity whose principal office will not be located in the State of Florida

Magellan Complete Care does not operate as a subsidiary of, or a joint venture with, any other entity.

Florida MHS, Inc., (d/b/a Magellan Complete Care), was formed in 2011 and licensed by the Florida Office of Insurance Regulation as a full risk Health Maintenance Organization in 2012. Magellan Complete Care is the current SMI Specialty Plan delivering services in Regions 2, 4, 5, 6, 7, 9, 10, & 11.

Founded in 1969 as a pioneering managed behavioral health organization, Magellan Complete Care’s ultimate parent company (Magellan Health, Inc.) began providing managed mental health and substance abuse services as a sub-contractor to Florida health plans in the 1990s. Our pharmacy affiliate, Magellan Rx Management, first implemented a Medicaid pharmacy program with the State of Florida in 2001, and has been actively serving Floridians in the Medicaid program ever since.

c. Number of Full-time Staff, by Operational Function to be Located in the State of Florida and Out of State

Magellan Complete Care currently has 376 Florida-based FTEs allocated for the SMI Specialty Plan. This number is projected to grow to 405 Florida-based staff determined upon expansion to Regions (1, 3, and 8) for this ITN. In addition, we have 62 out-of-state employees dedicated to Magellan Complete Care.

The Magellan Complete Care staffing model builds upon the core Magellan Complete Care team that is currently in place and adds staff based upon enrollment levels and regions of the state we anticipate being awarded. Based upon the focus of our specialty plan, enrollees with SMI, our care coordination/case management model of care places a great emphasis on having a large number of community-based employees who are enrollee-facing and work directly with local advocacy groups, caregivers, and providers.

In addition to the identified staffing, Magellan Complete Care will also have access to Magellan Health’s full complement of corporate staffing resources to draw upon. These professionals have decades of experience serving Floridians and the appropriate skill set in managing state Medicaid memberships. Magellan Complete Care will draw upon corporate resources to assist with the following, but not limited to, functions: information technology, legal, and human resources. These Magellan Corporate resources are already dedicated to Magellan Complete Care.

As outlined above, Magellan Complete Care is headquartered in Miami, Florida, with a satellite office in Orlando. Magellan Complete Care will also have access to Magellan’s other nationwide office locations that will provide support for after-hours coverage as well as disaster recovery back-up.

The current and projected FTEs by operational function area are based on a projected membership of approximately 70,000 enrollees and include the following:

>Claims Processing:
>>Existing FTE: 55
>>Projected FTE: N/A
>>Location: State of Missouri

>Enrollee/Member Services (including Claims Resolution):
>>Existing FTE: 64
>>Projected FTE: 7
>>Location: State of Florida

>Provider Relations/Education and Community Outreach:
>>Existing FTE: 28
>>Projected FTE: 3
>>Location: State of Florida

>Network and Vendor Management:
>>Existing FTE: 14
>>Projected FTE: N/A
>>Location: 12 FTE in State of Florida

>Utilization and Prior Authorization:
>>Existing FTE: 72
>>Projected FTE: 5
>>Location: State of Florida

>Case Management and Disease Management:
>>Existing FTE: 120
>>Projected FTE: 11
>>Location: State of Florida

>Medical and Pharmacy:
>>Existing FTE: 9.5
>>Projected FTE: N/A
>>Location: State of Florida

>Quality and Appeals:
>>Existing FTE: 29.5
>>Projected FTE: N/A
>>Location: State of Florida

>Finance:
>>Existing FTE: 4
>>Projected FTE: N/A
>>Location: 2 FTE located in State of Florida

>Leadership and Administration:
>>Existing FTE: 13
>>Projected FTE: N/A
>>Location: State of Florida

>Peer Recovery and Family Support:
>>Existing FTE: 12
CRITERIA 2: THE EXTENT TO WHICH OPERATIONAL FUNCTIONS... WILL BE PERFORMED IN ...FLORIDA.

Magellan Complete Care currently performs virtually all operational functions (e.g. enrollee/member services, provider relations, utilization and prior authorization, case management, disease and quality functions, and finance and administration) in the State of Florida, located in Miami.

Our claims process begins with our Florida-based staff, including Provider Support Specialists, who are involved in provider education about the claims submittal and resolution process, including electronic data interchange (EDI), coding, claim pend cause, duplicate billing reduction, and encounter acceptance. We also have a Claims Resolution Team with nine staff located in Miami, Florida, that are available to handle claims disputes and related issues. We also have a Vendor Manager Analyst responsible for claims oversight. Back office processing is completed at the Magellan Midwest Center of Excellence to leverage enterprise-wide claims processing best practices to ensure timely and accurate claims payment.

Magellan Complete Care performs the majority of its operational functions in Florida, as demonstrated below:

>Corporate Headquarters / Principal Office:
>>7600 NW 19th Street, Suite 400, Miami, Florida 33126

>Satellite Offices:
>>6870 Shadowridge Drive, Orlando, Florida 32812 (office for Region 7 Care Management Team, Provider Support Specialists, Pharmacy Team)
>>1200 South Park Center, Suite 250, Orlando, Florida 32819 (2nd operational office in central Florida that enables Magellan Complete Care to efficiently manage central and north Florida membership, as well as duplicating enrollee/member services, UM, and CM in-state operations which further enhance business continuity and disaster recovery plans).

>Claims Education and Resolution Services:
>>7600 NW 19th Street, Suite 400, Miami, Florida 33126

>Enrollee/Member Services:
>>7600 NW 19th Street, Suite 400, Miami, Florida 33126
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Provider Relations:
>>7600 NW 19th Street, Suite 400, Miami, Florida 33126

Utilization and Prior Authorization:
>>7600 NW 19th Street, Suite 400, Miami, Florida 33126

Case Management:
>>7600 NW 19th Street, Suite 400, Miami, Florida 33126

Disease Management and Quality Functions:
>>7600 NW 19th Street, Suite 400, Miami, Florida 33126

Finance and Administration:
>>7600 NW 19th Street, Suite 400, Miami, Florida 33126

Magellan Health, Inc., the parent company to Magellan Healthcare, Inc., which in turn is the immediate parent of Florida MHS, Inc. (d/b/a Magellan Complete Care), is dedicated to investing in Florida with more than 900 employees and contractors in multiple offices across several lines of business. With more than 20 years of building a foundation in Florida, Magellan Health, Inc. has contributed to Floridians as a valued community partner. Our relationships with key Florida stakeholder groups demonstrate our investment and commitment to improving health outcomes

Evaluation Criteria:

1. Whether the respondent’s corporate headquarters will be located in Florida (it is not a subsidiary of or a joint venture with any other entity whose principal office will be located outside of Florida).

2. The extent to which operational functions (claims processing, enrollee/member services, provider relations, utilization and prior authorization, case management, disease management and quality functions, and finance and administration) will be performed in the State of Florida.

Score: This section is worth a maximum of 15 raw points. Each of the above components is worth a maximum of 5 points each as described below. 5 additional points will be awarded if respondent meets Items 1(a) and 2(a) below.

For Item 1:

(a) 5 points for corporate headquarters in Florida and no parent or joint venture organization outside Florida;
(b) 0 points if no relevant corporate headquarters in Florida.

For Item 2:

(a) 5 points if all functions will be performed in Florida;
(b) 4 points for 6-7 functions to be performed in Florida;
(c) 3 points for 4-5 functions to be performed in Florida;
(d) 2 points for 2-3 functions to be performed in Florida;
(e) 1 point for 1 function to be performed in Florida;
(f) 0 points for no functions to be performed in Florida;
(g) 0 points if only community outreach, medical director and State administrative functions will be performed in Florida.

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SRC# 4 – Contract Performance (Statewide):

The respondent shall state whether, in the past five (5) years (since July 14, 2012), it has voluntarily terminated all or part of a managed care contract under which it provided health care services as the insurer; has had such a contract partially or fully terminated before the contract end date (with or without cause); has withdrawn from a contracted service area; or has requested a reduction of enrollment levels. If so, describe the contract; the month and year of the contract action; the reason(s) for the termination, withdrawal, or enrollment level reduction; the parties involved; and provide the name, address and telephone number of the client/other party. If the Contract was terminated based on the respondent’s performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination. Include information for the respondent as well as the respondent’s affiliates and subsidiaries and its parent organization and that organizations’ affiliates and subsidiaries.

Response:

Magellan Complete Care (Florida MHS, Inc. d/b/a Magellan Complete Care) was created for the purpose of managing and delivering innovative, comprehensive, integrated medical and behavioral health services for Florida Medicaid enrollees with serious mental illness (SMI) and their family members regardless of eligibility category.

Magellan Complete Care integrates the Florida-specific and national capabilities of its affiliate health care companies in behavioral health, radiology, pharmacy, and Medicaid managed care services under the ultimate parent company Magellan Health Services, Inc. (“Magellan”). Our combined expertise makes us uniquely qualified to serve all the health care needs of enrollees with serious mental illness (SMI) in all eligibility categories.

CRITERIA 1, 2, 3, and 4: TERMINATED CONTRACTS
Magellan Complete Care has not voluntarily terminated all or part of a contract to provide managed health care services as an insurer; has not had such a contract partially or fully terminated before the contract end date (with or without cause); has not withdrawn from a contracted service area; and has not requested a reduction of enrollment levels.

Likewise, none of Magellan Complete Care’s parent company or affiliates, nor their affiliate organizations, as ever voluntarily terminated all or part of a contract (other than a provider contract) to provide managed health care services as an insurer; has not had such a contract partially or fully terminated before the contract end date (with or without cause); has not withdrawn from a contracted service area; and has not requested a reduction of enrollment levels.

Neither Magellan nor any of its subsidiaries or affiliates has, while providing managed care services as an insurer, had terminations for performance issues related to provider network management, claims processing or solvency concerns.

Magellan and its affiliate organizations have on rare occasions elected not to renew a contract upon expiration; but we have never terminated any such contract before contract end date.
Evaluation Criteria:

1. The extent to which the respondent or parent or subsidiary or affiliates have requested enrollment level reductions or voluntarily terminated all or part of a contract.

2. The extent to which the respondent or parent or subsidiary or affiliates has had contract(s) terminated due to performance.

3. The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to patient care rather than administrative concerns (e.g., reporting timeliness).

4. The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to provider network management, claims processing or solvency concerns.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each as described below.

For Item 1:

(a) 5 points for no voluntary termination of all or part of a contract, no requests for enrollment level reduction and no service area withdrawals;
(b) 0 points for any voluntary terminations, requests for enrollment level reductions, or service area withdrawals.

For Item 2:

(a) 5 points for no involuntary terminations;
(b) 0 points for any involuntary termination based on performance.

For Item 3:

(a) 5 points for no contract terminations related to patient care;
(b) 0 points if termination related to patient care.

For Item 4:

(a) 5 points for no contract terminations related to provider network management, claims processing or solvency concerns;
(b) 0 points if termination related to performance issues related to provider network management, claims processing or solvency concerns.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

B.  **Agency Goals**

**SRC# 5 – Disease Management (DM) Program (Statewide):**

The respondent shall describe its proposed approach to implementation of specific disease management programs and how they will be used to advance the Agency’s goals as stated in Attachment A, Instructions and Special Conditions, **Section A., Overview, Sub-Section 15.**, Program Objectives and Goals, of this solicitation. The respondent’s description shall include:

a. A description of each proposed disease management program;

b. A description of the algorithm used to identify and stratify eligible enrollees by severity and risk level;

c. A description of the evidence-based guidelines utilized in the approach;

d. A description of how disease management programs are integrated with case management/care coordination programs; and

e. A description of performance metrics used to evaluate the efficacy of the disease management program, including cost-savings, increase in treatment adherence, and measurement of the impact on potentially preventable events, including relevant experience to provide support for the use of the specific performance metrics.

**Response:**

**OVERVIEW**

Magellan Complete Care has developed a comprehensive set of disease management programs that meet NCQA standards, and are innovative and evidence-based and that meet and exceed AHCA’s goals as stated in Attachment A, Instructions and Special Conditions, **Section A., Overview, Sub-Section 15.**, Program Goals and Objectives:

> Reducing potentially preventable inpatient and outpatient hospital events, and unnecessary ancillary services
> Improve birth outcomes
> Rebalance long-term services and supports systems by increasing the percentage of enrollees receiving services in the community, instead of an institution.

We also understand that AHCA’s goals for awarding contracts include additional objectives that enrollees receive all medically necessary services in a timely manner and in the most appropriate setting thereby achieving the best possible quality outcomes while containing costs. We also understand that AHCA is interested in awarding contracts to plans that offer:

> Comprehensive, quality driven provider networks
> Streamlined process that enhance the enrollee and provider experience
> Expanded benefits that improve outcomes for enrollees, top quality scores and high rates of enrollee satisfaction
To deliver an efficient, high quality, innovative, cost effective and integrated health care delivery model,

Magellan Complete Care’s system of care, including our disease and care management model incorporate those goals in a manner which is innovative and best suited for the unique needs of SMI enrollees. All Magellan Complete Care enrollees have a serious mental illness, and at least one-half of our enrollees have physical comorbidities and/or co-occurring disorders (SUD and/or AUD). Many also experience social stressors such as housing instability, food insecurity, abuse, and involvement with the criminal justice system. This complexity demands that we offer an integrated model of behavioral health (BH), physical health (PH), and social supports that are required to maintain and enhance the health of our enrollees. This includes broad networks of BH, PH, and social services providers; streamlined and supportive processes for enrollee and provider ease-of-use; and, quality and care management processes (UM/DM/CM/CC) that are fully integrated and drive continual improvement and innovation to enhance quality and outcomes.

Our fully integrated disease management (DM) programs are an important element of this integrated system, and incorporate a whole-person approach to management of physical health co-morbidities in our SMI enrollees. Magellan Complete Care is also continually identifying opportunities to enhance how we are managing and serving these individuals. As part of those ongoing efforts, we are partnering with, and have engaged Shared Health, a wholly-owned subsidiary of Blue Cross Blue Shield of Tennessee to support continued enhancements to our DM, population health, and quality management programs. Through this partnership, we leverage Shared Health’s 24 years of experience covering 1.3 million members to enhance our models for stratification of enrollees; targeting of DM, quality, and population health interventions; and, engagement and outreach campaigns.

Our programs also integrate population health management and its approaches to identify needs of our enrollees within diverse populations; provide effective services and programs that promote healthier lifestyles; ensure adherence to treatment protocols; and, coordinate care across the enrollee journey. Our DM and population health management programs leverage technologies such as telehealth, enrollee messaging, and social media to support our enrollees with self-care and health management. They also incorporate different types of interventions that are targeted based on the risks and complexity of the enrollee, and that are shown to be most effective in achieving improved health outcomes and quality.

CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT PROPOSES AN INNOVATIVE AND EVIDENCE-BASED APPROACH...

1.1 Overview of Approach
Clinical research and the direct experience of our parent company and Magellan Complete Care shows that the SMI population is more likely to have a chronic physical illness and the severity and impact of that illness is much greater. Our analysis of the Magellan Complete Care population has shown that about 50 percent of our enrollees have at least one chronic illness, more than 30 percent have two or more chronic illnesses and more than 40 percent have two or more behavioral health conditions. Our analysis of the broader Florida SMI population shows us that more than 60 percent of claims expense is for the treatment of physical health conditions, emphasizing the importance of robust programs to provide integrated management of both physical health and behavioral health conditions.
Magellan Complete Care’s model of care involves active outreach to the enrollee through completion of HRAs, other condition specific branching assessments, ICCM outreach, regular monitoring of services and utilization, communication with providers, etc. We believe in a “no wrong door” approach for enrollees in accessing ICCM and disease management services. Enrollees can be referred for any program at any time. Having a robust presence in the community and promoting interaction with our enrollees on a regular basis assists in this process and any of those interactions can lead to the identification of enrollees eligible for the DM program.

Key components of our program include:

> Member engagement and activation programming targeted to unique enrollee characteristics, including specific customization for children and youth

> Wellness specialists to assist the enrollee and care coordination team with DM and population health programs

Collaboration and coordination with the provider to support the enrollee’s plan of care, and improved health outcomes

> Ongoing collaboration and coordination with our analytic and quality teams to identify key conditions, drivers of intervention effectiveness, and program outcomes

> Integrated medication management and medication therapy management (MTM)

> Integration and continual collaboration and coordination with utilization management (UM), CC/CM, benefit design, and provider support services to support the right care, in the right location, at the right time for our enrollees

> Self-care tools and supports

> 24/7 access to our CareLine for enrollee’s routine symptom and health education questions, utilizing evidence-based algorithms that allow enrollees to be directed to the appropriate level of care, and access to Magellan Complete Care’s Healthwise health education tools

> Enrollee outreach and support specialists, as part of our innovative Integrated Health NeighborhoodTM which serves as an independence, well-being, and recovery community hub in each of our regions.

> Incorporation of recovery and resiliency principles in the management of co-occurring SUD/AUD

Our programs are built around best-practice, evidence-based, nationally recognized clinical guidelines for management of specific physical health diseases, but also consider, and have been specifically adapted to reflect the unique needs of SMI enrollees. These include management of potential drug-drug interaction issues or complications from behavioral health medications; enrollee need for additional services and support for self-management; expanded enrollee education to address the impact of behavioral health conditions on compliance; and, increased enrollee and outcomes monitoring due to the complexity and fragility of the population being served. Magellan Complete Care is also committed to the concepts of recovery and resiliency for our SMI enrollees, including the management of their physical health, which is fundamental to
meeting AHCA’s goals of rebalancing long-term services and support systems and increasing the percentage of enrollees receiving services in the community, instead of an institution.

In addition to the disease management programs for cancer, diabetes, asthma, hypertension/congestive heart failure, substance use, and special programs focused on pregnant enrollee/healthy birth outcomes discussed in this response, our entire program and our approach to disease management is built around innovative principles for management of mental health. Magellan Complete Care maintains DM programs targeting specific mental health diagnoses, including schizophrenia, bipolar disorder, major depressive disorder, and first-episode psychosis (for adolescents and children). All of our physical health DM and population health programs also include key elements for the integrated management of our enrollees’ behavioral health diagnoses.

This approach recognizes that the combined effects of PH-BH comorbidities, and the treatment requirements and medication therapies of each may often complicate the management of either or both illnesses. We recognize that the complexity posed by our enrollees’ need to manage both a mental health condition and a physical health condition simultaneously means that their stability in either domain will vary from time to time. Our programs reflect our integrated approach to physical health and behavioral health care management and the need for seamless management of enrollees as they progress from the self-care oriented elements of DM to the more extensive support provided by case management and care coordination.

As with all of our care management programs, we are also continuously monitoring the effectiveness of our DM and population health programs, the needs of our enrollees, our providers and AHCA to refine and develop new programs based on those results. We are committed to continuing that collaboration and partnership to develop solutions that work for this complex and vulnerable population.

Magellan Complete Care DM and population health programs are a fully integrated element of our biopsychosocial care coordination and delivery model. They have been specifically built around the unique needs and requirements of the SMI population. They also incorporate the use of new, and innovative technology and enrollee engagement solutions to enhance access to services, improve quality and outcomes, enhance collaboration and coordination with providers, and increase social supports for our vulnerable population.

In addition to integrating behavioral, physical health, and social services and supports into a single, seamless model to manage enrollee health, these programs also incorporate the SAMHSA four-quadrant model for enrollee stratification and management for individuals with a behavioral health diagnosis. Our enrollee interventions, including DM, are built around concepts of an entire system of care that include education, self-care support, monitoring and management of gaps-in-care, case management, care coordination, recovery and resiliency services, referral to appropriate community resources, and monitoring of health care status until optimal health status is achieved.

As a specialty health plan for individuals with SMI, all of our enrollees will be challenged with behavioral health conditions such as bipolar disorders, schizophrenia, and major depression. Therefore, we do not have a DM program separately focused on mental health as a broad diagnosis, but instead have programs dedicated to specific mental illnesses. Mental health
management is also an integral element of our physical health programs and everything we do as a health plan. Our DM approach is uniquely designed to recognize the complex interplay between behavioral and physical health conditions, as well as frequent co-occurring disorders such as substance use disorder (SUD)/alcohol use disorder (AUD) as well as social determinants of health. Programs are also designed to support specific populations that may have additional, or unique needs, including children and adolescents, women, and pregnant enrollees.

Enrollees are evaluated for physical health, behavioral health, and social risks and are segmented and stratified by the nature, severity and complexity of those risks. We also capture and consider social determinants for predictive modeling, risk stratification, and identification of appropriate interventions. When creating predictive models of inpatient risk, as well as analyses of drivers of HEDIS measure compliance, Magellan evaluates enrollee response information on the health risk assessment which indicates whether the patient has stable housing and/or lacks transportation to medical appointments. If a patient does not have a health assessment, Magellan utilizes the United States Census Bureau geocoder tool to link enrollee addresses with census tract via latitude and longitude. Factors related to the patient’s area of residence are included in models to create a SocioEconomic Burden Score (SES).

The SES incorporates household size, marital status, educational attainment, primary language spoken, disability status, participation in the labor force including withdrawal from labor due to disability, and presence of children under the age of 18 in the home. In 2018, the score will be expanded to include crime statistics for the region in which patients reside. These factors are not exact measurements of the social determinants of health but are used as proxies of patients who face unstable housing, dangerous living environments, challenges with childcare and lack of economic parity due to an inability to access the workforce. The higher the patient’s SES, the more social risk factors the patient tends to have, which contributes to a reduced likelihood of remaining adherent to medications, and increased likelihood of inadequate access to care.

Going forward, the DM and ICCM teams and our quality teams will also leverage the SES to help drive the selection of appropriate action outside of enrollee identification. We have found the score to be an important factor in improving the accuracy of our predictive models, and our driver analyses and we believe it can do the same for defining enrollee personas and identifying the best interventions given those enrollee characteristics, and using the patient’s SES score to drive appropriate prescriptive tasks for our intervention teams to complete with the members (e.g. if a patient appears in an area of high crime, with high rates of single parent households, then we should be ensuring we review access to childcare as a potential barrier to access to healthcare). We are also planning to further enhance the model by identifying metrics associated with food security/insecurity, which has been shown to be associated with outcomes for specific chronic illnesses such as hypertension and diabetes.

Our risk stratification model, which is discussed in greater detail in a later section of this response, segments members into the following categories for health management:

>Wellness and Prevention:
>>Population health management and support
>>Focus on PCP and PBHP (primary behavioral health provider) assignment and engagement
>>Prevention and wellness education
>>Prevention and wellness messaging and reminders (mPulse)
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>>Gap in care monitoring, messaging and reminders (includes HEDIS, EPSDT/CHCUP, birth outcomes, and preventable events)
>>Active monitoring for rising risk, including new diagnoses and changes to medication therapies
>>Medication Therapy Management (MTM) through Magellan Rx
>>Access to Magellan Computerized Cognitive Behavioral Therapy (CCBT) tools described in greater detail below
>>Screening and referral for SUD/AUD, smoking cessation and weight management
>>Access to recovery and support services through IHN

>Low Risk:
>>All Wellness and Prevention programs noted above
>>Focus on Health Home assignment and engagement, or PCP assignment and engagement if Health Home not available in community
>>Disease management education
>>DM self-care education and support tools
>>Self-care messaging and reminders
>>Disease-specific messaging and reminders
>>Disease-specific gap in care monitoring, messaging and outreach
>>Online applications for disease tracking and monitoring (available, when fully evaluated by Magellan Complete Care and approved for use)

>Moderate Risk:
>>All Wellness and Prevention programs and low-risk DM programs noted above
>>Focus on Health Home assignment and engagement, or PCP and PBHP assignment and engagement if Health Home not available in community
>>CM-assisted DM and support, as described in the program descriptions that follow
>>Wellness Specialist outreach, support and management
>>Management may include remote monitoring for specific conditions (Being evaluated by the plan for conditions such as CHF, COPD, diabetes which lend themselves to these types of programs. Magellan Complete Care will also specifically be exploring the use of gamification and behavioral therapy that has proven of value in management of chronic disease in pediatric enrollees. Program implementation dependent on Florida provider availability and state reimbursement rules.)

>Monitor Risk:
>>Active, analytically-based monitoring for enrollees demonstrating rising risk (increased ER use, changes to medication therapy, higher than expected utilization, increasing social stressors, etc.)
>>Active monitoring, regular outreach and support, for enrollees previously identified for DM/CC/CM, but who have previously refused
>>All Wellness and Prevention and DM programs noted above
>>Focus on Health Home assignment and engagement, or PCP and PBHP assignment and engagement if Health Home not available in community
>>Active enrollee outreach and engagement with Recovery Support Specialists, Health Guides, and Homeless Outreach Specialists, Peer Specialists, and Community Outreach Specialists
>>Community Health Worker (CHW) outreach and engagement for health management support and gaps-in-care, and targeted interventions to address rising risk (when program fully implemented)
>High Risk:
>>All Wellness and Prevention and DM programs noted above
>>Focus on Health Home (note, this may include Integrated Behavioral Health Home for this enrollee category) assignment and engagement, of specialist, PCP and PBHP assignment and engagement if Health Home not available in community
>>Assignment to disease specialty team, if available for enrollee chronic illness
>>Active CC/CM, including focus on care gap closure
>>Active monitoring for rising risk for destabilization
>>Active enrollee outreach and engagement with Recovery Support Specialists, Health Guides, and Homeless Outreach Specialists, Peer Specialists, and Community Outreach Specialists

>Ultra-High Risk:
>>All Wellness and Prevention and DM programs noted above
>>Enhanced care coordination with Integrated Care Case Management (ICCM)
>>Active, ongoing monitoring and management of rising risk and care plan management
>>Active enrollee outreach and engagement with Recovery Support Specialists, Health Guides, and Homeless Outreach Specialists, Peer Specialists, and Community Outreach Specialists.

As noted above, enrollees at each risk level also have access to services and supports provided as part of our population health wellness and prevention programs; DM and self-care support; and community support services through our Integrated Health NeighborhoodSM ensuring that all enrollees or caregivers are focused on prevention, health management, recovery and resiliency.

Interventions targeted at enrollees are driven by the type of illness(es) the enrollee has, their risk and complexity, social risk factors, accessibility, likelihood of engagement, and likely method of engagement. This allows us to define different “personas” or enrollee profiles for the types of enrollees that can be engaged through the various outreach and management mechanisms. Definition of these categories is an iterative process, with results being continuously refined. Magellan Complete Care regularly analyzes the results of different types of interventions for achieving engagement and improving enrollee outcomes and makes appropriate improvements or refinements to its programs.

In addition to self-care supports and active case management, interventions include:

>Published materials (website, printed materials, newsletters, emails, text messages, and social media)
>Welcome calls and health risk assessment and screenings
>Phone calls
>Automated reminders, including phone, text, and mobile apps
>Enrollee gap-in-care reporting and reminders for providers
>Clinic and community wellness and DM education sessions
>In-person outreach and education, including direct provider outreach.

Our online programs, materials and supports are available on multiple technology platforms, and Magellan Complete Care provides SafeLink smartphones to support health and prevention messaging and reminders. Engagement and enrollee activation interventions are also integrated with our quality monitoring, management and improvement programs to support management of disease-specific gaps in care, as well as prevention and wellness and care plan gaps.
One of the unique elements of Magellan Complete Care’s DM program is our Integrated Health NeighborhoodSM (IHN). Through our experience, we know improved overall health and wellness can only be achieve where members live ---in Florida’s neighborhoods and communities. The IHN customizes our system of care by region, with the goal of improving members’ care, quality of life and health outcomes with a focus on where the enrollee lives and receives care. We created the IHN to foster relationships and collaboration with community partners to enable us to effectively coordinate care with the community supports and services the enrollee knows and trusts and the provider delivery systems that the enrollee can easily access.

Our IHN team members live and work within the communities where enrollees reside. These team members have first-hand knowledge of community strengths, resources, services and service gaps. IHN team members include ICCMs, Health Guides, Peer Specialists, and Community Outreach Specialists. Teams are also supported by Housing Specialists, Employment Specialists, Clinical Pharmacists, Medical Directors and others.

In addition to these roles, Magellan Complete Care is evaluating the use of Community Health Workers (CHWs) for inclusion as members of our IHN teams. The CHWs would be engaged to support health education, direct outreach to enrollees and to support gap closure, with a specific focus on those enrollees demonstrating rising health risks. Though Florida’s CHW networks are still emerging, we believe they can be serve an important role, particularly in prevention, wellness, and enrollee self-care education.

Magellan Complete Care also has programs specifically targeted at children and youth. These include:

1.1.a Increase in Early and Periodic Screening, Diagnostic, and Treatment (EPSDT):
Magellan Complete Care has developed a comprehensive EPSDT/CHCUP program for its enrollees consistent with State and Federal requirements. Our program emphasizes the importance of the child’s health home and supports the primary care provider, child, and family relationship. In partnership with our network providers, we offer comprehensive healthcare services through primary prevention, early intervention, diagnosis, and medically necessary treatment to correct or ameliorate defects and physical or mental illness discovered by the screening of members under age 21.

Magellan Complete Care promotes prevention of complications through evidence-based practice guidelines, help members access and engage in care, and evaluate clinical and psychosocial outcomes on an ongoing basis. Experience has shown that aligning enrollee and provider incentives combined with outreach and education can significantly improve utilization of preventive services. We continuously monitor program effectiveness to ensure EPSDT/CHCUP-eligible members are receiving timely care including EPSDT/CHCUP screenings, developmental screenings, well-child/well-adolescent visits, and childhood/adolescent immunizations. For hard-to-reach members, Health Guides will make a face-to-face visit to offer assistance with scheduling and appointment and transportation. In medically underserved areas, Magellan Complete Care deploys alternative regional strategies for direct outreach to enrollees to close gaps in service providers.

To support the PCPs, Magellan Complete Care PSSs (licensed clinicians) use a broad set of tools to provide training and technical assistance, reinforce evidence-based practice guidelines, and
provide access to online enrollee registries with gaps in care and scorecards. For high-volume practices, we collaborate with the practice on outreach assistance if needed.

1.1.b Prevent and/or reduce obesity, asthma, or other chronic conditions:
Prevention and reduction of chronic conditions in children requires proactive efforts to raise awareness, educate, and promote lifestyles that support healthy outcomes. Magellan Complete Care’s approach optimizes connections between members and their families, their health home, and other resources in the IHN. We identify children through the initial and annual HRA, care coordination, referrals, and through continuous data mining. When appropriate, referrals are made to our chronic condition program or to specialists to address conditions that may need further medical or behavioral health interventions.

We are developing region-specific My Healthy Neighborhood Toolboxes for condition care (e.g. childhood obesity) and another for use in clinics and schools. The Toolbox includes healthy eating and activities based on neighborhood resources – e.g. farm to school, farmer’s markets that take Supplemental Nutrition Assistance Program (SNAP), seeds packets, list of community activities/greenways/parks, etc. These toolboxes and the flexibility of the use of Health Guides (or CHW’s once the program is implemented) in the IHN at the regional level are strategies to gain scale and efficiency in meeting the needs of members in small regional populations.

Each child enrolled in our program receives a My Healthy Neighborhood Toolbox customized based on their age, region, and condition. For example, a child diagnosed with obesity might receive a ChooseMyPlate.gov placemat and log sheets, listing of area farmer’s markets that take SNAP; location of community gardens; list of community activities, greenways, and parks; how to access apps and online tools; and “getting started” items like hacky sack, a Frisbee, or sidewalk chalk. We partner with community agencies and the schools to usher members into achieving optimal health outcomes.

1.1.a Focus on Teens and Adolescent Health, Including Trauma-informed Care, ACES, and Resilience:
Magellan Complete Care continues to promote EPSDT screenings, well-adolescent visits, and immunizations including the HPV vaccine. Our assessment process includes screening adolescents for substance use and risky sexual behaviors and provides solutions for awareness, education, and connection to resources to promote healthy choices. We also assess for abuse and experiences of trauma and when identified, connect enrollees with resources, such as providers and therapists experienced in the care of teens and adolescents who are victims of abuse.

In this area, Magellan Health stands on a reputation as an innovator in trauma-informed care and as thought leaders. Our PSSs train providers in effective trauma-informed care including the importance of safety and stabilization as the first step toward recovery. Our goal is to prevent and treat problematic behaviors and behavioral illness, as well as to promote positive mental health in young people. Promoting the value of emotional well-being and a high level of psychosocial functioning, our staff and providers assist young people and their families in realizing their strengths, meeting their challenges, and enjoying a spirit of hope for resiliency and optimal recovery. Our system-of-care approach addresses each individual’s unique needs, helping them to reach their potential of successfully living at home, achieving in school, and participating in their communities.
Our emphasis includes assessment and addressing vulnerabilities or potential developmental disruptions involving: learning and memory, attachment, social relatedness, and self-regulatory control. Magellan Complete Care stresses the critical importance of enhancing young people's ability to achieve developmental competence along with a positive sense of self-esteem, mastery, well-being, and social inclusion along with a strengthened ability to cope with adversity. Magellan uses the Child and Adolescent Needs & Strengths (CANS) tool to inform service coordination and to measure the impact of behavioral health services on high-risk youth. We have seen statistically significant improvements in scores at six and 12 months from 12.9-19.4 percent in the six states where we use the instrument.

In addition to our programs targeted to children and youth, Magellan Complete Care also has a contractual agreement with AHCA to provide the Healthy Behaviors Program to engage enrollees and reward them for making healthy lifestyle changes. The program, which is an integral element of our DM and CC/CM programs, offers incentives to enrollees who successfully meet the goals of each program. The three programs being offered are:

> Tobacco Cessation
> Weight Management
> Substance Abuse Treatment

The Healthy Behaviors Program also requires providers to assess and educate enrollees through materials provided by Magellan Complete Care during their participation in the programs. We include [General SRC #05, Attachment 1: Healthy Behaviors Program Description].

Magellan Complete Care also incorporates innovative programs using computerized cognitive behavioral therapy (CCBT) to assist members in managing various illnesses. Through Magellan’s CCBT programs, we offer an enhancement to traditional telephonic and face-to-face care. This proven, quality, web-based platform has been shown to decrease the need for higher levels of care, increase access to preventative behavioral health programs, and reduce the prescribing of inappropriate (and sometimes dangerous) medications.

Magellan’s industry leading, online CCBT programs, powered by Cobalt Therapeutics, LLC, and (a fully owned subsidiary) provide an innovative, technology-based solution that enables increased access to clinically effective tools for behavioral health conditions, improved outcomes, and reduced overall costs. CCBT has been shown to be just as effective, or more effective, than prescription medication for long term health outcomes. CCBT is a short-term, goal-oriented, method that focuses on problem-solving and building skills such as: identifying unhelpful thinking, modifying beliefs, and changing behaviors. Cobalt has received SAMHSA’s highest rating available for CCBT tools.

The efficacy and effectiveness of CCBT has been validated and supported in more than 1,000 clinical outcome studies, and it is recommended in treatment guidelines as the first line of care for insomnia, anxiety, phobias, panic disorder, and obsessive compulsive disorder (OCD); and as a first line option for depression and substance use, by the American Psychiatric Association (APA), the American Psychological Association (APA), the American Academy of Sleep Medicine (AASM), and the Agency for Healthcare Research and Quality (AHRQ) guidelines.

Magellan’s Cobalt-powered collection of online CCBT programs is the only suite of its kind. The Cobalt suite of products applies to more than 85 percent of behavioral health conditions seen in
primary care and behavioral settings. Using our Cobalt platform, enrollees can complete mental health screenings in the provider’s office (on iPad) or in the comfort of their own home (computer, iPad or smartphone). Based on the automated risk stratification of enrollee responses on those standardized screenings, the enrollee can complete the online CCBT curriculum appropriate for their risk level, or be referred for higher acuity care and care management. Participants can progress through the sessions at their own pace and access the programs anywhere, and anytime that works with their personal schedule. The sessions can be repeated and reviewed as many times as the enrollee desires.

Besides bringing screening and care to the enrollee, the advantage of the Cobalt CCBT platform is that it integrates mental health screening and treatment into the primary care practice through capabilities allowing providers to monitor completion of screenings and refer members for additional treatment if needed. The CCBT platform is provider-friendly and can be coupled with Magellan’s Virtual Care Solution, which provides an automated desktop for provider monitoring and management of enrollees using these programs. Magellan’s Cobalt solutions are also convenient for enrollees who reside in rural areas or who prefer not to travel to a clinic setting to receive care. Cobalt makes CCBT very accessible, especially in areas where behavioral health providers are not available.

Magellan Complete Care is looking to further expand its use of remote and online DM and remote monitoring and care delivery as part of our programs and strategy for telehealth services. Our goal is to expand these programs to include online and mobile applications for enrollee chronic illness tracking and monitoring. We believe these can be particularly effective in supporting self-management for the types of conditions highlighted by the state in this SRC. In fact, our partner, Click Therapeutics (developer of our Clickotine Smoking Cessation product) is currently testing a Congestive Heart Failure (CHF) monitoring and management application that it has been developing. As an organization with a long history in behavioral health, we are also interested in the potentially for “gamifying” applications for use with children and adolescents. These types of programs, some of which are already in use in Medicaid plans throughout the country, have been helpful in increasing engagement and compliance. As part of our strategy, we will also be evaluating the use of remote monitoring for more complex enrollees, particularly with chronic illnesses such as CHF/hypertension, COPD, and diabetes. Remote monitoring has already been demonstrated to be effective across multiple settings, and is widely used with Medicare populations. As with all Magellan Complete Care programs, before launching, each of these solutions will be evaluated for clinical effectiveness and outcomes.

Throughout 2016 and into 2017, Magellan Complete Care has also developed a number of new targeted and focused programs, beyond the DM programs identified by AHCA in this section. Those targeted programs are specifically tailored to meet the needs of members presenting with complex behavioral health and physical health conditions of high import and need in the SMI population, and which may be driving inappropriate or very high usage of high acuity services. Subject matter experts and specialty management teams have been assigned to enrollees with these specific conditions and needs. These focused programs include:

>Sickle Cell Disease
>Depressive Disorder
>Schizophrenia
>Transplants
>High Risk Pediatric Programs
>First Episode Psychosis (adolescents and young adults).

Each of these programs employs specialized teams and targeted interventions aimed at managing the complex interplay between behavioral health and physical health diagnoses and the treatment of each.

1.2 Common Framework for DM Programs
Magellan Complete Care DM programs go well beyond the traditional programs used by other health plans, by emphasizing direct interaction and contact with enrollees in addition to self-care support. Individuals with SMI face additional challenges with increased isolation and homelessness. Successfully engaging enrollees often requires repeated contact attempts using multiple strategies (written, telephonic, and in-person) and a strong method for tracking and documenting contact attempts and enrollee contact information. In addition to our standard methods of outreach to members as detailed in other sections of this proposal, we use a number of specialized outreach efforts to locate often hard to reach enrollees with SMI.

Rather than trying to engage difficult-to-reach enrollees with sometimes-unproductive phone calls and letters, we deploy the following additional outreach methods:

>Health Guides locate and meet face-to-face with enrollees in their homes or other locations to help them navigate the health care system

>Peer Support Specialists provide ongoing support and contact with members, supplementing other enrollee engagement efforts, and modeling successful treatment, medication adherence, and healthy lifestyles based on their own experience and training

>Provider Support Specialists educate physical health providers on BH needs of enrollees and BH providers on physical health needs and monitoring. Our PSS can also provide a range of practice supports, working with providers to assess their readiness for delivering integrated care, and assist with practice transformation. They also commonly work with providers to develop or enhance programs to serve our enrollees.

>Integra Health, a contracted provider, goes out in-person to locate and conduct outreach to members that are hard to locate and for who there has been no engagement

Our programs are designed to support and empower enrollees and their caregivers (with enrollee consent) to effectively manage their ongoing condition(s) and prevent complications by working with their providers on adherence to treatment and medication regimens, ongoing monitoring of applicable labs/vital signs, adopting a healthy lifestyle, and care coordination among and with behavioral health, medical providers, and social supports.

Programs support the physician or provider/patient relationship and treatment plan, emphasizing prevention of complications through evidence based practice guidelines, helping members access and engage in care, and evaluating clinical and psychosocial outcomes on an ongoing basis. The program includes population-based, group, and individual approaches for managing the enrollee’s illness, in combination with tailored approaches for managing enrollees’ behavioral health conditions. These programs and activities promote a holistic approach to improve the enrollee’s physical and mental well-being through easy to use tools, coaching and outreach.
We use a person-centered treatment planning approach that places the enrollee and family in the center of the planning process and involves all stakeholders in the enrollee’s care. This approach promotes communication, integration, and coordination of care and services, reducing inefficiency and duplication of services. We deliver behavioral health services through a large established credentialed and contracted network that has the capability to provide services across the State and across the continuum of care.

Magellan Complete Care staff who perform DM functions are also Registered Nurses in the State of Florida with current unrestricted licensure. This is a higher level of licensure than many health plans require. They have a minimum of three years clinical practice experience and one year minimum of health insurance/managed care experience and DM, within the scope of their licensure, based on the standards of the discipline. Depending on the enrollee’s individual needs, an enrollee may also receive services and supports from all or just a few of the Interdisciplinary Care Coordination Team (ICCM) members. This requirement for higher licensure and skill levels reflects our understanding of the complex needs of our members and the clinical demands of their multiple illnesses.

DM staff, known as Wellness Specialists, educate and support moderate risk enrollees (ICCMs work with the high risk population) and enrollees identified as rising risk. Wellness Specialists are registered nurses or have a combination of health education credentials and training and expertise in DM. The Integrated Health Neighborhood community-based teams include Health Guides (navigators) and Peer Support Specialists (individuals with lived experience with SMI who have been certified to deliver support to others) who identify and connect enrollees to resources that support the enrollees’ DM goals.

The Magellan Complete Care staff coordinating the DM Program activities are allocated and located to best meet the program needs of our population and to comply with the state’s contract. These staff members are part of the care coordination team which works with each enrollee or the enrollee’s guardian and the enrollee’s providers. If the enrollee or the enrollee’s guardian provides consent for the caregiver to receive information related to the enrollee’s treatment and care coordination activities, the Magellan Complete Care program staff also engages with the enrollee’s caregiver during his/her participation in the program.

In addition to Wellness Specialists, Peer Support Specialists, and Case Managers delivering individual education and support to enrollees, other members of the Care Coordination Team do the practical work of assisting members to engage in care, adhere to their provider’s treatment plan, and attend scheduled appointments. Peer Support Specialists and Health Guides, interacting with enrollees where they live and work, are trained to recognize, support, and refer when an enrollee seems to be stressed or in crisis, isolated or lacking social support, or not taking medications appropriately or safely.

Targeted engagement activities for enrollees identified as eligible for the program occur through mailing of a Welcome Letter to introduce them to the program.

>For enrollees under the age of 18 identified as eligible for the Disease Management Program, the Enrollee’s parent or legal guardian will be provided with the introductory program materials
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We contact the enrollee to participate either in-person or by phone. After two attempts, if the staff member is not able to reach an enrollee by telephone, an “unable to reach” letter will be mailed.

If the staff member is able to reach an enrollee, he or she will also establish whether the enrollee has been participating in a DM program offered outside of Magellan Complete Care. For enrollees who were previously participating in a program offered external to Magellan Complete Care, the staff member will seek information from the previous program provider to ensure continuity of care planning.

If the enrollee agrees to participate in a DM program, a designated member of the enrollee’s Care Coordination Team (i.e. Health Guide or Wellness Specialist) will provide education about the program and its benefits, and how to use program services, through in-person contact, internet connectivity and/or telephone calls.

Enrollees are notified that they are able to opt-out of the program at any time, and will be provided information on how to opt-out if they choose to do so so the Magellan Complete Care team tracks eligible enrollees in the clinical information system. Program enrollment is tracked, as is information on ongoing engagement through analysis of members’ care coordination plans. Enrollee participation data, including frequency and forms of contact, is tracked by the Health Services Department.

The intensity and frequency of interventions for enrollees in DM programs will shift as an enrollee’s condition or circumstances changes. Enrollees will be regularly assessed for health literacy, skills in self-management, screening for depression, level of confidence, and motivation for making a behavior change throughout their participation in the program. The findings from these ongoing assessments as well as information shared by the enrollee’s providers will inform the enrollee’s goals and interventions as documented in the care coordination plan. The care coordination plan includes short and long term goals and interventions that are tailored to the enrollee’s conditions, risks and readiness for behavior change. For many enrollees in this population, social isolation is a key concern, so goals and interventions may include a focus on identifying friends and families who are able to support the enrollee in managing his/her hypertension. Additionally, many care coordination plans developed for enrollees in this population will address topics of recovery and resiliency, and highlight the importance of creating crisis and/or safety plans.

Once providers and treatment are accessed, the Magellan Complete Care team assists the enrollee in adhering to treatment and medication regimens. This includes ongoing monitoring of applicable labs/vital signs, adopting a healthy lifestyle, and care coordination among behavioral health and medical providers. Enrollees are also engaged through reminders (phone, mail, email, messaging, and the use of smartphone apps for illness monitoring and care reminders) to complete health management activities, and close gaps in care. For child and adolescent enrollees of the plan, education is also provided to parents and guardians to support them in better understanding the requirements for managing the enrollee’s health. All enrollees are provided with the following health education tools:

Health Education Written Materials: Age-appropriate, and appropriate reading level, cultural appropriateness, and based on current health standards and evidence.
Smartphone Apps: Age-appropriate smartphone apps to support the enrollee or the enrollee’s guardian in monitoring symptoms, logging medications, and other self-care management activities

>Enrollee Website: Contains a health and medication library and interactive assessments and health tools for self-management of cancer conditions and symptoms, in English and Spanish

>Prevention, wellness and gap-in-care messaging

>Access to Cobalt and Clickotine CCBT Platforms

>Online, Interactive Courses from Healthwise™:
>>Online programs are used in the manner best suited to the enrollee: independently with orientation from the Wellness Specialist, Health Guide, or Peer Support Specialist; as part of a group class on self-management of conditions; or individually when a Wellness Specialist or ICCM engages with moderate or high risk enrollees
>>Course content is engaging and evidence-based, and it allows enrollees and the multidisciplinary CC/CM team to measure understanding and track progress and completion
>>Display is appealing and appropriate for lower literacy levels.

Enrollees identified as moderate risk and rising risk (monitor risk category), also receive one-on-one wellness coaching/support which is facilitated by our Wellness Specialists and/or Peer Specialists and includes:

>Techniques facilitated by specialists who have learned to cope with their own mental illnesses, and who are trained to share their experience through healthy living activities such as group workshops

>Help for enrollees and their families to regain hope, learn wellness self-management, and work with their providers to improve both mental and physical health

>Identifying and addressing lifestyle issues that may be addressed include tobacco use, being sedentary, obesity, substance use, early health screenings, and healthy eating.

The DM team works closely with the enrollee using various tools and approaches to assist the enrollee in understanding and managing risk factors, which might affect the outcomes and progress of their illness. Areas of engagement include:

>Monitoring and closing gaps in care
>Monitoring changes in health status
>Evaluating and monitoring social risk factors, including changes in social risks
>Education in crisis triggers, safety risk assessment, and actions to take when the enrollee is in crisis or is at risk due to changes in condition or other factors
>Education in appropriate use of emergency department or other higher-intensity services
>Active monitoring of enrollees by the DM team to identify over-utilization of the emergency department, or indicators of rising risk or enrollee intervention
>Education in the importance of the enrollee’s treatment plan and the effects of non-compliance
>Active monitoring of enrollee compliance with treatment plans, by DM team members
>Education of the enrollee on the importance of medication non-compliance
>Active monitoring of enrollee medication therapy compliance (includes late-to-refill monitoring, and monitoring of changes in medication therapy due to new encounters)
>DM team coordination of services and resources, and assistance to enrollee in removing barriers to access (transportation, assistance making appointments, etc.)
>Ongoing evaluation of enrollee educational needs by DM team
>DM team assistance in connecting enrollee to a provider (PCP, PBHP, IHH, specialty providers)

Our Health Guides and Disease Management staff will connect our enrollees to community resources where possible. One example of this outreach would be to encourage healthy eating through connections to community gardens and Food Share programs throughout the community. Primary Care Providers (PCP’s) play a leadership role in the management of enrollee illness. Magellan Complete Care supports providers in delivering evidence based care through education, monitoring, and feedback as well as supporting patient engagement in care and coordinating different components of the treatment plan. We place particular emphasis on closing gaps in care and medication management, given the special considerations and medication-related risks for the SMI population.

For enrollees at advanced stages of their illness(es), and who are unlikely to recover, we also provide Advanced Illness Management through our ICCM program, and Palliative/Hospice Care for individuals at End of Life (EOL). This may include programs for pain management if appropriate.

1.2. a Cancer Disease Management
Cancer is recognized as one of the leading causes of death and disability in the United States. In 2016, there were an estimated 1,685,210 new cancer cases diagnosed and 595,690 cancer deaths in the US. Cancer remains the second most common cause of death in the US, accounting for nearly 1 of every four deaths. There are over 100 different forms of cancer, 1 in 17 deaths are due to lung cancer with lung cancer as the most common cancer in men. Breast cancer is the most common cancer in women. The American Cancer Society estimates that 12,990 new cases of cervical cancer will be diagnosed by the end of 2016. In the year of 2016 an average of 4,120 women will die from cervical cancer.

The absence of effective preventive care for many individuals with SMI, due to known issues of engagement and compliance, creates an environment that leads to a very high prevalence of modifiable risk factors such as tobacco use, lack of physical activity and poor nutrition that can increase cancer risk. Effective coordination and care management is also needed to address the reality that the mental illness itself is often a barrier to management of physical health conditions. Mental illness makes it harder for individuals to access care, adhere to a therapeutic regimen, keep follow up appointments and navigate the health care system.

Magellan Complete Care’s Cancer DM program addresses co-occurring medical and behavioral health conditions as well as substance abuse by combining health care, social support, and peer support with care coordination tools that foster communication and shared treatment planning among providers. The clinical basis for our program was established by the American Cancer Society, Centers for Disease Control (CDC), National Cancer Institute, and the American Journal of Clinical Oncology, focusing on a comprehensive and general approach to the management of cancer, including elements to:
>Promote self-management of cancer through personalized enrollee interventions
>Coordinate care with providers to reinforce treatment plans
>Complete referrals to other departments, support groups and community resources based upon acuity, medical status, or enrollee needs
>Reinforce evidence-based practice guidelines
>Complete an annual enrollee satisfaction survey for process improvement purposes.

We include [General SRC #05, Attachment 2: Cancer Disease Management Program Description].

While population-based, our Cancer DM Program’s approach is individualized and includes education and peer support to help enrollees engage and embrace self-care and healthy behaviors, work with providers, and comply with treatment.

Because there are so many different types of cancers and even more types of treatment modalities, the focus of this Cancer DM program is to assist enrollees in managing the long list of symptoms and side effects that enrollees typically experience due to cancer and the corresponding treatments.

The purpose of the Cancer DM Program is to support and empower enrollees and their caregivers (with the enrollee’s permission) to effectively receive and manage their ongoing condition(s), manage symptoms and side effects, and prevent complications by working with their providers. This includes assisting enrollees in finding appropriate and accessible cancer treatment providers. Cancer-specific and wellness engagement and education interventions include the following:

>One-on-one wellness coaching and support based on the program parameters outlined for our DM program elements defined above, and including the following cancer-specific elements:
  >>Lifestyle issues that may be addressed include tobacco use, being sedentary, obesity, substance use, early screenings, sun exposure, and healthy eating.
  >>>Cancer Specific Health Education Written Materials: Appropriate reading level, cultural appropriateness, and based on current health standards and evidence. This includes MCG Chronic Care Guidelines 20th Edition, Healthwise™, and recovery and resiliency enrollee materials
  >>>Health and medication library and interactive assessments and health tools for self-management of cancer conditions and symptoms, in English and Spanish available on the enrollee website
  >>>Cancer-specific online, Interactive Courses from Healthwise™, which include managing cancer, cancer-related health behaviors and lifestyle choices that affect the path of cancer disease (tobacco, weight, exercise, early screenings, sun exposure).

Care coordination activities include:

>Helping enrollees choose a provider(s), make an appointment, or arrange transportation
>Facilitating sharing of information among treating providers including multiple specialists often involved in an enrollee’s cancer care.

Our Cancer DM Program supports the physician or provider/patient relationship and treatment plan, emphasizing prevention of complications through evidence-based practice guidelines,
helping enrollees access and engage in care, and evaluating clinical and psychosocial outcomes on an ongoing basis.

1.2.b Diabetes Disease Management
The Diabetes DM Program is aimed at improving the health outcomes for enrollees with diabetes. The program uses a holistic approach to achieve the best possible therapeutic outcomes based on assessment of enrollee needs, ongoing care monitoring, evaluation and tailored enrollee and practitioner interventions. Diabetes is widely recognized as one of the leading causes of death and disability in the United States. According to the American Diabetes Association, there are 29.1 million people in the United States or 9.3 percent of the population who have diabetes. Diabetes is associated with an increased risk for a number of serious, sometimes life-threatening, complications.

The disease can often lead to blindness, heart and blood vessel disease, stroke, kidney failure, amputations, and nerve damage. Diabetes control can help reduce the risk of complications and decrease the cost of care. The American Diabetes Association predicts that as many as 1 in 3 Americans will have diabetes in 2050 if the present trend continues. The projection of the year 2050 burden of diabetes in the US adult population is dynamic, with an increase in mortality and prediabetes.

Among populations with SMI, the incidence of diabetes is even higher, often exacerbated by poor nutrition or other risk factors including the medications often used to treat SMI conditions. The Magellan Complete Care SMI population has diabetes incidence rates that are 2.6 times higher than that in the general Medicaid population, and this condition is often exacerbated by the medications used to treat mental health conditions.

As with our other DM programs we address co-occurring medical and behavioral health conditions, the treatment requirements for each, including complications that may be associated with the use of psychotropic medications, as well as substance abuse. We combine health care, social support, and peer support with care coordination tools that foster communication and shared treatment planning among providers.

Our approach to diabetes DM includes the common elements identified for our programs. Integrated care guidelines are used as a resource to identify potential problems, risks or interactions between the different conditions. For example, some drugs used to treat behavioral conditions can have an effect on blood sugar levels in regards to diabetes. Enrollees on drugs for both diabetes and behavioral health conditions will need more active monitoring of their levels. All enrollees in the diabetes DM Program will receive:

> Initial and ongoing diabetes condition assessments, education, assistance in goal setting, and support for skills development in self-management of diabetes

> Interventions that remind the enrollee to participate in:
  >> Condition self-monitoring activities (e.g., blood glucose monitoring, daily food and exercise logs)
  >> Health screenings (e.g., retinal eye exam, nephropathy screening test or evidence of nephropathy)
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Maintain a blood sugar reading log requiring enrollees to measure your blood sugar at the same time each day (paper-based or through the use of diabetes monitoring applications once approved for use within Magellan Complete Care)

Immunization (e.g., annual flu, pneumovax, etc.)

Self-direction and skill development in the area of independent administering of medication and medication adherence

Self-management support and development of self-management plans and/or relapse prevention plans so individuals can attain personal health goals (e.g., what a person with diabetes is to do when blood sugar levels are very low and very high)

Closing identified gaps in care (HbA1c testing at least twice per 12 months for controlled diabetes and every three months for uncontrolled diabetes) *(this also includes closing gaps as an inpatient)

Monitor and implement interventions to improve performance on outcome measures such as the Healthcare Effectiveness Data and Information Set (HEDIS®), controlling diabetes related measures, preventable events, and enrollee surveys to evaluate the clinical and patient perspectives, and the effect on overall cost and health care service utilization.

Encouragement to participate in the development and ongoing review of the care coordination plan. Interventions are identified for each enrollee based on risk level, strengths, and opportunities, and an enrollee of the care coordination team will be assigned to be responsible for following through on each intervention.

Magellan Complete Care uses a combination of administrative data and predictive modeling as well as ‘real time’ referral sources to identify enrollees with diabetes who are eligible for the Diabetes DM Program. Administrative data is produced through regular reporting that is completed each month, and the data is reviewed at least monthly to identify individuals with diabetes.

Magellan Complete Care’s Diabetes DM identification process includes the following:

Identifies enrollees who meet criteria for the Diabetes DM program
Identifies the enrollee’s caregiver, who with the enrollee’s consent, is permitted to engage and receive information on the enrollee’s care and participation in the Diabetes DM program
Stratifies enrollees into low, moderate, high, or ultra-high-risk categories based upon medical and behavioral health conditions and issues
Promotes self-management of diabetes through personalized enrollee interventions
Coordinates care with providers to reinforce treatment plans
Completes referrals to other departments, support groups and community resources based upon acuity, medical status, or enrollee needs
Reinforces evidence-based practice guidelines
Completes an annual enrollee satisfaction survey for process improvement purposes.

We provide [General SRC #05, Attachment 3: Diabetes Disease Management Program Description, which outlines the scope, structure and activities of Magellan Complete Care’s
Diabetes DM Program for our SMI enrollees. The clinical basis for our program was established by the American Diabetes Association Guidelines for the diagnosis and management of diabetes.

1.2.c Asthma Disease Management
Among Magellan Complete Care’s SMI enrollees, asthma occurs at 1.6 times the rate (12.3 percent of enrollees) of occurrence among the general Medicaid population. An asthma attack is distressing and can be a potentially life-threatening experience. That can be even more the case for enrollees dealing with SMI. The absence of effective preventive care for many individuals with SMI creates an environment that leads to a very high prevalence of modifiable risk factors such as tobacco use, lack of physical activity and poor nutrition. Effective coordination and care management is needed to address the reality that the mental illness itself is a barrier to management of physical health conditions. Mental illness also makes it harder for people to access care, adhere to a therapeutic regimen, keep follow up appointments, and navigate the health care system.

Scientific advances have greatly improved the understanding of the mechanisms that cause Asthma attacks and have led to effective medical interventions to prevent morbidity and improve quality of life. However, the burden in prevalence, health care use, and mortality remains high. Asthma remains a significant public health problem in the United States. 1 in 12 (25 million) Americans have asthma. Rates for asthma have continued to rise for the past three decades. Asthma affects children as well as adults with 7 million out of the 25 million being children. Asthma as a disease crosses all socioeconomic classes but does have a higher prevalence among those who live below the poverty level. Racial and ethnic disparities exist as well, with African Americans having the highest rates and black children the greatest rise in their rates of asthma diagnoses from 2001 to 2009. Hispanics who live in the United States account for 3 out the 25 million, with those of Puerto Rican origins being impacted more than other Hispanics groups. Costs in the billions are associated with asthma and those costs continue to rise as well. Costs related to a person’s quality of life are also impacted.

Our experience has shown that enrollees with SMI respond well to engaging in their health care when trusted health care relationships exist. In addition, our enrollees favor telephonic and face-to-face contact when interacting with their health care team. Accordingly, when dealing with moderate and high risk members, we use face-to-face interventions and a high frequency of telephonic contact or progress reporting to ensure that enrollees are receiving the support they need to manage their Asthma. These approaches include telephonic outreach and onsite coaching interaction with a Care Coordination Team member, as well as referral to group classes offered by program staff and regular follow up with their treating providers.

The goals of the Asthma Disease Management Program include utilizing evidence based and team approaches to:

> To increase the number of enrollees who use their asthma medications appropriately and decrease the emergency room and inpatient visits for enrollees to treat asthma flare-ups. Wellness Specialists (disease managers) and other members of the Care Coordination Team support enrollees as they learn to self-manage their asthma. The following are examples of evidence based care enrollees are engaged to incorporate into their daily lives for managing asthma.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

> Maintain and improve the health of Magellan Complete Care enrollees by increasing their health knowledge and ability to engage in treatment and shared decision making with their providers.

> Monitor and implement interventions to improve performance on outcome measures such as the Healthcare Effectiveness Data and Information Set (HEDIS©), controlling high asthma related measures, preventable events, and enrollee surveys to evaluate the clinical and patient perspectives, and the effect on overall cost and health care service utilization.

> Maintain an asthma management log to measure and track medication use and conditions (paper-based or through the use of asthma management applications once approved for use within Magellan Complete Care).

> Improve Magellan Complete Care enrollees’ engagement in their health and ability to self-manage their asthma, with support from structured coaching, tools and outreach -based on evidence based guidelines, enrollee empowerment strategies and tools to prevent and manage exacerbations of their condition.

> Improve coordination of care for enrollees with Asthma including medication reconciliation and evaluation of medication safety.

> Support Magellan Complete Care providers (both physical and behavioral) in their plan of care and efforts to educate the enrollee about asthma, delivering care which is consistent with national guidelines and evidence- based practice.

> Monitor and implement interventions to improve performance on outcome measures such as the Healthcare Effectiveness Data and Information Set (HEDIS©), controlling high asthma related measures, preventable events, and enrollee surveys to evaluate the clinical and patient perspectives, and the effect on overall cost and health care service utilization.

> Reduce morbidity and mortality related to Asthma for Magellan Complete Care enrollees.

> Magellan Complete Care’s Asthma Disease Management Program is offered to all eligible Enrollees diagnosed with Asthma. The program incorporates education, motivational and emotional support, easy to read materials, and group and individual resources in alignment with the enrollee’s conditions, needs, and readiness for behavior change.

> Magellan Complete Care’s Asthma Disease Management Program also includes the same core components for our other programs. Once an enrollee has been identified for the Asthma Disease Management Program, the enrollee is welcomed to the program. Members who decline or dis-enroll are re-approached after six months and asked to participate. If an enrollee has been identified incorrectly with asthma, this information is noted in the clinical system and the enrollee is removed from the program listing. If the enrollee provides consent for the caregiver to receive information related to the enrollee’s treatment and care coordination activities, then the Magellan Complete Care program staff also engages with the enrollee’s caregiver/guardian during his/her participation in the DM program. For enrollees under the age of 18 identified as eligible for the Asthma Disease Management Program, the Enrollee’s parent or legal guardian will be provided with the introductory program materials.
As noted in previously, integrated care guidelines are used as a resource to identify potential problems, risk or interactions between the different conditions. For example, some drugs used to treat asthma can have an effect on lithium levels, which are prescribed in the treatment of bipolar disorder. Enrollees on both drugs will need more active monitoring of their levels.

The enrollee’s DM Team assists the enrollee in understanding his/her condition and provides the education and tools to improve self-management of his/her asthma, using various outreach and engagement approaches, which may include smartphone apps or manual logs to monitor symptoms and medication use. Participants will be helped to develop symptom response plans which demonstrate they know how to identify an exacerbation of their condition and have a plan to deal with it, including knowing who and when to call for help.

All enrollees in the Asthma Disease Management Program will receive:

> Initial and ongoing asthma condition assessments;

> Education, assistance in goal setting, and support for skills development in self-management (containing asthma disease-specific information);

> Prompting interventions that remind the enrollee to participate in:
>> The management of their condition (e.g., term controller medications for asthma, information discussing Asthma trigger identification)
>> Health screenings (practitioner follow up visits)
>> Immunizations (e.g., annual flu, pneumovax, etc.)

> Maintain an asthma management log to measure and track medication use and conditions (paper-based or through the use of asthma management applications once approved for use within Magellan Complete Care)

> Self-direction and skill development in the area of independent administering of medication and medication adherence;

> Self-management support and development of self-management plans and/or relapse prevention plans so individuals can attain personal health goals (e.g., what a person with asthma is to do when they become short of breath or begin to wheeze); and,

> Closing identified gaps in care (e.g., if a gap is identified for a controller inhaler medication).

> Encouragement to participate in the development and review of the Care Coordination Plan.

Interventions are identified for each enrollee based on risk level, strengths, and opportunities, and a member of the Care Coordination Team will be assigned to be responsible for following through on each intervention. The intensity and frequency of interventions for enrollees enrolled in the Asthma Disease Management Program will shift as an enrollee’s condition or circumstances changes. Enrollees are regularly assessed for health literacy, skills in self-management, level of confidence, and motivation for making a behavior change throughout their participation in the Asthma Disease Management Program as well as screening for depression. The findings from these ongoing assessments, as well as information shared by the enrollee’s providers, will update the enrollee’s goals and interventions as documented in the Care Coordination Plan.
Both the initial assessment and follow up interactions include assessment of medication adherence. Since there are so many potential interactions and risks, we expect that many of the participants will have medication regimen evaluation by our clinical pharmacist. Outreach to the treating physicians to discuss potential changes occurs when enrollee safety issues are identified. We support adherence to drug regimens by encouraging treating providers to simplify them whenever possible. Peer Support Specialists are able to work with enrollees to encourage medication adherence.

Asthma is a chronic respiratory condition characterized by airway sensitivity, inflammation of the airways and potentially severe, but reversible airway constriction. This program, offered to both adult and pediatric populations, helps enrollees with asthma understand how to monitor and manage their asthma symptoms and to avoid triggers and reduce exacerbations related to their conditions. Education is provided regarding: appropriate use of asthma medications, condition self-management, developing a symptom response plan, and identifying and avoiding triggers. It also includes information about side effects of the drugs used for asthma care in light of the enrollee’s behavioral health condition. For example, use of rescue inhalers can cause increase jitteriness that could be confused with increased anxiety or early mania.

1.2.d Hypertension Disease Management
Among Magellan Complete Care’s SMI population, hypertension occurs at 2.2 times the rate as that in the general Medicaid population. As with diabetes, medications used for treating SMI, along with other population risk factors can increase the risks of hypertension and exacerbate efforts to management the disease.

The goal of this program is to increase the number of enrollees who maintain their blood pressure readings within normal ranges, adhere to their medication regimen, and reduce their lifestyle risks through behavioral change. The program also seeks to decrease the emergency room and inpatient visits for hyper or hypertensive episodes and other complications from hypertension (i.e. heart attacks, strokes, etc.). The care coordination plan and the educational components of the program address symptom identification and ongoing condition management. Team-based care that includes the enrollee, the primary care provider (PCP), and other health care providers can help reduce and control blood pressure. Population-based levers employed in the program include:

> Normalize blood pressure readings - maintain blood pressure at or less than 130/80
> Maintain regular PCP visits including appropriate lab tests if needed to ensure that minimal cardiovascular, renal, or endocrine complications exist
> Manage lipids to national guidelines: equal or less than 100mg/dl or less than 70 for recent cardiovascular events
> Normalize blood sugar levels, especially if also diabetic, as high blood sugar levels often cause high blood pressure levels (these go hand in hand)

Enrollees are also instructed that lifestyle changes can help control blood pressure, and are advised to take the following actions:

> Maintain a blood pressure reading log: measure blood pressure at the same time each day (paper-based or through the use of blood pressure monitoring applications once approved for use within Magellan Complete Care)
Encourage enrollee participation in smoking cessation programs
Support healthy eating – reducing sodium intake, minimize grains and sugars in the diet
Create a plan that includes daily activity (i.e., walking)
Minimize stress
Design a plan for medication adherence
Limit alcohol consumption
Maintain a healthy weight
Keep blood sugars within control, especially if diabetic to further decrease the chances of hypertension
Education to understand what hypertension is, its causes, and the risks of uncontrolled hypertension
How to monitor blood pressure
Education about all aspects of healthy diet, exercise, normalizing blood pressure readings, medications versus lifestyle changes, and the effect of high blood sugar on high blood pressure readings, and the effect of high blood pressure/long term complications

If an enrollee already has high blood pressure, the provider may prescribe medications and lifestyle changes. Lifestyle changes are just as important as medications. The enrollee must follow the PCP’s instructions and stay on medications. The enrollee should not stop taking medications before talking to his/her PCP or pharmacist. All drugs may have side effects; therefore enrollees need to talk to their PCP regularly. Wellness Specialists (disease managers) and other members of the care coordination team support enrollees as they learn to self-manage their hypertension.

The specific objectives of Hypertension DM interventions are to:
Maintain and improve the health of Magellan Complete Care enrollees with hypertension by increasing their health knowledge about their condition and their ability to engage in treatment and shared decision making with their providers.

Improve Magellan Complete Care enrollees’ engagement in their health and ability to self-manage hypertension, with support from structured coaching, tools and outreach based on evidence based guidelines, enrollee empowerment strategies, and tools to prevent and manage exacerbations of their condition.

Increase the number of enrollees who maintain their blood pressure readings within normal ranges, adhere to their medication regimen, and reduce their lifestyle risks through behavioral change

Improve coordination of care for enrollees with hypertension including medication reconciliation and evaluation of medication safety.
>Support Magellan Complete Care providers (both physical and behavioral) in their plan of care and efforts to educate the enrollee about hypertension, and in delivering care which is consistent with national guidelines and evidence-based practice.

>Monitor and implement interventions to improve performance on outcome measures such as the Healthcare Effectiveness Data and Information Set (HEDIS®), controlling high blood pressure and heart disease related measures, preventable events, and enrollee surveys to evaluate the clinical and patient perspectives, and the effect on overall cost and health care service utilization.

>Reduce morbidity and mortality related to hypertension for Magellan Complete Care enrollees.

Within each of these areas a whole-person approach is taken, which includes psychosocial assessment, lifestyle habits, behavioral health status, and presence of specific disease conditions and co-morbidities. These considerations are particularly important for conditions such as CHF/hypertension and diabetes which are heavily influenced by lifestyle, diet, exercise, stress, etc. These factors are taken into account when designing an enrollee-driven self-management plan of care.

Integrated care guidelines are used as a resource to identify potential problems, risks or interactions between the different conditions. For example, some drugs used to treat behavioral conditions can have an effect on blood sugar levels in regards to hypertension. Enrollees on drugs for both hypertension and behavioral health conditions will need more active monitoring of their levels.

Participants are helped to develop symptom response plans which demonstrate they know how to identify an exacerbation of their condition and have a plan to deal with it, including resources for ongoing blood pressure monitoring and documentation as well as knowing who and when to call for help if needed. In addition to the general program awareness interventions described for other DM programs, the Hypertension Disease Management Program may include:

> Maintain a hypertension management log to measure and track vital signs, nutrition, and medication use and conditions (paper-based or through the use of hypertension management applications once approved for use within Magellan Complete Care)

> Remote monitoring for enrollees facing challenges in managing their symptoms as these programs are developed

> Group education programs, including nutrition education, and clinic days Participation in hypertension support groups, including through social media

> Initial and ongoing hypertension condition assessments, education, assistance in goal setting, and support for skills development in self-management of hypertension

> Interventions that remind the enrollee (written materials, text reminders, phone calls) to participate:

  >> In condition self-monitoring activities (e.g. self-blood pressure monitoring and documentation, daily food and exercise logs)

  >> Health screenings
>>Immunization reminders (e.g. annual flu, pneumovax, etc.)
>>Self-direction and skill development in the area of independent administering of medication and medication adherence;
>>Self-management support and development of self-management plans and/or relapse prevention plans so individuals can attain personal health goals (e.g., what a person with hypertension is to do when blood pressure levels are very low and very high);
>>Support to encourage participation in weight management, smoking cessation or other programs to limit exacerbation of symptoms;

For many enrollees in this population, social isolation is a key concern, so goals and interventions may also include a focus on identifying friends and families who are able to support the enrollee in managing his/her hypertension. Additionally, many care coordination plans developed for enrollees in this population will address topics of recovery and resiliency, and highlight the importance of creating crisis and/or safety plans.

1.2.e Mental Health Disease Management
As noted throughout this section, the entire focus of the Magellan Complete Care specialty SMI plan is on managing severe mental illness. As such, we do not have a separate disease management program just focused on mental health. Monitoring and management of mental illness and co-occurring disorders (AUD/SUD) is woven into all of our treatment programs (including DM). Our approach to mental health is built around concepts of integrated biopsychosocial care management and the SAMHSA Four-Quadrant model for stratification, assignment and management of enrollees based on the scope and complexity of both physical health and behavioral health conditions.

Our model also recognizes the concepts of recovery, including the potential for the enrollee to be self-sustaining. All of our programs are focused on achieving stabilization of the enrollee, thereby limiting their need for, and use of higher acuity inpatient, hospital-based and institutional care. As noted previously, we have woven the use of screening tools (including CCBT) into primary care and other treatment modalities. Our screening tools and risk stratification (described later in this section) also focus on assessing member stability and biopsychosocial risk factors that may affect both mental health and physical health. Enrollees are stratified by their level of risk and complexity, and are assigned to the appropriate level within our care management programs.

Because all our members are already diagnosed with a serious mental illness, our focus is on managing the stability of that illness and opportunities for recovery. Enrollees at higher acuity levels may be assigned to one of our specialty care management programs, including:

>Schizophrenia
>Bipolar disorder
>First-Episode Psychosis (adolescents and young adults)
>Program for Use of Long-Acting Injectables (LAI)

Enrollees in those programs are closely monitored and managed as part of our ICCM model. In addition to programs for our more complex members, Magellan Complete Care provides training and education materials to all members to assist them with the management of their mental illness. Similar training and education is made available to all participating providers.
To further meet the needs of this complex and high utilizing membership, Magellan Complete Care of Florida has developed an enhanced Integrated Behavioral Health Program (IBHP) in collaboration with the key network providers. This collaborative effort has been developed as an enhancement to our existing care coordination program. The program differentiates itself with the co-location of Magellan Complete Care of Florida staff within the provider clinics to support to coordination process.

The Magellan Complete Care of Florida’s IBHP team preserves the responsibility as the enrollee’s health plan primary case manager. Magellan Complete Care of Florida provides health plan case management activities and will not delegate any of its primary health plan case management functions. Magellan Complete Care of Florida assigns an Integrated Care Case Manager (ICCM) and Health Guide (HG) who work together, on site, as the liaison between the enrollee and their care and service providers.

The IBHP supports the provision and coordination of physical health (PH), behavioral health (BH), and psychosocial care and services by increasing connections to outpatient treatment, facilitating communication between all treating providers and support systems, providing community based, high touch support through a multidisciplinary team and approach. The IBHP assists enrollees in navigating the health and support services system including resources to address the enrollee’s social determinants of health.

1.2.e.1 Major Depression Disorder Program
The Major Depressive Disorder Care Management Program is aimed at improving the health outcomes for people with Major Depressive Disorder. The program uses a holistic approach to achieve the best possible therapeutic outcomes based on assessment of enrollee needs, ongoing care monitoring, evaluation and tailored enrollee and practitioner interventions.

Major Depressive Disorder is one of the most prevalent mental health disorder in the United States. Information provided by the National Institute of Mental Health (NIMH) indicates that in 2015 over 16 million adults (an estimated 6.7 percent of all U.S. adults) had experienced one major depressive episode in the last 12 months. In addition, in 2015, about 3 million adolescents aged 12-17 (representing 12.5 percent of the U.S. adolescents) had one major depressive episode in the last year. According to the Centers for Disease Control and Prevention (CDC), depression is the leading cause of disability and the estimated annual cost of the disorder in the United States is in billions of dollars.

The goals of the Major Depressive Disorder Care Management Program include utilizing evidence-based and team approaches to:

> Maintain and improve the health of Magellan Complete Care enrollees with Major Depressive Disorder by increasing their health knowledge about their condition and their ability to engage in treatment and shared decision making with their providers.

> Improve Magellan Complete Care enrollees’ engagement in their health and ability to self-manage Major Depressive Disorder, with support from structured coaching, tools and outreach based on evidence based guidelines, enrollee empowerment strategies, and tools to prevent and manage exacerbations of their condition.
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>Improve coordination of care for enrollees with Major Depressive Disorder including medication reconciliation and evaluation of medication safety.

>Support Magellan Complete Care providers (both physical and behavioral) in their plan of care and efforts to educate the enrollee about Major Depressive Disorder, and in delivering care which is consistent with national guidelines and evidence-based practice.

>Monitor and implement interventions to improve performance on outcome measures such as, enrollee surveys to evaluate the clinical and patient perspectives, and the effect on overall cost and health care service utilization.
>Reduce morbidity and mortality related to Major Depressive Disorder for Magellan Complete Care enrollees.

All enrollees in the Major Depressive Disorder Care Management Program will receive:

>Initial and ongoing Major Depressive Disorder condition assessments, education, assistance in goal setting, and support for skills development in self-management of Major Depressive Disorder.

>Interventions that remind the enrollee to participate:
>>In condition self-monitoring activities (such as self-help activities to monitor one’s moods and thoughts)
>>Medication management appointment with a psychiatrist
>>Individual, group and family therapy appointments

>Self-direction and skill development in the area of independent administering of medication and medication adherence

>Self-management support and development of self-management plans and/or relapse prevention plans so individuals can attain personal health goals (e.g., what a person with Major Depressive Disorder is to do when experiencing a depressive episode or is in crisis);

>Closing identified gaps in care for any applicable HEDIS measure

>Encouragement to participate in the development and ongoing review of the care coordination plan. Interventions will be identified for each enrollee based on risk level, strengths, and opportunities, and a member of the care coordination team will be assigned to be responsible for following through on each intervention.

The intensity and frequency of interventions for enrollees enrolled in the Major Depressive Disorder Care Management Program will shift as an enrollee’s condition or circumstances changes. Enrollees will be regularly assessed for health literacy, skills in self-management, screening for depression, level of confidence, and motivation for making a behavior change throughout their participation in the Major Depressive Disorder Care Management Program. The findings from these ongoing assessments as well as information shared by the enrollee’s providers will inform the enrollee’s goals and interventions as documented in the care coordination plan.
The care coordination plan includes short and long term goals and interventions that are tailored to the enrollee’s conditions, risks and readiness for behavior change. For many enrollees in this population, social isolation is a key concern, so goals and interventions may include a focus on identifying friends and families who are able to support the enrollee in managing his/her Major Depressive Disorder. Additionally, many care coordination plans developed for enrollees in this population will address topics of recovery and resiliency, and highlight the importance of creating crisis and/or safety plans.

1.2.e.1.a Interventions for Symptom and Chronic Condition Self-Management
The care coordination plan and the educational components of the program address symptom identification and ongoing condition management. For example: the use of daily logs for monitoring moods, thoughts, sleep and appetite patterns will be reviewed for people with Major Depressive Disorder. Coaching to sensitize enrollees to the importance of taking medications and seeing the psychiatrist and the therapist on regular basis will be provided. Safety planning will be discussed.

1.2.e.1.b Intervention for Medication and Safety
Both the initial assessment and follow up interactions with the enrollee will include assessment of medication adherence. Since there are so many potential interactions and risks, we expect that many of the participants will have medication regimen evaluation by our clinical pharmacist. Outreach to the treating physicians to discuss potential changes occurs when enrollee safety issues are identified. We support adherence to drug regimens by encouraging treating providers to simplify them whenever possible. Peer Support Specialists are able to work with enrollees to encourage medication adherence.

Those who take different medications at different times of the day may have difficulty following medication regimes. Providing education related to medication adherence, including information on strategies for remembering medication regimes, can help enrollees enhance compliance and motivation.

The Care Coordination Plan is used to track the enrollee’s progress, focusing not only on symptom management and adherence to treatment for the enrollee’s Major Depressive Disorder condition, but also behavior change and progress to reducing lifestyle risk factors.

1.2.e.1.c Intervention for Emotional Support and Engagement:
We recognize the value of and need for addressing the emotional needs and support of our enrollees. All enrollees in the Major Depressive Disorder program will be screened for depression. The Care Coordination Team will engage with the enrollee in-person, via telephone, and with online tools, as indicated by the enrollee’s preferences and needs. All staff members working with enrollees will be trained in motivational techniques. With their experience living with SMI, Peer Support Specialists often bring team enrollees important and timely insights about the enrollee’s motivation. They also model recovery, resiliency and healthy lifestyles for enrollees. By coordinating and engaging all participants in the enrollees’ care, we can help provide consistent messages and emotional support. Additionally, community support groups and classes will be a source of learning and support for enrollees with Major Depressive Disorder.

1.2.e.1.d Condition-Specific Interventions:
ICCMs and other members of the Care Coordination Team support enrollees as they learn to self-manage their Major Depressive Disorder. The following section includes examples of evidence
based care enrollees are engaged to incorporate into their daily lives for managing Major Depressive Disorder.

Major Depressive Disorder is a chronic condition that requires ongoing management of chronic symptoms such as depressed mood, loss of energy, decreased interest in daily activities, suicidal ideation and behavior, sleep and appetite problems. This program helps enrollees understand how to manage their symptoms of Major Depressive Disorder and prevent frequent depressive episodes. Education is provided regarding how Major Depressive Disorder impacts physical and mental health; how to take care of self by following proper diet, nutrition, and exercise regime; how to take medicines and follow up with doctors’ and therapists’ appointments; how to develop and maintain a safety plan. Many drugs used to treat SMI conditions may interact with current medicine regime. It may be necessary for the physical health and behavioral health providers to discuss treatment regimens if this becomes an issue.

The goal of this program is to increase the number of enrollees who: (a) have knowledge of their condition and treatment, (b) are connected to a psychiatrist, a therapist and a targeted case manager, (c) demonstrate decreased depressive and crisis episodes, (d) learn safety planning, (e) adhere to their medication regimen, and (f) reduce their lifestyle risks through behavioral change. The program also seeks to decrease the emergency room, inpatient visits and average length of stay for Major Depressive Disorder related crisis such as suicidal behavior.

1.2.f Substance Abuse Disease Management
SMI enrollees have a high prevalence of co-occurring substance abuse disorders (SA), which includes substance use disorder (SUD) and alcohol use disorder (AUD), relative to non-SMI populations. In fact, a recent analysis of Magellan Complete Care membership shows that 16 percent of our members have co-occurring SA. That rate rises to 25 percent in pregnant enrollees. Individuals with SMI may use alcohol and/or non-prescription drugs to ease the symptoms of their disease. Issues with non-compliance in the SMI population may further increase use of illicit drugs and alcohol during lapses in the enrollee’s medication therapy due to that non-compliance.

Treating SMI enrollees with co-occurring SA is also complicated, since treatment options may be negated or complicated by the treatment of the enrollee’s SMI. Early identification of high-risk enrollees through mental health and the use of substance abuse screening tools by providers and our staff, is critical to get enrollees the care they need at the right time, in the right place and in the right amount. Screening tools are made readily available through online and printed resources, as well as through the SmartScreener capabilities built into our Cobalt CCBT platform. Those tools can either be self-administered by the enrollee or by the provider. Magellan Complete Care also encourages the use of SBIRT (evidence-based practice for screening, brief intervention, and referral to treatment) by primary care and other providers to improve timely and appropriate identification and referral for treatment.

Regular and early screening and identification leads to prevention and/or early intervention and promotes community tenure, which results in improved quality of life, satisfaction for our enrollees, and cost effectiveness. When our HRA screening, predictive modeling, or provider identify an enrollee, who could benefit from additional treatment, we then work with treating providers to obtain a referral to a provider and obtain a recommendation to coordinate this level of care for the enrollee.
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Magellan Complete Care staff use national evidence-based guidelines as a basis for assessment, evaluation, quality management and improvement, identification of care gaps, enrollee and provider education, key interventions and outcomes measures for behavioral conditions of our enrollees. Behavioral health specific tools and resources available to them include Magellan’s proprietary behavioral health medical necessity guidelines and the American Society of Addiction Medicine (ASAM) Criteria.

Most importantly, the Magellan Complete Care Integrated Care Coordination Model, is built around the concept of using all enrollee touchpoints to screen for and identify SA and facilitate enrollee assignment to appropriate treatment programs when needed. We regularly analyze claims and encounter data through our predictive modeling tools, to identify enrollees whose utilization suggests SA. This includes monitoring for higher than normal ED usage, or patterns of visits to multiple EDs, which may signal drug-seeking behavior or alcohol abuse. Enrollees who are identified for the program have either been diagnosed or treated for a substance abuse disorder or are at risk for developing a substance abuse disorder. If available, the following information is used to identify enrollees who may benefit from the SA programs:

> Authorizations
> Screening tool results
> Utilization management records
> Referrals from other health plans
> Internal referrals from Magellan Complete Care care coordinators/care managers, or co-located care/case managers
> Referrals from other health programs, providers, enrollees, families, and utilization management departments
> Health risk appraisals/assessments

We understand that integrated treatment of SA is extremely important in individuals with SMI as CODs are often a contributor to non-adherence in care and self-management for life-threatening health conditions. The enrollee with substance abuse needs to be stabilized before additional treatment can occur successfully.

From our parent company Magellan, we have significant history of prioritizing service integration for individuals with co-occurring disorders (CODs). Treatment planning begins with screening by behavioral and physical health providers. Our recovery expertise and sound evidence based practice approaches have been utilized in the development of our behavioral health program approaches, including best practice protocols in the area of addiction and recovery services.

As with our other programs, we emphasize a whole person approach across the spectrum of care and service needs recognizing that destabilization in other areas such as physical health, mental illness, or social supports may encourage alcohol or substance abuse and reduce likelihood of recovery. Our provider network partnerships are built with this goal in mind, consisting of traditional healthcare providers, behavioral health specialists, and other community agencies and resources with a shared commitment to person-centeredness, evidence-based treatment, robust communication, and teamwork, all built around concepts of a recovery-oriented system of care (ROSC).

Magellan Complete Care provides recovery support provided through referrals for additional treatment, services, and community-based programs by behavioral health care providers, peer...
providers, family enrollees, friends and social networks, the faith community, and people with experience in recovery. Recovery support services help people enter into and navigate systems of care, remove barriers to recovery, stay engaged in the recovery process, and live full lives in communities of their choice.

Magellan Complete Care recognizes those risks and complications and has developed a targeted program to specifically address these issues. Our program delivers specialized programming for enrollees with behavioral health and SA with or without co-morbid medical conditions. When identified, we incorporate this into the plan of care. Enrollees that have multiple chronic conditions are designated as high-risk enrollees and receive complex and enhanced care coordination services.

In the case of co-occurring SA, our program includes a special focus on specific populations, including:

> Enrollees with complex or high risk BH/SUD/AUD (assigned to ICCM)
> Enrollees with complex or high BH/SUD/AUD and co-morbid sickle cell disease (assigned to sickle cell specialty program)
> Enrollees with complex BH/SUD/AUD and co-morbid diabetes (assigned to case-management assisted DM)
> Enrollees with complex or high risk BH/SA who are pregnant (assigned to pregnancy management program)
> Enrollees who are EPSDT eligible and with complex or high risk SED or SMI, along with SUD/AUD (assigned to pediatric ICCM)

Our deep experience with these programs in the Florida market has also provided us with an understanding of the availability of providers and effective programs to support the needs of SMI members with SA. Magellan Complete Care covers intensive outpatient programs as well as partial hospitalization and expanded intensive outpatient therapy (IOP). At times, we will also go out of network, e.g., when Care Managers have coordinated residential placement with other entities to get a higher level of care for an enrollee.

Through the use of analytics and predictive machine modeling, we proactively identify enrollees who may have SA. Based on the clinical information obtained, enrollees are stratified into three levels of risk. Reach and engage strategies are tailored to the specific level of risk assigned to the enrollee at the time of referral; and consist of telephonic and/or mail outreach activities. Enrollees identified as high risk or ultra-high risk are referred to the Magellan Complex Case Management Program. Enrollees identified as moderate risk receive telephonic outreach and education and enrollees identified as low risk receive self-management support and are encouraged to access and follow the substance abuse modules within our Cobalt CCBT programs:

> Disorder specific educational materials are made available to enrollees via email, Magellan Complete Care’s website and/or through mail. All written materials are in an easily understandable format and are written at or below the 4th grade reading level

> Enrollees also have access to, and are encouraged to complete the substance abuse modules in our Cobalt CCBT programs
>Care Managers, Peer Support Specialists, Health Guides and Care Workers who conduct outreach, follow established scripts and related protocols during the outreach process.

>Once contact is made with the enrollee, the program is explained. The care coordination team member assigned collects information about any previous behavioral health, SA, or care coordination/case management, disease management services the enrollee has received, and identifies any gaps between recommended treatment and actual care/services provided to the enrollee.

>For enrollees diagnosed with substance abuse, a health risk assessment (HRA) and focused substance abuse assessment is administered. Questions within the HRA screen enrollees for alcohol and non-prescription drug abuse. Enrollees who report no substance abuse or drinking less than 3 drinks on any occasion are stratified as low risk. Other enrollees are able to enroll in the SA specific coaching/care coordination program.

If the enrollee accepts SA coaching/care coordination, the enrollee is considered “enrolled.” The enrollee is then transferred to a clinical team member who will further assess the enrollee, utilizing a substance abuse specific assessment tool, develop, implement and maintain an individualized care plan. The assessment and care plan address the enrollee’s multiple health, behavioral, social, and substance abuse needs to ensure continuity, quality and effectiveness; and facilitates the appropriate collaboration of the enrollee’s family and/or caregivers, health care providers and community case managers in the development and implementation of the enrollee’s care plan.

As applicable, the assessment and care plan will also identify methods to link treating providers with allied health and social service agencies to facilitate access to substance abuse and other services necessary for the implementation of the enrollee’s care plan. This includes, but is not limited to medically necessary services such as pharmacy, mental health, equipment and supplies, rehabilitative therapies, transportation and interpreter services.

If the enrollee declines coaching/care coordination, educational materials are sent (with the enrollee’s permission). No additional outreach occurs for enrollees who decline coaching/care coordination. However, the enrollee may subsequently request to be reassessed for coaching/care coordination enrollment or be re-referred. If the enrollee denies substance abuse, the enrollee is provided information about how to access educational information on the website, availability and access to Cobalt, and how to access a provider.

Enrollees are also given access to web-based materials which are available on Magellan Complete Care’s web site. The web-based materials include but are not limited to:

>Self-assessment of SA, health and wellness, with recommendations/ education/interactive sessions based on assessment outcomes

>Behavior change action planning with feedback during the process of planning and practicing new skills

>Wellness tools

>Online seminars on SA and various health topics
Fact sheets that provide quick information on SA and various health topics

Comprehensive library containing articles on Substance Abuse, medical disorders, behavioral disorders, activities of daily living and life planning (e.g. financial, legal planning)

- Spanish language materials,
- Drug interaction data base,
- Provider search

Enrollee management within the program includes:

- Initial assessment utilizing the HRA and the substance abuse specific assessment tool(s), and Cobalt SmartScreener serves to establish rapport between the enrollee and SA Care Manager/assigned SA team member as well as to gather and review the following information:
  - Information gathered during the HRA and SA specific assessment tool
  - Enrollee’s self-selected health goals
  - Enrollee’s reported symptoms, treatment history, stressors, challenges that present as obstacles towards achieving self-selected goals
  - Enrollee’s reported strengths

- Coaching calls occur at a frequency necessitated by the enrollee’s SA disorder. During SA coaching sessions, progress towards the enrollee’s desired life goals is reviewed and modifications are made to the plan of care if necessary. Depending on the severity level, the care manager consults with the Behavioral Health Medical Director or clinical manager to determine root causes and interventions that may reduce the severity levels. The care manager and/or assigned team member continues to consult with the medical director and supervisor at agreed upon time frames until reductions in severity levels are achieved.

- Reassessments using the HRA and ongoing SA specific assessments will be re-administered periodically throughout the enrollee’s enrollment in the SA CM program and at discharge to track progress and monitor outcomes. The frequency of assessments and follow-up will be based on the risk/severity of the enrollee.

- Discharge and Case Closure: The enrollee is discharged from the SA CM program when the care manager and enrollee agree that the enrollee is on the right path to meet his/her established SA health and service goal(s). Enrollees complete a discharge survey prior to discharge to confirm criteria are met. The enrollee may also be discharged if contact with the enrollee is lost. Prior to discharging due to lack of contact, the care manager will make 3 telephonic outreach attempts and will send the “Trying to Reach You” letter. If contact is not made, the enrollee will be administratively discharged from the program. Enrollees may self-select to re-enroll in the SA CM program at any time after discharge, at which time new screening/stratification occurs.

- Interventions: Individualized interventions are based on assessment findings during coaching sessions and enrollee preferences. The SA CM program and staff offer a multitude of interventions including education and coaching; provider-specific interventions (behavioral health and primary care with enrollee permission); collaborative interventions; and, interventions to reduce readmissions.
>Enrollee Retention in SA CM: The coaching retention process is immediately implemented when enrollees are unavailable for their scheduled coaching session. The retention process includes several phone calls followed by a letter to the enrollee if retention efforts fail. These include:
>>The enrollee is discharged from the SA CM program and notified by letter if there is no evidence from reliable reports of risk for harm or acute clinical deterioration
>>If additional attempts are unsuccessful, discharge occurs with notification to the enrollee, designated behavioral health practitioner, and/or health plan

We also identify community, social, and recovery services that are available at the county level and has developed a resource guide which is available to key stakeholders. Social Workers on staff are available to assist in the identification of local community resources to aid the enrollee. Care Coordination staff share information regarding local community agencies, or faith based organizations that may be of assistance with the enrollee and/or provider(s), when indicated.

~Enrollee Story: Health Guide Assistance for Positive Results~
Marty (Name changed to protect privacy), a 57-year-old enrollee of Magellan Complete Care, had a history of depression, alcoholism, isolation, and lacked motivation in daily activities. He had at least 10 hospital admissions in 2016 due to suicidal ideation. Marty did not have housing and had difficulty following up with his physical and behavioral health providers. He felt he was at risk for self-harm and death, if permanent housing was not made available to him.

Our Health Guide was assigned to Marty to follow up with the discharge planner at the hospital and to help assist with housing. The Health Guide continued to assist Marty with his scheduled appointments with providers, provided resources for local AA meetings, provided information about when he should go to the ER, and also linked him to community-based resources for socialization.

Positive results include:
>Involved in his healthcare needs and attends provider appointments
>Attended AA meetings on a weekly basis
>No ER visits or hospital admissions in the four months after Health Guide intervention
>Expressed that he is happy and actively involved in the community and enjoys daily activities
>Obtained housing and said it was important for his recovery and for his overall health needs

“Magellan Complete Care has changed my life, I am so thankful for all the help I received, how fast and efficient. I was able to go to my providers, now I can live a normal life, I just can't thank you enough; you saved my life.” – Marty

CRITERIA 2: THE ADEQUACY OF THE RESPONDENT’S DESCRIPTION OF HOW ITS RESPECTIVE DISEASE MANAGEMENT PROGRAMS...
AHCA has stated that its overall program objective is to ensure enrollees receive all medically necessary services in a timely manner and in the most appropriate setting, thereby achieving the best possible quality outcomes while containing costs. Additional goals include the availability of comprehensive, quality-driven provider networks; streamlined processes that enhance enrollee and provider experience; expanded benefits to improve outcomes, quality scores and enrollee satisfaction; and, delivering an efficient, high-quality, innovative, cost-effective and integrated health care delivery. For DM programs in particular, AHCA highlights the goals of reducing
preventable events and unnecessary use of ancillary services; improving birth outcomes; and, rebalancing LTSS.

Magellan Complete Care believes that all parts of our fully-integrated biopsychosocial system of care, and our DM programs in particular, support those goals. Our DM programs are built around a system of coordinated health care interventions and communication to support enrollee self-management and availability of self-management tools and care delivery options in multiple settings; and, streamlined processes to encourage and facilitate enrollee ease of participation. Our programs also integrate innovative new technologies to support chronic illness screening and monitoring; wellness, prevention and self-care reminders; and enrollee education and engagement. Magellan Complete Care programs are also built around a fully-integrated BH-PH system of care that supports the physician or practitioner/patient relationship and care plan; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines, and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

Magellan Complete Care wellness, prevention, and DM programs are based on current best practice and approved national guidelines and are fully integrated within the different levels of the ICCM. Innovative outreach approaches and technology are used to maximize enrollee engagement utilizing the enrollees' preferred method of communication. Existing community supports and programs are also tapped as an additional ongoing element for these enrollee outreach approaches. We also support a flexible approach to enrollee engagement and care coordination that includes existing support from successful community programs.

Magellan Complete Care’s DM Program is built around the following core components that are consistent with AHCA’s eight goals:

Goal 1: Receiving Medically Necessary Services in a Timely Manner and in the Most Appropriate Setting. Thereby Achieving the Best Possible Quality Outcomes While Containing Costs

Magellan Complete Care’s DM programs are specifically designed with clear linkages to quality and outcomes monitoring and improvement. Each program is linked to HEDIS and other care and outcome measures, including EPSDT, birth outcomes and preventable events. Enrollee education, engagement, self-care support and clinical management are all focused on identifying enrollee gaps-in-care, understanding barriers to gap closure, assisting the enrollee in removing those barriers, and improving enrollee health and outcomes.

Our programs reinforce evidence-based practice guidelines for care needs and appropriate site of care. They also include ongoing monitoring of enrollee rising risk, such as inappropriate utilization, new diagnoses, or changes in medication therapies which can indicate the need for enrollee education or other interventions to support appropriate use of services and avoid preventable events.

Engagement and support tools and services include multiple mechanisms to support enrollees in managing their health. Those enrollees who are stable enough, capable, and interested in managing their own health have access to a broad range of education, and self-care monitoring and managing tools available in paper form, as well as online and mobile platforms. Health education materials, which are based on current clinical evidence, are designed to be age-appropriate, understandable at the enrollee reading level, and culturally appropriate. These materials, which are also available in both English and Spanish, include Milliman Chronic
Condition enrollee materials. Online and interactive tools are also available on the enrollee website, and through our Cobalt and Clickotine platforms.

More complex enrollees, or those not able to manage their care are supported by our Wellness Specialists or ICCM staff in our specialty disease care management programs providing individual monitoring, coaching and support. Enrollees also have access to a broad range of supports and support specialists through our IHN.

Our goal is also to work with our providers to assist them in being active partners in managing the health of enrollees. Our field-based representative model includes dedicated Provider Relations Managers and Provider Support Specialists (PSS) in each region to ensure real-time, personalized support. Our Provider Relations Manager serves as the primary contact to providers and manages the overall support needs of their assigned region. This role also includes the management of provider issues and concerns and ensures these issues are addressed in a timely manner.

Magellan Complete Care’s goal continues to be the transformation of the system of care and, with our continued support, we are shifting care coordination and quality improvement resources to the point of care through the integrated care provider-based models. Our PSS are proof of our commitment to our network providers and to provider-led system change in Florida. An enrollee of the regional Integrated Health Neighborhood team and the Magellan Complete Care PSS facilitate and support our partnerships with our providers to develop and improve integrated care models. The PSS team consists of licensed behavioral health clinicians or RN’s with significant behavioral health experience. These highly trained and qualified clinicians, who are expert at working with enrollees who are living with SMI, enable us to be more effective with providers and their office staff.

Our PSS teams identify opportunities for practice transformation activities that will have a lasting impact on the system of care throughout Florida and the way our enrollees interface with the healthcare system. The PSS teams are tasked with focusing on the clinical needs of the provider network. We believe that actively engaging the network through education, training and knowledge provides a level of commitment and partnership that will yield improved health and wellness and an improved enrollee experience. Magellan Complete Care views this integrated care model as an investment and adds considerable value to the provider network by creating access to local subject matter experts who help improve our collective capability and capacity to serve special populations in a meaningful way.

Each PSS team consists of locally-based behavioral health experts with years of experience working directly with enrollees to provide clinical care, history working within behavioral health access points and have a thorough understanding of quality protocols, best practices and person centered care to ensure our enrollees needs are addressed at the right time, the right level and grounded in principles of recovery. Our unique and comprehensive approach is built upon:

> An ongoing and evolving understanding of our enrolled populations and sub-populations
> Hiring provider support specialists who live and work in our communities
> A focus on provider partnerships to drive innovation and improve enrollee outcomes
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> Practice transformation and improvement activities

> Brokering provider relationships across specialties to support integration of care

> Knowledge sharing to increase awareness, support parity and reduce stigma

> A comprehensive array of covered services and supports

> Effective provider and community stakeholder collaboration

> Appropriate provider credentialing and contracting

> A robust and accessible provider network

> High quality network management and monitoring practices

> Ongoing provider support and technical assistance

> Connecting providers with their quality performance related to the patients they serve, and helping to foster the enrollee and provider relationship

> Provide monthly on-site education, support and training on HEDIS and enrollee engagement

Goal 2: Availability of Comprehensive, Quality-Driven Provider Networks
Magellan Complete Care’s programs are built around concepts of enrollee engagement, enhanced access to care in the best and most appropriate setting, and provider support in the management of care. Each level of our programs includes a goal of engaging enrollees with the types of providers that are appropriate for their level of risk and complexity. The availability of a comprehensive, quality-driven provider network is essential to accomplish that goal, and Magellan Complete Care continues to drive toward network expansion, with special focus on developing expanded, and enhanced capabilities for our provider partners. As part of this ITN response, Magellan Complete Care is also proposing significant enhancements to our reimbursement models to include creation of shared savings pools and expanded performance improvement incentive programs as well as value-based purchasing programs. These programs are designed to encourage provider participation and alignment of outcomes and quality incentives.

Connection with PCPs and PBHPs is particularly important for enrollees at lower risk and complexity levels, where engagement with providers is the first line of defense for managing enrollee health and outcomes. At higher risk and complexity levels, our focus is on engaging enrollees with integrated health homes (IHH), which Magellan Complete Care is working to establish across the regions we serve. The IHH provides for enrollee biopsychosocial management at a single site of care, increasing convenience for enrollees and driving improved outcomes. It also includes value-based reimbursement to ensure alignment of provider, enrollee and Magellan Complete Care goals for performance and outcomes improvement.

Beyond the more traditional sites for delivery of care, our programs also include the use of various telehealth and tele-monitoring solutions for enrollees. This element of our model provides for enhanced access to care and delivery of those services in a manner and at a location that is most convenient for our enrollees. These programs also significantly expand access to services in rural
and outlying areas, as well as for provider services that are in high demand relative to available capacity. Though these programs are still in early stages of development, Magellan Complete Care believes the use of telehealth, including remote monitoring of enrollees with certain chronic conditions, will be a significant, positive development for our enrollees and their health outcomes.

Goal 3: Streamlined processes that enhance enrollee and provider experience
Magellan Complete Care’s programs are designed to support active and regular engagement of both enrollees and providers. As mentioned previously, we employ multiple platforms and tools to facilitate enrollee engagement, with a goal of ease of use, around evidence-based models for DM.

Our mission is to help our enrollees find their way through the health care system and DM is an integrated part of that approach. The DM team keeps track of how the enrollee is doing, helps enrollees make and keep appointments, coordinates with community agencies and resources, and understands what the enrollee is going through. The DM team acts as a conduit between enrollees, their providers, counselors, family, and caregivers to set goals for feeling better and enjoying a healthier life.

Providers also receive training and materials explaining the programs available to enrollees. Through the Provider Portal they also have the ability to review enrollee care plans, gaps in care, and results for engagement and outreach. Providers also regularly receive gap-in-care reports for the enrollees under their care.

Our entire program design is structured to eliminate friction in the engagement of both the enrollee and providers. As part of program design, we also receive regular feedback from enrollees through annual satisfaction surveys. Providers are also regularly surveyed for their feedback. Feedback from both of these sources serves as important elements for program and process improvement. The following quote from Banyan Health System speaks to our commitment to partnership and the strength of our collaboration and coordination.

~~Quote from Alan Kuppers, LMHC Director of Managed Care & Utilization Management~~
“Banyan Health System highly endorses Magellan Complete Care’s initiative. Having collaborated with Magellan Complete Care for many years we feel Magellan Complete Care is a managed care company best capable of delivering for their members. Magellan Complete Care not only “walk the walk, but they talk the talk.” Without Magellan Complete Care’s unique style of managing members and their strong commitment and collaboration with Banyan Health System the severely mentally ill would no doubt find themselves struggling to navigate the often-cumbersome world of healthcare.”

Goal 4: Expanded Benefits to Improve Outcomes, Quality Scores and Enrollee Satisfaction
As part of this ITN response, Magellan Complete Care has adopted all of the expanded benefits identified by AHCA. We have also adopted additional expanded benefits that include:

-Nutritional Counseling
-Post Discharge Meals
-Waived Copayments
-Intensive Outpatient Treatment – Mental Health
-Intensive Outpatient Treatment – Substance Use Disorders
In addition to the covered benefits, expanded benefits and the expanded benefits listed above, Magellan Complete Care offers several of the in lieu of services outlined in the current contract. These services include:

- Crisis Stabilization Units
- Detoxification or Addictions Receiving Facilities licensed under s 397, F.S.
- Mobile Crisis Assessment and Intervention
- Ambulatory Detoxification Services
- Self-Help/Peer Services
- Partial Hospitalization Services

By offering in lieu of services, members are afforded the opportunity to receive some services in a different location, different intensity and different modalities to fit their level of functioning and in helping the enrollee get the right services in the right location at the right time.

Magellan Complete Care has learned over the past four years that not all enrollee needs can be addressed through Medicaid covered services and expanded benefits. The SMI specialty enrollees have unique needs that Magellan Complete Care feels are important to address for the holistic wellbeing of the enrollee. Magellan Complete Care managers work with enrollees to address the social determinants of health. Magellan Complete Care assists members in locating appropriate housing options including shelters, temporary housing and permanent housing, works with the criminal justice system to reduce recidivism and increase diversions to care, supports members through the internal peer support process and assists members in locating local community resources to assist with day to day living needs.

We believe these additional benefits are important for managing the health of our SMI enrollees and supporting the delivery of care in the right place, at the right time, and to improve quality, outcomes and enrollee and provider satisfaction.

In addition to these more traditional services, as noted earlier in this response, Magellan Complete Care provides enrollees with new treatment and care management options, including:

- Telemedicine
- Remote monitoring
- Online and mobile monitoring and health management tools
- CCBT

Services provided through the IHN are also a significant enhancement for our SMI enrollees, providing needed navigation and recovery support through solutions such as our Homeless Housing Program, Jail In-ReachTM, and Employment Support. All of these benefits serve to support our complex and vulnerable SMI enrollees with a fully-integrated system of care that supports wellness, prevention, care management, recovery and resiliency.

Goal 5: Delivering Efficient, High-Quality, Innovative, Cost-Effective and Integrated Health Care Delivery
Magellan Complete Care’s goal is the transformation of the system of care, and with our continued support, shifts care coordination and quality improvement resources to the point of care through the development of fully-integrated models. Our DM Programs are fully integrated with our ICCM program and our delivery system partners, ensuring education and support for enrollees along
with coordination of clinical resources across the continuum of wellness, health, and medical decision support and care. Our goal is to ensure that all enrollees receive personalized, high-quality health care tailored to their physical, behavioral, and social needs. Our programs address co-morbid physical and behavioral health conditions and consider the whole health of the enrollee. These include, but are not limited to, the following components:

> Education based on the enrollee assessment of health risks and chronic conditions
> Symptom management including addressing needs such as working with the enrollee on health goals
> Emotional issues of the caregiver
> Behavioral management issues of the enrollee
> Communicating effectively with providers
> Medication management, including the review of medications that an enrollee is currently taking to ensure that the enrollee does not suffer adverse effects or interactions from contra-indicated medications

Our experience and research has shown us that enrollees with serious mental illness (SMI) also experience significant activation issues that can affect engagement, including:

> Difficulty navigating the system
> Difficulty communicating with the provider or dealing with poor interpersonal skills of the provider
> Perceived disrespect and lack of caring
> Provider assumption that lack of engagement is due to MH issues rather than practical, everyday barriers
> Not being taken seriously: At times patients may feel providers think they were “faking” PH illness
> Long waiting times, noisy, crowded waiting areas, or hurried atmosphere that can be difficult environments for people experiencing MH symptoms
> Diagnosis overshadowing: Even when seeking PH care there is a focus on MH issues

In addition, there is a high prevalence of substance use, obesity and smoking. Unfortunately, many individuals with SMI also have difficulty accessing routine primary care, following their treatment plans and navigating the complex health care system. A large part of the focus of our programs is aimed at identifying barriers to care, and ensuring that enrollees are comfortable with, and directed toward these lower acuity services, and avoiding preventable inpatient and outpatient events and unnecessary ancillary services. A fully integrated system of care, care management, and support is important for achieving those goals.

Our experience with managing both SMI and physical health conditions has taught us that individuals with SMI need an approach that is customized to take into account their behavioral health condition as well their individual needs. Recognizing this, Magellan Complete Care has developed innovative approaches to managing common disease conditions in our enrollee population that are built around our model of fully integrated biopsychosocial care management and delivery and our Integrated Health Neighborhood model. This reflects our understanding of
the need for a complete system of care that is so critical for SMI enrollees, to support their health and health management.

Goal 6: Reducing Preventable Events and Unnecessary Use of Ancillary Services
Magellan Complete Care’s integrated system of care management, which includes DM, incorporates monitoring and management of gaps-in-care and preventable events, as well as performance on EPSDT/CHCUP and birth outcomes. Our programs have been specifically designed and built around management of those outcomes. This includes specific focus on enrollee engagement with their PCP and PBHP, or assignment to an IHH, or specialty chronic illness management team if more appropriate. We consider enrollee engagement with their provider, a “first line of defense” in health prevention, management of the enrollee’s health, limiting preventable events, and minimizing inappropriate utilization of services. Integration of that care with well-defined clinical protocols and standards for care for use by providers, is also critical for limiting unnecessary use of ancillary services. Magellan Complete Care has built a system that supports those goals.

As noted previously, as part of this ITN response, Magellan Complete Care is also proposing significant new Provider Incentive Programs and Value-Based Purchasing Models built around targeted outcome improvements (including preventable events), and the generation of savings in total cost of care and services in higher-acuity settings. We believe these new programs will be well received by our provider community and will provide important incentives to achieve improvement goals.

Magellan Complete Care also provides support materials for providers, sharing evidence-based care guidelines that integrate the behavioral and physical health needs of the enrollee, such as guidelines for people with schizophrenia and cancer or diabetes. Providers have access to enrollee gap-in-care information through the provider portal, as well as regular reporting.

> Coordinating care with providers to reinforce treatment plans

> Complete referrals to other departments, support groups and community resources based upon acuity, medical status, or enrollee needs

> Community-based teams, including Health Guides (navigators) and Peer Support Specialists (individuals who have had the same life experience with SMI who have been certified to deliver support to others) who identify and connect enrollees to resources that support the enrollees’ DM goals

> Recovery and resiliency principles and promoting self-management through personalized enrollee interventions

Access to these tools and supports is important to assist providers in understanding and managing the unique care needs of the SMI enrollee and improved outcome results.

Goal 7: Rebalancing LTSS
Magellan Complete Care’s entire system of care is built around the concepts of recovery, resiliency, and independence, with a goal of increasing enrollee community tenure and limiting the use of LTSS. Though all of our enrollees have at least one serious illness, SMI, our programs are oriented toward improving health and assisting the enrollee in self-care management. Our
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IHN model cocoons the enrollee in a system of community-based services and supports that goal by increasing access to housing, employment, healthy food, management of care while engaged with the correctional system. For our enrollees who are often extremely complex and fragile, these services are often critical to ensuring stable health and delivery of care outside an institutional setting. The following enrollee stories provide examples of the importance of these programs, along with our entire system of care and care management, in achieving those goals:

~Enrollee Success Story – Kenneth (Name changed to protect privacy)~
"Thank you so much. You just don't know what you have done for me. Thank you."
– Kenneth

Kenneth had several inpatient admissions over a short period due to complications from a respiratory condition. He was not engaged with the health plan, not attending appointments, was mismanaging his durable medical equipment, and his team could not reach him.

His Care Coordinator intervened with a home visit. He shared during visit that he wanted to give up and was embarrassed by his current situation.

The Care Coordinator helped Kenneth coordinate appointments with primary care and behavioral health providers, and connecting with local community resources for housing, food, and clothing. They also helped Kenneth with obtaining a state ID card, birth certificate, and social security card.

Kenneth is now attending his appointments, is participating in his TCM program, Recovery and Peer Support programs, and getting regular support from his local church and food pantry. His outlook has improved and his is eager to see what his future holds for him.

~~Enrollee Success Story: Mark (Name changed to protect privacy)~~
"Thank you, I don' know what I would' ve done without you and Magellan Complete Care for helping me stay back on track with my health" – Mark

Mark’s health was declining despite frequent hospital admissions. Mark is experiencing homelessness and is living with Schizophrenia, Depression, Polysubstance abuse, Hepatitis C, and Seizures. The enrollee uses the emergency room and hospital stays to meet his regular ongoing healthcare needs.

The team discovered hat Mark did not have any family or social supports needed to get on the path to recovery. It was recognized that Mark needed additional advocacy and potentially an assigned guardian.

Magellan Complete Care helped Mark obtain housing. They linked him with outpatient providers to transition his life from a long history of chronic homelessness, hospital dependency, and trouble sticking with his treatment plans, to a healthier and happier life. Mark now follow a prescribed medication plan, sees a therapist, attends N.A. meetings, and follows up with his outpatient providers on a regular basis. He also shares his living space with his emotional support dog, who he refers to as his companion.

As a result of the intervention and collective efforts between the health plan, community resources and providers a coordinated care plan was developed. The previously reliance on the hospital was shifted into an actionable, sustainable and holistic plan of care.
Mark now has a court-assigned guardian, has stable housing in an assisted living facility, is seeing his doctors regularly and is treatment adherent. So while he was formerly categorized as being at ultra-high risk, he is now categorized as being low-risk.

Goal 8: Improving Birth Outcomes

Though pregnancy is not considered a disease state, the unique requirements for our pregnant enrollees demand the kind of unique and dedicated focus Magellan Complete Care maintains to identify and manage our SMI members who are pregnant. Regardless of the chronic illnesses (BH or PH) enrollees who are pregnant are managed within our Pregnancy Management Program to ensure that their pregnancy is managed in an integrated fashion, alongside those other conditions. In addition to our current strong commitment to pregnancy management through our targeted Pregnancy Care Management, Magellan Complete Care is proposing additional enhancements as part of our response. These include incorporating the use of Centering Pregnancy programs; integration of Florida’s robust Doula network; expansion of our contraception programs; including our very effective LARC incentives and programs; and expansion of provider incentives for healthy birth outcomes. These programs, as well as the full details of our Pregnancy Care Management program are discussed in more detail in MMA SRC 2 of this ITN response.

Magellan Complete Care has an OB/GYN Psychiatrist on staff to oversee management of these members. We also maintain a dedicated OB/GYN Case Management Team, which includes an RN and four case managers. Our clinical pharmacist participates in weekly OB clinical rounds as needed. OB team members consult with the clinical pharmacist who will review the enrollee’s medication profile, contraindications and drug interactions and make recommendations as appropriate. A risk-benefit assessment must be performed initially and throughout pregnancy and post-partum period to the enrollee of initiating, continuing, or discontinuing medications. Ideally, women with SMI should obtain a consultation to discuss the safest treatment including:

>Available information on the risks of medication exposure during pregnancy and breastfeeding
>Treatment alternatives during pregnancy (e.g., psychotherapy, couples counseling, attention to psychosocial stressors)
>The patient’s likelihood of a psychiatric relapse or complications from other chronic illnesses during pregnancy and the postpartum period
>Ongoing monitoring to evaluate whether medications may have to be adjusted and discontinued

The Magellan Complete Care (Magellan Complete Care) Mother Baby Connections Program is a perinatal program that is a specialized and integral segment of the AHCA approved and NCQA compliant Magellan Complete Care Care Coordination and Complex Case Management Program and addresses the special needs of pregnant women with serious mental illness, including a higher incidence of substance misuse/abuse, lifestyle risks such as obesity and tobacco use and co-morbid psychiatric illness and chronic conditions. The Magellan Complete Care clinical team, enrollees, and providers are able to access any aspect of the AHCA approved and NCQA compliant Care Coordination and Disease Management Program components.

The primary goal of the perinatal program is to reduce and prevent pregnancy related complications and complications related to the pregnant enrollee’s mental illness and treatment. The program is designed to improve prenatal and behavioral health care for pregnant enrollees by promoting healthy behaviors and controlling risk factors during pregnancy and the postpartum
period with care delivered in the right setting and in a cost-effective manner. The program provides ongoing, comprehensive care that increases the enrollee’s awareness of her condition and the value of treatment and self-management. The detailed standards of the Mother Baby Connections Program are located in applicable policies and procedures.

Our data shows that pregnant women in our health plan are significantly more likely to have substance abuse, urological and dermatological risk drivers, along with infectious disease (excluding TB, hepatitis and HIV) and mood disorders (both bipolar and depression). They are less likely to have psychotic/schizophrenic, diabetes, hypertension, or cardiac risk drivers, but that's not to say that we don't have pregnant women with those risk categories. Our programs are specifically designed to identify and manage those risks.

In addition, pregnancy, birth, and parenting are pivotal events in a woman's life and are considered biopsychosocial events. All women experience pregnancy both emotionally and physically. The normal psychological adaptation to pregnancy and attainment of the maternal role is not well researched with even less available research related to women with serious mental illness. More is known about the physiological changes during pregnancy including hormonal, cardiovascular, hematologic, metabolic, renal and respiratory changes and the impacts on co-morbid diseases and contributions to complications during pregnancy. Our programs reflect a focus on those risks.

Particular concerns for pregnant enrollees with SMI include:

> The impact of pregnancy on behavioral health issues
> Risks and benefits to the enrollee of initiating, continuing or discontinuing medications
> Risks of medications on fetus and the newborn
> Potential of co-occurring substance abuse (including tobacco, alcohol and opioids) and the impact to mother, fetus and newborn
> Ambivalence about the pregnancy, attachment to the fetus and active engagement in care
> High prevalence of modifiable risk factors such as tobacco use, substance use/abuse, dental caries, lack of physical activity and poor nutrition
> Possible co-morbid conditions such as asthma, diabetes, hypertension, sickle cell anemia
> Increased risk of pregnancy related complications such as gestational diabetes, pre-eclampsia, pre-term birth
> Pain control intrapartum and postpartum
> Potential for delivery of a high-risk newborn including congenital anomalies, pre-term birth, low birth weight, withdrawal symptoms due to medications (e.g. opioid related Neonatal Abstinence Syndrome)
> Relapse of SMI condition in postpartum period
>Potential challenges related to parenting, especially if the infant is born prematurely or with high risk conditions

>Presence of co-morbid/co-occurring conditions

Effective coordination and care management is needed to address the reality that the mental illness itself is a barrier to the management of pregnancy. Mental illness makes it harder for people to access care, adhere to a therapeutic regimen, keep follow up appointments and navigate the health care system. Additional detail about these programs is provided in MMA SRC #2 – Birth Outcomes.

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT’S ALGORITHM…
Magellan Complete Care uses multiple tools to identify enrollees at risk and refer them to the appropriate care coordination or provider programs based on their level of risk. To minimize the time between when an enrollee’s needs are identified and when the enrollee receives services, we have multiple avenues for identification. We review varied data sources and reports to identify enrollees with DM diagnoses at least monthly. Enrollees will be identified as eligible for the DM Program through a variety of additional sources, including:

>Claims and encounter data: Claims data is used to identify enrollees who have specific diagnoses
>Pharmacy data: Pharmacy data is used to identify enrollees who are prescribed medications for Cancer management

>HRA data: The HRA is a proprietary assessment tool developed by Magellan’s medical and behavioral health experts. This assessment is comprised of medical, preventive, behavioral, psychosocial, and lifestyle questions that are tailored to the SMI population. On this questionnaire, enrollees self-identify whether they have any chronic conditions, and comorbid conditions. We are also currently in the process of developing a new, separate HRA for our child and adolescent SMI members. See [General SRC #05, Attachment 4: HRA Child-Adolescent] for detail.

>Data collected through Magellan Complete Care UM or CC/CM programs: Enrollees may be identified as eligible for DM Programs based on case management program referrals, discharge planner referrals, concurrent review referrals, transition reports, prior authorization requests, among other referral sources

>Information from health management, wellness or coaching programs: Data from Magellan’s clinical information system is used to identify enrollees with targeted diseases and with gaps in care

>Information from patients and providers: Enrollees may self-refer or be referred by their provider into the DM program

Once enrollees are identified we complete the following additional key activities:
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> Evaluate the enrollee to determine that they meet criteria for the DM Program as defined in our  
DM program description, including enrollee behavioral and physical health complexity and level of fragility

> Caregiver is identified, who with the enrollee’s consent, is permitted to engage and receive  
information on the enrollee’s care and participation in the DM program

> Stratification into low, moderate, high, or ultra-high-risk categories based upon medical and  
behavioral health conditions and issues

Magellan Complete Care has licensed ImpactPro to enhance our predictive modeling capabilities.  
We have modified the tool to incorporate behavioral health conditions, social support status and  
other issues that are unique to this population. The tool assesses future utilization, and assigns  
each person a likelihood of hospital admission and other health service utilization based on  
previous claims and other data, including enrollee reported information. The model relies on the  
use of a more robust data set than most models, including:

> Enrollment information (age, gender)  
> Medical and behavioral claims (diagnoses, costs of care, events)  
> Outpatient pharmacy claims  
> Lab results  
> Information from clinical systems  
> Selected health risk assessment data

In addition to identifying the top-tier risk population on a monthly basis for possible complex case  
management, ImpactPro also identified gaps in care that can be used to improve clinical care and  
outcomes and mitigate the risk of increased utilization.

In addition, as noted earlier in this response, we also capture and consider social determinants  
for predictive modeling, risk stratification, and identification of appropriate interventions. When  
creating predictive models of inpatient risk, as well as analyses of drivers of HEDIS measure  
compliance, Magellan evaluates enrollee response information on the health risk assessment  
which indicates whether the patient has stable housing and/or lacks transportation to medical  
appointments. Factors related to these measures are included in models to create a  
SocioEconomic Burden ScoreTM (SES). Going forward, the DM and ICCM teams and our quality  
teams will also leverage the SES to help drive the selection of appropriate action outside of  
enrollee identification. We are also planning to further enhance the model by identifying metrics  
associated with food security/insecurity, which has been shown to be associated with outcomes  
for specific chronic illnesses such as hypertension and diabetes.

Based on the results of these analyses and ongoing CC/CM activities, enrollees are stratified into  
the following risk categories, with the level of support and intervention varying depending on that  
enrollee classification. As of June 2017, Magellan Complete Care had approximately 3,240  
members participating in CC/CM. Members are stratified into the following risk categories:

> Ultra-High Risk/Enhanced Care Coordination is identified as an enrollee who is likely to admit  
within 90 days
High Risk is identified as an enrollee who is in need of short-term case management for identified short-term needs that are easily resolved within a defined period of time. This category also includes enrollees assigned to our disease specialty teams (congestive heart failure, high-risk diabetes, mood disorders, schizophrenia, high-risk pregnancy, sickle cell disease, first episode psychosis). This risk category is further broken into the following sub-groups:

>Short-Term Management: Individuals with a short-term need easily resolved in a limited period of time

>Disease-State Specialty Team: Individuals at high-risk who have diagnoses included in one of our disease specialty teams (schizophrenia, bipolar disorder, CHF, high-risk diabetes, sickle-cell disease, high-risk pregnancy, and first-episode psychosis in youths and adolescents)

Monitor Risk is defined as an enrollee meeting High or Ultra High risk criteria but is unable to be reached or has refused intervention. These enrollees are assigned to a CC Health Guide for monitoring and follow-up at regular intervals. Monitor risk will also include enrollees who are showing evidence of rising risk, including excessive ER or other acute services use, changes in medication therapy, etc. This enrollee segment is actively monitored and flagged for more intensive intervention by a health guide (or CHW, as that program is developed).

Moderate Risk criteria are identified as:

>Score of 1-4 on HRA
>Navigational/coordination needs that may necessitate monthly follow-up for a few months, until the enrollee is stable and/or has all needed outpatient services in place

If the enrollee’s needs are more condition-specific, with moderate educational and coordination needs and qualifies for one of the case management assisted DM programs, for management by a Wellness Specialist

Low Risk criteria are defined as follows:

>Score of 0 on HRA
>Minimal needs identified
>Step-down cases from case management or CCM programs
>Individuals with a single, well-controlled disease state who are provided with self-care and health education support

Wellness and Prevention criteria are defined as follows:

>Score of 0 on HRA
>Minimal needs identified
>No physical health co-morbidity
>No more than two BH diagnoses

It is important to note that enrollees are expected to move between stratification levels, although our goal is to move toward stabilization and sustainable management of the enrollee’s health, with enrollees graduating to less intensive intervention levels as those goals are achieved. Step-down criteria to move to a different level of care management are as follows:

1. 90 Days Community Tenure: 0 incidents of ER or Inpatient Utilization for 90 days.
2. Member refused Care Management
3. CC Health Guide unable to contact for 14 days after the program opening is completed and 3 outreach attempts.
4. Member is compliant with outpatient treatment and has demonstrated progress towards care plan goals
Our program uses a combination of administrative data and predictive modeling as well as ‘real
time’ referral sources to identify members with targeted diseases who are eligible for DM
programs. Administrative data is produced through regular reporting procedures that are followed
each month, and the data is reviewed at least monthly to identify individuals with targeted
diseases. This data is used to:

>Identify enrollees who meet criteria for a specific condition and co-morbidities using HRA, claims,
Rx data, etc.
>Score enrollee risk and support needs based on results of key inputs evaluated using our
predictive modeling algorithm
>Stratify enrollees into low, moderate or high-risk categories based upon medical and behavioral

Magellan Complete Care has licensed ImpactPro to enhance our predictive modeling capabilities.
The commercially available tool has been modified by Magellan to incorporate behavioral health
conditions, social support status and other issues that are unique to our populations. The tool
assigns each enrollee a likelihood of hospital admission and other health service utilization based
on previous claims and other data, including enrollee reported information, thereby supporting
AHCA’s goal of managing utilization of higher acuity services. The model relies on the use of a
more robust data set than most models, including:

>Enrollment information (age, gender),
>Medical and behavioral claims (diagnoses, cost of care, events),
>Outpatient pharmacy claims, and
>Health Risk Assessment data

In addition to identifying members with targeted diseases and their risk levels, ImpactPro also
identifies gaps in care according to about 800 rules that imbed evidence-based care. Closure of
these gaps in care can improve clinical care and outcomes and mitigate the risk of increased
utilization.

We have found that risk identification and stratification cannot be done solely through claims
analysis, particularly when claims data are unavailable or there is a lack of an extensive history
of claims. Additionally, there are critical components of information for DM approaches and
interventions, particularly for Magellan Complete Care’s SMI enrollees that can only be provided
by self-report from enrollees. These include health habits, living situation and social
connectedness, which are all important predictors of outcomes. Therefore, Magellan Complete
Care uses information captured via a Health and Wellness Questionnaire (HWQ) to further identify
the key areas of risks and needs of the SMI population. The core domains of the HWQ include:

>Living Situation
> Hospital/Office Visit History
> Substance Abuse and Tobacco Use History
> Social Activity
> Physical Activity
> Nutrition Habits
> Preventive Test History
> Depression Screening
> Chronic Condition and Behavioral Health History
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>Rating of Health
>Confidence and Readiness Rating for Behavior Change

Magellan Complete Care’s HRA can be administered in person or telephonically. Once the Care Management Team is informed that an individual is enrolled in the Plan, staff reaches out to the enrollee through written materials, telephonically and face to face, to welcome them to the Plan, and gather the HRA as well as documenting our New Enrollee interview. Together, these tools are used for a baseline understanding of the enrollee’s recent health history and current needs. All enrollees in an institutional setting receive a face to face evaluation, if possible.

Our goal is to complete an initial assessment for most enrollees living in the community within 30 days of enrollment and 15 days for enrollees living in an Assisted Living Facility or other institution. We use Health Guides and Peer Support Specialists to help locate individuals who are homeless or otherwise hard to find. The baseline information collected through administration of the HRA form allows Magellan Complete Care to stratify the population and identify those who are at greatest risk. Relying on a unique scoring system that assigns different values to higher risk elements, such as ER use and presence of chronic and disease specific conditions such as hypertension, Magellan Complete Care stratifies the population into three risk tiers (High, Moderate and Low) risk based on the self-reported responses on the HRA. The risk level guides the level of optimal care management that addresses each person’s specific needs. Members who are stratified as moderate or high risk will have additional clinical needs assessment completed to determine if they meet criteria for participation in the DM Program and to provide information for care planning.

HRAs, which are updated on an annual basis or when an enrollee experiences a key trigger event such as an inpatient admissions, provide important insights to identifying the needs of members and opportunities to support members in managing their conditions. This information supplements the monthly data identified through our predictive modeling process and the ongoing, real-time identification through utilization management, enrollee and provider referrals, and other referral sources. Enrollees who are newly identified as eligible for a DM Program are then referred to the Wellness Specialist via the clinical information system for follow-up and outreach.

The enrollee’s responses on the HRA and the new enrollee interview are an important source of high level information about the enrollee and a vehicle for initial engagement in the DM Program. Other sources of information about the enrollee’s strengths and opportunities will be gathered from among several sources, including:

>ImpactPro is used for identifying members with co morbid conditions, predicting and stratifying risk, and identifying gaps in care (e.g. no recent HbA1c test or retinal eye exam) each month.

>Evidence-based assessments utilizing Milliman Care Guidelines’ disease condition management tools for hypertension disease management.

>Magellan Complete Care’s proprietary integrated care guidelines, which address condition/condition and drug/condition interplay specific to conditions common in the SMI population.

>Interview with the enrollee as well as their family and supports, if indicated and agreed by the enrollee.
Discussion with the enrollee’s treating providers for physical and behavioral health care.

CRITERIA 4: THE ADEQUACY OF THE RESPONDENT’S DESCRIPTION OF HOW…

Magellan Complete Care DM programs are an integrated part of our Integrated Care Case Management (ICCM) organization and programs. Our DM programs form only one element as part of a system of clinical programs, education and interventions for our enrollees experiencing a chronic illness and who demonstrate a level of risk and complexity in their needs that is appropriate for that level of management. Enrollees demonstrating higher levels of risk and complexity have access to the same programs, but also receive case management or care coordination support that is appropriate for their needs. Movement of enrollees from one program or level is seamless and fully integrated across all disciplines.

The Magellan Complete Care DM programs follow AHCA’s clinical program requirements, applicable NCQA Standards, and applicable State and federal regulations and requirements. Our DM staff use the same Case Management Society of America’s Case Management Standards of Practice and National Association of Social Work Case Management Guidelines as those used by our other ICCM team members.

As noted previously, our care coordination model starts with an expanded health risk assessment which has been enhanced to capture physical health, behavioral health, substance use and social risks and enrollee stability in each area. That enhanced assessment, along with the rest of our fully-integrated model, has been informed by the robust and detailed analysis of enrollee stability and outcome predictors that is completed by Magellan Complete Care on a regular, ongoing basis. This assessment, along with the use of more specialized screenings (when needed) is used at multiple touchpoints with the enrollee, allowing us to regularly monitor enrollee stability and move the enrollee between DM, CC, and CM programs, reflecting the appropriate level of care coordination (low to ultra-high-risk) and the programs that best support the enrollee in achieving recovery and resiliency.

Throughout the enrollee’s tenure, we are also regularly assessing risk and update care plans using data from all available enrollee touchpoints, including Health Guides and Case Managers, providers, and the Magellan Complete Care enhanced predictive modeling tool. A detailed desktop procedure has been created for clinical staff to reference, as needed. At any time, the primary Case Manager will use clinical judgment to determine the enrollee risk level and appropriate case management program enrollment.

Beyond the DM programs already discussed in this section, where warranted, based on enrollee need, he or she may be moved into, or out of, one of the many specialized care management programs we have developed to address the specific needs of the Magellan Complete Care membership, including:

> Depressive disorders
> Bipolar disorder
> Schizophrenia
> Sickle Cell Disease
> Children/Youth with Special Health Care Needs
> First Episode Psychosis (under development)
We emphasize a whole-person approach across the spectrum of care and service needs. Our provider network partnerships are also built with this goal in mind, consisting of traditional healthcare providers, behavioral health specialists, long-term services and supports (LTSS), and other community agencies and resources with a shared commitment to person-centeredness, evidence-based treatment, robust communication, and teamwork.

Magellan Complete Care programs which have been approved by AHCA and meet NCQA standards, establish requirements when an enrollee refuses DM services. We make repeated attempts to engage all identified enrollees in our programs. We require our staff to make multiple attempts to engage the enrollee, using a variety of methods, and document the enrollee’s refusal and reasons in TruCare.

CRITERIA 5: THE EXTENT TO WHICH THE RESPONDENT’S DISEASE MANAGEMENT PROGRAMS...
We employ several strategies for supporting self-management and treatment adherence:

<<Motivational Interviewing>> is used to prioritize the problems which the enrollee feels are most important to solve, and to determine whether the enrollee’s readiness to address the problem and to set an actionable goal. All Care Coordination staff are trained ongoing in motivational interviewing, and all Discharge Health Guides have been trained in the “teach back method” to repeat back intent of discharge plans.

<<Medication Therapy Management>> is an important, integrated element of all of our CC/CM programs, including our specialty care management programs focused on high risk populations such as pregnancy, schizophrenia, bipolar disorder, sickle cell, diabetes, COPD, and CHF. We take a high-touch, active approach to enrollee medication therapy management, actively engaging with the enrollee, BH and PH providers. Members are regularly screened for risks associated with their behavioral health diagnosis and medications, as well as physical comorbidities.

A Clinical Pharmacist is also a regular participant in the care coordination team and reviews enrollee medications in collaboration with the prescribing physicians on the team. The Pharmacist is responsible for identifying over- and under-utilization, potential drug-drug interactions, and optimal therapeutic regimens. The Pharmacist consults on complex cases where there is risk to the enrollee due to potential drug interactions between drugs for chronic medical conditions and psychotropic medications. Our medication therapy management programs (MTM) also provide for analysis of claims data to identify gaps or potential concerns. Magellan Complete Care has also developed specific programs to encourage the use of long-acting injectables (LAI) to ease enrollee compliance with medication regimens.

Magellan Complete Care staff includes an In-house Pharmacy Director who meets regularly onsite with Medical Directors to discuss medication management for enrollees. The in-house Pharmacy Director, who is also part of the <<Magellan Complete Care Whole Health Rx...
Medication Management Program is a regular participant in our ICCM team meetings. Magellan Complete Care Whole Health Rx has demonstrated significant improvements for both our members and the plan, including significant reductions in: medical spend, poly-pharmacy, members with depression (taking antipsychotic without antidepressant, and use of controlled substances. We also see significant improvements in management of bipolar disorder. The Whole Health Rx Medication Management Program is:

> Cost-free, comprehensive, integrated approach to assist providers in managing enrollee medication therapy

> Connect primary care physicians, behavioral health providers, and nurse practitioners to identify and resolve gaps in care and inappropriate prescribing

> “Late to refill” identification and notification of members through our Magellan Whole Health Rx program

> Pharmacy “Lock-In” program

> Using our Whole Health Rx advanced proprietary clinical protocols, we screen pharmacy and medical claims with the purpose of identifying prescribing patterns that are inconsistent with evidence-based, best practice guidelines for individual diagnoses and co-morbid PH-BH conditions

> Evidence-based information system that supports management of medication therapies for members with behavioral health and co-morbid physical health conditions

> Medical, behavioral, lab and/or pharmacy data received by Magellan Complete Care

> Algorithms applied to identify non-compliant members and other risk factors

> “Late to refill” identification

> Non-adherent to core psychotropic medications

> Bipolar disorder and have likely stopped use of mood stabilizer

> May not have received recommended lab tests

> Are receiving therapy with significant drug-drug interactions

> Multi-channel consultation between Magellan Complete Care pharmacist staff and PH/BH providers

> Targeted educational materials and clinical consultative services with providers and staff.

As an example of the specific medication management programs we have implemented is our project for monitoring and management of patients with diabetes to prevent ketoacidosis in members taking pharmaceuticals (particularly common for BH pharmaceuticals) that would contribute to high blood sugar. Program staff working with the targeted members interact directly with one of our clinical pharmacists (PharmD) to provide high-touch management of medication therapies for these members.

Program staff also make reminder calls for medication adherence; attend appointments with enrollees to discuss medications with providers; go to pharmacies with enrollees or determine if home delivery is available; pick up prescriptions for high-risk enrollees; encourage use of free pill boxes from pharmacies for ease of daily medication adherence; encourage use of visual reminders for daily medication adherence, such as calendars. Our ICCM team members involved
in discharge planning and management of enrollee transitions of care review any changes to enrollee medication therapies that may have taken place in the new care setting to look drug-drug interactions or other issues that could occur. Members are also instructed to bring information for all new medications with them to their post-discharge follow up appointment.

Magellan Complete Care’s DM programs incorporate education, motivational and emotional support for the enrollee and for caregivers, easy to read materials, co-management of co-morbid behavioral health and substance use disorder (SUD/AUD) conditions, (incorporating the principles of recovery and resiliency), and group and individual resources in alignment with the enrollee’s conditions, needs, and readiness for behavior change.

5.1 Symptom Management
Our programs address symptom management at all touch points with enrollees. As noted in the program descriptions above, we provide enrollee self-care education and support to understand and manage symptoms. This may include tools and programs for symptom tracking, reminder messaging, or remote monitoring support. Program staff follow the care plan and the educational components of the DM program to address symptom identification and management such as the use of peak flow meters, glucometers and daily weights for enrollees with asthma, diabetes and congestive heart failure respectively. Programs also includes coaching to sensitize enrollees to symptoms such as the importance of shortness of breath, increasing weight, increased urination, and light-headedness is critical to self-empowerment and mitigation of decompensation.

Our program processes involve assessment, problem and care gap identification, goal setting, and condition-specific interventions. Our program has a unique patient assessment which is tailored to the clinical and psychosocial characteristics of the SMI population. All enrollees are screened for behavioral conditions and substance use disorders. Based on the enrollee’s responses they may be asked additional questions to further understand their individual needs and to identify specific care needs and gaps.

Planned interventions are disease specific. For example, behavioral health gaps in care have different goals than substance abuse gaps in care. Interventions also take into account the enrollee’s psychosocial and support system. The enrollees’ plan of care includes a plan for self-management which is tailored to the enrollee’s behavioral health condition, preferences and supports. e.g., caregiver support, Peer Support, Health Guide, and Integrated Care Case Manager (ICCM) support.

Our enrollees are also supported with self-management tools and strategies that are individualized to recognize and maximize enrollee strengths, and to develop skills that enhance recovery and resiliency. Goals include increased understanding of disease(s), education to become more effective self-managers of their conditions, support to better coordinate care among behavioral and physical health providers and prescribers, and support to enrollees in creating and sustaining behaviors that result in improved health.

We use the Milliman Care Guidelines as well as customized tools to take into account the behavioral health conditions to support the interactions the nurses have with enrollees. This allows a consistent, evidence-based approach to identifying symptoms and developing an adequate response plan. In some cases it may be difficult for the enrollee to recognize symptoms, or to differentiate them from their behavioral health condition, so the team will engage family members, the behavioral health providers, and others involved in the enrollee’s life to help them
assess their symptoms. Team members also use a pain assessment with enrollees and, depending on the results, contacts the provider regarding concerns.

5.2 Emotional Support
We recognize the value of addressing the emotional needs and support of our enrollees. This is even more the case for enrollees dealing with co-occurring physical health conditions. The ICCM team will engage with the enrollee in person, via telephone, and with online tools, as indicated by the enrollee’s preferences and needs.

Our DM programs offer a comprehensive and innovative integrated approach to address co-occurring medical and behavioral health conditions by combining health care, social support, and peer counseling that meets the enrollee where they are. Our strategies are highly individualized and promote enrollee recovery and resiliency, self-management, and engagement in shared decision-making. We embed our behavioral health expertise into all of our DM processes including engagement, screening, assessment, care planning, interventions, and evaluation.

All team members are trained in Motivational Interviewing techniques. With their experience living with SMI, Peer Support Specialists often bring team enrollees important and timely insights about motivation. They also model recovery, resiliency and healthy lifestyles for enrollees. By coordinating and engaging all participants in the enrollees’ care, we help provide consistent messages and emotional support.

Key to Magellan Complete Care’s success with this model is the IHN, which is customized for each region, recognizing that the availability and capabilities of providers and enrollee support services will vary. Consistent with concepts defined for Recovery Oriented Systems of Care or ROSC, the goal of this model is to create a multi-faceted network of supports and treatment options to improve enrollee stability and opportunities for recovery. As an example, we have found that in Regions 10 & 11, the most significant contributing factor for non-adherence and non-compliance was homelessness. Magellan Complete Care has directed significant focus for its <<Homeless Housing Program>> to these regions to address these issues to support improved enrollee engagement and compliance with care management programs, including DM.

Magellan Community Care’s goal to improve enrollees’ care, quality of life and health outcomes can only be achieved within the context of where the enrollee lives. This is especially the case for fragile SMI enrollees whose mental illness, and sometimes the medications used to treat that illness, can exacerbate physical health fragility. Our IHN team members live and work within the communities where our enrollees reside. The IHN is Magellan Complete Care’s vehicle to drive close collaboration with providers, community partners and resources, allowing us to customize care and provide a seamless, one-stop system of services and supports, which is critical for our enrollees who have co-occurring behavioral health and physical health diagnoses and may have difficulties navigating treatment and care.

5.3 Behavior Change
While population-based, our DM Program’s approach is highly individualized and includes peer support to help enrollees engage and embrace self-care, healthy behaviors, working with providers, and adherence to treatment. The care plan is used to track the enrollee’s progress, focusing not only on symptom management and adherence to treatment for the enrollee’s condition, but also behavior change and progress to reducing lifestyle risk factors. We develop
the care plan and goals with the enrollee. We employ Motivational Interviewing to assess where enrollees are as far as readiness to change.

In addition to Wellness Specialists, Peer Support Specialists, and Case Managers delivering individual and group education and support to enrollees, other members of the Care Coordination Team do the practical work of assisting members to engage in care, adhere to their provider's treatment plan, and attend scheduled appointments. Peer Support Specialists and Health Guides, interacting with enrollees where they live and work, are trained to recognize, support, and refer when an enrollee seems to be stressed or in crisis, isolated or lacking social support, or not taking medications appropriately or safely.

We recognize the value of and need for addressing the emotional needs and support of our enrollees. All enrollees in DM programs are screened for depression. The team will engage with the enrollee in-person, via telephone, and with online tools, as indicated by the enrollee's preferences and needs. All members working with members are trained in motivational techniques. With their experience living with SMI, Peer Support Specialists often bring the team important and timely insights about the enrollee's motivation. They also model recovery, resiliency and healthy lifestyles for enrollees. By coordinating and engaging all participants in the enrollees' care, we can help provide consistent messages and emotional support. Additionally, community support groups and classes will be a source of learning and support for members.

Communication with Providers:

As noted previously, providers are provided with ongoing communication through the provider portal, and gap in care reporting which identifies enrollees engaged in DM or other ICCM programs. We will also directly contact the treating physicians to discuss potential changes when enrollee safety issues are identified.

The team will develop care plans with the input and advice from the treating providers and with required approval from members. The team will monitor progress toward goals with regularly scheduled follow-up calls or onsite visits to the enrollee, PCP, pediatrician, specialty providers, and/or family and through real time monitoring of the care plan through our care management portal. The goals will be modified as the enrollee's progress/needs change and as the treating providers change their treatment plan and recommendations.

Magellan Complete Care supports providers in delivering evidence based care through education, monitoring of the enrollee's condition and treatment plan, and feedback as well as supporting patient engagement in care and coordinating different components of the treatment plan. We place particular emphasis on closing gaps in care and medication management, given the special considerations and medication-related risks for the SMI population.

For high volume practices or health homes, Magellan Complete Care will designate resources including Wellness Specialists and case managers who will work with providers and their patients. With appropriate authorization from members or their legal representative, Wellness Specialists communicate with providers as needed to coordinate care. The communication with the providers occurs via telephone, fax or mail, according to the urgency of the situation.

For enrollees who have Cancer and other chronic conditions or special needs requiring ongoing care from a specialist, Magellan Complete Care will also provide authorization for “standing referrals” to reduce any barriers or administrative burden for the provider and the enrollee.
The Magellan Complete Care Provider Manual includes information regarding how we work with providers to support enrollees with cancer. Any provider is welcome to refer an enrollee to the program. Providers receive information about their patient’s progress via shared documents including the care coordination plan.

CRITERIA 6: THE EXTENT TO WHICH THE RESPONDENT HAS DESCRIBED A METHODOLOGY....

6.1 Ongoing Program Analysis
Magellan Complete Care is committed to continuous monitoring and improvement of our disease management programs. Programs are reviewed and evaluated on an annual basis to assess program effectiveness. The programs are also monitored and assessed on an ongoing basis during the program year to track progress toward meeting program goals, national benchmarks and clinical outcomes. Each program has a set of: a) process measures; b) clinical quality measures; and, c) cost measures that are unique to that program and are used to measure program performance on a regular basis. As an example, the specific measures for the hypertension DM program are as follows:

>Process Measures: Participation rates, engagement rates
>Clinical Quality Measures: Comprehensive hypertension care
>Cost Measures: Total cost, Rx cost, medical cost

We maintain an online system of clinical program dashboards that report performance against each measure over time, allowing for real-time modifications to programs and interventions to enhance effectiveness. These dashboards are also used to monitor performance of our programs for achieving targeted improvements in outcomes for each chronic illness category.

We evaluate the success of the programs using a variety of measures, including:

>HEDIS scores
>Care plan gaps
>I/P, ER and readmission rates
>EPSDT and birth outcome measures if appropriate,
>Other measures required by AHCA to evaluate clinical outcomes over time

We regularly assess, and expect to see improvements in the health and well-being of program participants and compare the rates in gaps in care over time as demonstrated by the key indicators we monitor. We measure gaps in care using our predictive modeling software that also informs the interventions the Care Coordination Team pursues with the enrollee such as setting up follow up appointments, and identifies enrollees who may be demonstrating rising clinical risk. Over time, we expect that the number of gaps should decrease as members develop regular follow up schedules through participation in the programs.

The measures used to evaluate the Magellan Complete Care disease management programs are population-based, and are analyzed in comparison to benchmarks or goals, based on available industry standards. As part of this process we evaluate performance on process measures (e.g., participation and engagement rates); clinical quality measures specific to the disease; and cost
measures (e.g., total cost, Rx cost, medical costs); and, performance on HEDIS measures specific to that disease.

6.2 Detailed Program and Intervention Assessment
Magellan Complete Care also periodically completes detailed analyses of each of our programs and key interventions. We use the Plan-Do-Study-Act (PDSA) framework, for assessing program effectiveness. The PDSA framework is an established standard for quality assessment and continuous improvement. Using this framework, we define and measure the pre-intervention results for our enrollees; define the intervention and what it is attempting to address; measure the effects of the intervention for statistically valid sample of continuously participating enrollees; and recommend enhancements to interventions, if necessary, based on the results of that analysis.

Analyses of our programs and interventions are performed by our Advanced Analytics and Solutions Department and our Medical Economics Department. The departments which include health economists, actuaries and PhD health researchers, use statistically valid methods for sample selection and analysis of results.

In evaluating cost savings we use a 12-month intervention period for chronic medical cost savings calculations. For this analysis, enrollees are grouped into two mutually exclusive cohorts: chronic (intervention population) or non-chronic, propensity-matched (index population). The medical cost savings are calculated separately by service category, and enrollees need to be continuously enrolled in the plan for six months or longer to be included in the analysis. Baseline PMPM costs for both cohorts are calculated for the 12-month period preceding the initial time of the DM program intervention.

After the conclusion of the intervention period, PMPM costs are calculated for both cohorts for the 12-month intervention period. We calculate the non-chronic (index) cost trend from the baseline period to the intervention period, and then apply this index cost trend to the baseline chronic costs to determine projected chronic costs. Costs are assessed for the chronic measured population in the intervention period and then compared to projected chronic costs for this period to determine medical cost savings for this population.

As an example, we have recently completed a detailed analysis of cost and utilization impacts for individuals enrolled in our disease management programs. Results from key programs show:

>Diabetes Program: Annual costs for enrollees with a high disease burden (2+ co-morbid conditions, and 3+ any cause admissions) were more than $1,600 less for enrollees actively engaged in disease management. Total non-trauma ER use for enrolled/engaged enrolled declined by 21 percent. For enrollees with low disease burden (<3 any cause I/P admits), the reduction in ER usage was even more significant, at 54 percent.

>Asthma Program: Annual costs for all enrollees were reduced by 36 percent vs. an increase of 19 percent for enrollees that were not enrolled. Again, total costs for enrollees with a low disease burden fell by an even larger 57 percent. Total non-trauma ER usage fell by 35 percent, with usage by low-disease burden falling by 43 percent.

>Hypertension Program: Annual costs for all enrollees were reduced by 30 percent vs a 3 percent increase for enrollees not enrolled. Total costs for enrollees with a low disease burden fell by
59%. Total non-trauma ER usage fell by 27%, with a 43% decline in usage for enrollees with low-disease burden.

>Pregnancy Program: Approximately 1,046 Magellan Complete care enrollees were pregnant and delivered during 2016. The average age of our total population is 40, while pregnant women have an average age of 26. 145 cases are <18 years of age - 2 cases are 13 years of age. On average, our pregnant enrollees have been enrolled for 10 out of the last 12 months (not necessarily continuously), and have spent an average of $7996 per case, with $1,046 of that being for Rx. The non-pregnant population by comparison has been eligible for an average of 9 months and has spent approximately $5,605 per case in total, but $1,663 on Rx.

>Sickle Cell Management Program: Average total costs for those enrollees who completed the program were reduced by 41%, while IP utilization decreased by 58% and ER utilization decreased by 29%.

Magellan Complete Care has demonstrated equally impressive results for enrollees engaged across all our DM/CC/CM programs. Examples include:

>Admissions for adult high risk enrollees decreased by 47%
>Admissions for adult moderate and low risk enrollees decreased by 37%
>ER rates for all adults decreased over time, and PCP engagement increased by 43%
>PCP visits for youths in all risk levels increased by an average of 41%
>PCP visits for low risk adults increased by 58% and moderate risk adult visits increased by 28%
>Polypolypharmacy rates also saw significant reductions
>>84% of children who were on 4+ psychotropic medications had their medications reduced
>>73% of children who were on 5+ psychotropic medications had their medications reduced
>>79% of adults who were on 5+ psychotropic medications had their medications reduced

These data demonstrate the value of Magellan Complete Care disease management programs in yielding real, tangible benefits to our members.

6.3 Annual Program Reviews
The DM Program is reviewed and evaluated on an annual basis to assess program effectiveness. The program is monitored and assessed on an ongoing basis during the program year to track progress towards meeting program goals, national benchmarks and clinical outcomes. We evaluate the success of the program using a variety of measures. We use HEDIS measures and other measures required by AHCA to evaluate clinical outcomes over time. We also expect to see improvements in the health and well-being of program participants and we compare the rates in gaps in care over time.

We measure gaps using our predictive modeling software that also informs the interventions the CC/CM team pursues with the enrollee such as setting up follow up appointments for enrollees with diabetes who have not seen their provider in the last six months. Over time, the number of gaps should decrease as enrollees develop regular follow-up schedules. Data collected is
reviewed and analyzed by our analytics, care management and quality teams, the Health Services Medical Directors, and the directors of the pertinent departments to identify trends and patterns of care as well as provider and enrollee/caregiver satisfaction.

The results of the analysis will be reviewed and presented in the QI and UM meetings and is used to improve the overall quality of care for enrollees. Concerns with providers are reviewed and addressed by the Medical Director and the Peer Review Committee if necessary.

6.4 Enrollee and Provider Feedback
Satisfaction surveys specific to each disease management program are administered to both Magellan Complete Care enrollees and the enrollee’s providers on an annual basis to evaluate the program’s impact on members’ experience of care. Information gathered from ongoing enrollee feedback, complaints and compliments and surveys are analyzed and utilized to enhance staff performance and program processes. Our Provider Support Specialists also gather feedback from treating providers about successes and opportunities for program support and enrollee education. The Provider Support Specialists are nurses who work with providers on clinical patterns of care and help them access our tools such as enrollee profiles and care coordination plans.

We obtain feedback from enrollees and providers on a routine basis. Feedback is used to identify and address opportunities for program improvement. Sources of feedback include:

> Enrollee and provider satisfaction surveys
> Input regarding understandability and usability of program materials during enrollee and provider advisory committee meetings
> Enrollee and provider comments and complaints

Enrollee complaints are promptly forwarded to the appropriate department for resolution and provider complaints are processed according AHCA complaint policies

Magellan Complete Care considers the regular and ongoing assessment of the effectiveness of our DM programs for achieving targeted outcomes, to be a key element of program design, and reviews are integrated in all programs and interventions. Our continuous quality improvement (CQI) processes depend on this regular assessment of outcomes to support our goals of improving the health of our enrollees and delivering the greatest value for AHCA and the state.
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1. The extent to which the respondent proposes an innovative and evidence-based approach to disease management for the following conditions:
   (a) Cancer (Section 409.966, Florida Statutes);
   (b) Diabetes (Section 409.966, Florida Statutes);
   (c) Asthma;
   (d) Hypertension;
   (e) Mental health; and
   (f) Substance abuse.

2. The adequacy of the respondent’s description of how its respective disease management programs will be incorporated into its overall approach to advance the Agency’s goals.

3. The extent to which the respondent’s algorithm and risk stratification approach is well defined and describes the data sources that will be utilized.

4. The adequacy of the respondent’s description of how its disease management programs will be integrated into case management/care coordination programs.

5. The extent to which the respondent’s disease management programs include the following components:
   (a) Symptom management;
   (b) Medication support;
   (c) Emotional support;
   (d) Behavior change; and
   (e) Communication with providers, including the PCP/specialists.

6. The extent to which the respondent has described a methodology for evaluating the impact of the disease management programs and provided results/data based on previous experience that supports the reduction of potentially preventable events.

Score: This section is worth a maximum of 75 raw points with each component being worth a maximum of 5 points each.

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SRC# 6 – HEDIS Measures (Statewide):

The respondent shall describe its experience in achieving quality standards with populations similar to the target population described in this solicitation. The respondent shall include, in table format, the target population (TANF, ABD, dual eligible), the respondent’s results for the HEDIS measures specified below for each of the last two (2) years (CY 2015/ HEDIS 2016 and CY 2016/ HEDIS 2017) for the respondent’s three (3) largest Medicaid Contracts (measured by number of enrollees). If the respondent does not have HEDIS results for at least three (3) Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent’s largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one (1) of three (3) states for the last two (2) years.

The respondent shall provide the data requested in Exhibit A-4-a-1, General Performance Measurement Tool to provide results for the following HEDIS measures:

- Adults’ Access to Preventive/Ambulatory Health Services (Total);
- Child and Adolescent Access to PCPs (all 4 age bands reported as separate rates);
- Medication Management for People with Asthma (75% - Total);
- Controlling High Blood Pressure;
- Comprehensive Diabetes Care – HbA1c Control (<8%);
- Follow-up after Hospitalization for Mental Illness (7 day);
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation – Total);
- Antidepressant Medication Management – Acute Phase; and
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Response:

As the current Serious Mental Illness (SMI) specialty plan, Magellan Complete Care began accepting enrollees with SMI for delivery and management of fully integrated physical health and behavioral health care in July 2014. This SMI specialty plan concept was created through a partnership between AHCA and Magellan, as a way to truly focus on those complex health issues that people affected by SMI, and living in poverty, face. We know that these enrollees are super-utilizers within Medicaid, and AHCA was a national leader in developing this approach. Over the course of the last three years, we have worked to create a new model of care that truly addresses the unique issues our enrollees face day-to-day. It is important to note that no other Medicaid health plans in Florida exclusively serve a similar target population as that served by Magellan Complete Care. In fact, in discussions with NCQA, the organization confirmed that there are no comparators for the population we serve. To that end, we believe this model works for Floridians, is a best in class model, and will ultimately, over time, allow enrollees with SMI to lead healthier lives.

Challenges around consistent engagement and compliance, even on a short-term basis, much less longer-term regimens, are well-known issues for individuals affected by SMI. To address that, the concept of a fully-integrated biopsychosocial care management model, which is relatively new, has been developed, although, there are few examples of having implemented this solution at scale over a broad population. Our SMI enrollees that came into the health plan at its inception were not previously receiving integrated physical and behavioral managed care. As a result, these
enrollees were not as familiar or comfortable with the concepts of comprehensive integrated care management.

Given this historic lack of engagement and access to primary and specialty care, and the heavy burden of chronic disease in this population, Magellan Complete Care placed heavy initial emphasis on identifying enrollee physical health and behavioral health risks; initiating engagement; developing individual and population-wide plans for management; and beginning the process of continually improving outcomes for enrollees. We have also placed specific focus on clinical issues that present risks for persons with SMI populations. We know these enrollees experience higher rates of physical health comorbidities, co-occurring substance use, and social instability; with resulting life spans that are 20 to 25 years shorter than individuals without SMI. Working to stabilize those clinical issues is a primary focus, and serves as a bit of a “gateway” to addressing other physical health issues.

Internal analyses of Magellan Complete Care’s enrollees shows the much higher rates of chronic illnesses among our population. All of our enrollees have at least one SMI diagnosis, while more than 40 percent have two or more SMI diagnoses; approximately 50 percent have at least one physical health comorbidity; and, more than 30 percent have two or more physical health comorbidities. Our enrollees have diabetes incidence rates that are 2.6 times higher than in the general Medicaid population. They experience hypertension at 2.2 times and asthma at 1.6 times the rate in the general Medicaid population. Those rates are elevated in part by the effects of psychotropic medications, higher rates of smoking, and poor nutrition. Our enrollees also have higher rates of substance use disorder (16 percent) and lower rates of primary care utilization, although Magellan Complete Care enrollees are engaged with primary care at more than double the rate of SMI populations in the U.S.

Continuous quality improvement (CQI) has always been the backbone of Magellan’s services, but as this SMI program launched and matured, it is even more critical. The goal of our quality program is to ensure the provision of consistently excellent healthcare, health information, and service to Magellan enrollees. The values of patient-centered, community-focused, and evidence-based services are core to the Quality Program. CQI touches every functional area of the plan, including healthcare service delivery; service operations with members and providers; case management, disease management, and population health; core utilization management processes; network composition; compliance and risk management; and information management.

Magellan Complete Care staff obtain input from a broad spectrum of stakeholders, using a Plan Do Study Act (PDSA) framework. We monitor quality with metrics derived from multiple data sources to ensure the timely identification of barriers and interventions that lead to improvement. We use this model in all QI activities to resolve complex or multifaceted issues in a logical and systemic manner, as well as to engage stakeholders in planning efforts. The program has sponsorship from the CEO and top leadership of the organization including the Chief Medical Officer (CMO), who shares joint accountability with the Magellan Complete Care Director of Quality Management (QI Director) for quality outcomes. Quality is everyone’s job at Magellan Complete Care, and in fact, as evidence of our commitment, all Magellan Complete Care staff have at least one goal tied to quality in their annual performance assessments. Our experience has shown that supporting CQI and plan-wide quality ownership yields optimal service delivery and member outcomes, leads to systems improvement, and instills a pervasive culture of quality.
Magellan Complete Care believes that the continual improvement in our HEDIS outcomes results demonstrates the strengths of our model. In addition to the HEDIS, EPSDT/CHCUP, birth outcomes, and preventable events performance improvement initiatives described elsewhere in these responses, we have launched numerous other clinical interventions aimed at improving enrollee health results. The data confirms the value of those interventions. As an example, we were able to demonstrate a 49 percent reduction of preventable admissions and readmissions for enrollees engaged in DM/CC/CM programs in the period from 1/1/2015 through 9/15/2016. This reduction was present at all risk levels identified in Magellan Complete Care’s risk stratification model.

Our HEDIS interventions targeting closure of gaps-in-care are driven by the same goal of achieving even better improvement in our results. So far, they have shown significant success. Though some of our quality and outcome metrics may not currently meet AHCA’s minimum 50th percentile target, all HEDIS measures listed within this SRC reported for HEDIS 2016 and HEDIS 2017 have improved, and Magellan Complete Care is committed to continuing these improvements.

This improvement is not limited to the HEDIS measures listed within this SRC. Rather, this level of improvement is indicative of the effort Magellan Complete Care has invested in quality initiatives in 2016, which has yielded improvement in 90-percent of the 30 measures reportable to AHCA in 2017. Furthermore, the level of improvement per measure is on average seven percentage points per measure. As a basis for comparison, we analyzed the HEDIS scores for the top three Florida Managed Medicaid plans for HEDIS 2016 versus HEDIS 2017 using Quality Compass data for the same 30 measures. Competitor measures with a NR (not reportable) designation for either year were excluded from the count. Comparative performances was as follows:

>Format of the following data: Florida MMA Plan, number and % of measures improved, average percentage point improvement per measure:
>>MCC of Florida, 27 of 30 (90 percent) measures improved, <<6.67 average per measure point improvement>>
>>Wellcare of Florida, 16 of 30 (53 percent) measures improved, 0.95 average per measure point improvement
>>Sunshine Health Plan, 15 of 28 (54 percent) measures improved, 1.46 average per measure point improvement
>>Amerigroup Florida, 16 of 30 (53 percent) measures improved, -0.12 average per measure point improvement

For HEDIS 2017 (based on 2016 data), Magellan Complete Care met or exceeded the 50th percentile for 4 of the measures. Of note, Magellan Complete Care met or exceeded the 90th percentile in two measures critical for management of SMI, meaning that on both of these measures, our performance exceeded that of 90-percent of all Medicaid health plans, none of which are composed entirely of Medicaid enrollees with SMI. These included:
>Initiation of Alcohol and Other Drug Dependence Treatment (Initiation – Total)
>Medication Management for People with Asthma (75 percent - Total)

We met the 75th percentile for Adherence to Antipsychotic Medications, which is particularly relevant for our enrollees living with SMI, and we met the 50th percentile for Controlling Blood Pressure, which is critical from a clinical outcomes perspective.
Most significantly, improvements were made across a broader set of HEDIS and CHCUP/EPSDT measures. As noted above, across 30 reportable HEDIS measures 27 (90 percent) improved when comparing HEDIS 2016 against HEDIS 2017. Additionally, CHCUP/EPSDT participation, CHCUP/EPSDT screening, and Preventive Dental Services (PDENT) also improved. Our goal at Magellan Complete Care is to meet and exceed HEDIS and CHCUP/EPSDT benchmarks for our enrollees through continual improvement year over year. Individuals with SMI are known to experience much poorer health outcomes and experience much shorter lifespans than individuals without SMI. We are committed to demonstrating the value of a fully-integrated health plan solution to reverse those trends.

Magellan Complete Care understands the importance of quality and outcomes improvement for AHCA, and we fully-embrace and support the same goals. Our recent acquisition of Senior Whole Health, a healthcare company focused on serving complex, high-risk populations, providing Medicare and Medicaid dual-eligible benefits to more than 22,000 enrollees in Massachusetts and New York testifies to that commitment. Senior Whole Health has an outstanding reputation, strong track record and extensive experience facilitating high-quality, cost-effective health care to its members which is demonstrated by being a 4.5 Star Medicare Plan and also being in the highest quality tier in the State of New York. Senior Whole Health, which has been serving these populations since 2004, adds its deep experience and expertise, and its quality programs and results to the in-depth experience Magellan Complete Care has gained as Florida’s first SMI Specialty Plan. During its more than 13 years of operations, it has developed and refined its quality programs to address the unique needs of complex, high-risk populations. We look forward to integrating their programs and approaches to further enhance our programs for Magellan Complete Care.

In our drive to improve quality and produce outstanding outcomes for this population, we have looked beyond our internal resources and acquisitions. Magellan’s goal has been to establish meaningful partnerships with best in class organizations in other areas as well, so we may continue to learn, grow, and innovate in development of quality improvement initiatives and continued refinements of our overall system of care and care management.

As part of those ongoing efforts, we are partnering with, and have engaged Shared Health, a wholly-owned subsidiary of Blue Cross Blue Shield of Tennessee to support continued enhancements to our quality management, population health, and disease management (DM) programs. Through this partnership, we leverage Shared Health’s 24 years of experience covering 1.3 million members to enhance our models for stratification of enrollees; targeting of quality, DM, and population health interventions; and, engagement and outreach campaigns.

Magellan’s relationship with Shared Health began in 2016, as we partnered with their organization to successfully bid for the managed Medicaid Long Term Services and Supports (LTSS) contract in the Commonwealth of Virginia. Magellan Complete Care of Virginia was awarded that contract, and has collaboratively been working with Shared Health for the past year to leverage their Medicaid expertise to build the systems, frameworks, and strategies to successfully launch their plan as of August 1.

In addition to their collaboration with Magellan Complete Care of Virginia, Shared Health has also joined the Magellan Complete Care team as a consultative partner in developing our population health management framework, and as an expert advisor for HEDIS quality improvement. HEDIS
2017 rates for Blue Cross Blue Shield of Tennessee East Region exceeded the 2016 Quality Compass 50th percentile for 10 of 12 measures included in this SRC.

Areas of expertise for Shared Health that align with Magellan Complete Care's strategic vision include greater focus on sub-populations through data-driven analyses and well-developed community-based outreach strategy. Their algorithm using psychographics to better tailor interventions around demographic and cultural differences that may drive health disparities, includes use of self-reported data from enrollment files and through various health plan assessments, and census tract information. Additionally, Blue Cross Blue Shield of Tennessee has a rich history of working within the communities they serve, and conducts more than 500 community events a year to reach their Medicaid population across the state. An important area of focus for Magellan Complete Care in continuing to achieve population health improvements is to leverage similar data-driven strategies to create tailored programs and to increase our existing community presence to reach an even greater percentage of our members.

Magellan Complete Care believes that the addition of Shared Health as an important partner in these efforts, when combined with the deep understanding we have gained about our population and the key mechanisms that drive successful interventions, will yield continued significant improvements in quality and outcomes results for our enrollees.

We provide our completed Exhibit A-4-a-1, General Performance Measurement Tool. Our review of the SRC instructions and the responses to the Questions and Answers, notably in the use of “respondent” for purposes of the scores that can be submitted, were unclear. In an abundance of caution, we felt it necessary to provide you two separate spreadsheets to ensure that we answered in the way you intended. The first only includes scores for Magellan Complete Care of Florida, while the second spreadsheet includes scores for Magellan Complete Care of Florida and our other two largest contracts for similar target populations for the SMI specialty plan. Both are based in Massachusetts.

Magellan Complete Care Experience
Magellan Complete Care first received enrollees as a Managed Medicaid Specialty Plan for individuals living with Serious Mental Illness (SMI) starting on July 1, 2014. Performance for CY 2015/HEDIS 2016 and CY 2016/HEDIS 2017 is provided below for all of the measures identified in this SRC, and benchmarked against the NCQA’s 2016 Quality Compass Medicaid, All Lines of Business 50th percentiles. HEDIS Medication Management for People with Asthma, and the Children and Adolescents’ Access to Primary Care Physician measures require two years of continuous enrollment and were reportable for the first time for HEDIS 2017.

Magellan Complete Care improved on all measures for which we were able to report for both years.

>Adults’ Access to Preventive/Ambulatory Health Services (Total),
  HEDIS 2016=75.98, HEDIS 2017=77.29

>Child and Adolescent Access to PCPs (12-24 months),
  HEDIS 2016=NR, HEDIS 2017=NR. Magellan Complete Care enrollees begin at age 5, due to the need for a SMI diagnosis which is not clinically relevant until age 5.
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GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

>Child and Adolescent Access to PCPs (25 months-6 years),
HEDIS 2016=NR, HEDIS 2017=64.29

>Child and Adolescent Access to PCPs (7-11 years),
HEDIS 2016=NR, HEDIS 2017=70.55

>Child and Adolescent Access to PCPs (12-19 years),
HEDIS 2016=NR, HEDIS 2017=66.26

>Medication Management for People with Asthma (75% - Total),
HEDIS 2016=NR, HEDIS 2017=52.22

>Controlling High Blood Pressure,
HEDIS 2016=39.17, HEDIS 2017=56.20

>Comprehensive Diabetes Care – HbA1c Control (<8%),
HEDIS 2016=7.50, HEDIS 2017=39.17

>Follow-up after Hospitalization for Mental Illness (7 day),
HEDIS 2016=26.18, HEDIS 2017=27.30

>Initiation & Engagement of Alcohol and Other Drug Dependency Treatment (Initiation –Total),
HEDIS 2016=49.91, HEDIS 2017=50.93

>Antidepressant Medication Management – Acute Phase, HEDIS 2016=46.74, HEDIS 2017=49.05

>Adherence to Antipsychotic Medications for Individuals with Schizophrenia, HEDIS 2016=52.01,
HEDIS 2017=67.78

For HEDIS 2017 (based on 2016 data), Magellan Complete Care met or exceeded the 50th percentile for four of the measures listed in this SRC>>. Of note, Magellan Complete Care met or exceeded the 90th percentile in two measures critical for management of SMI, meaning that on both of these measures, our performance exceeded that of 90-percent of all Medicaid health plans, none of which are composed entirely of Medicaid enrollees with SMI. These included:

>Initiation of Alcohol and Other Drug Dependence Treatment (Initiation – Total)
>Medication Management for People with Asthma (75 percent - Total)

We met the 75th percentile for Adherence to Antipsychotic Medications, which is particularly relevant for our enrollees living with SMI. We met the 50th percentile for Controlling Blood Pressure, which is critical from a clinical outcomes perspective.

Among the measures below the 50th percentile, all measures for which we had at least two years of reported rates, improved. The percentage point <<increase>> for each measure when comparing HEDIS 2016 to HEDIS 2017 is captured in parentheses:

>Follow-Up after Hospitalization for Mental Illness (increase=1.12 percent)
>Antidepressant Medication Management (Effective Acute Phase) (increase =2.31 percent)
Adults’ Access to Preventive/Ambulatory Health Services (increase = 1.31 percent) Comprehensive Diabetes Care HbA1c Control (increase = 31.67 percent)

Child and Adolescent Access to PCPs was also below the 50th percentile. As stated earlier, the CAPS measures have only one year of performance available (HEDIS 2017) due to the continuous enrollment period so comparative rates are not available to assess improvement.
Evaluation Criteria:

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, for the HEDIS performance measures included in this submission requirement.

2. The extent to which the respondent exceeded the national mean and applicable regional mean for each quality measure reported and showed improvement from the first year to the second year reported.

Score: This section is worth a maximum of 160 raw points with component 1 worth a maximum of 10 points and component 2 worth a maximum of 150 points as described below:

Exhibit A-4-a-1, General Performance Measurement Tool, provides for seventy-two (72) opportunities for a respondent to report prior experience in meeting quality standards (twelve (12) measure rates, three (3) states each, two (2) years each).

For each of the measure rates, a total of 10 points is available per state reported (for a total of 360 points available). The respondent will be awarded 2 points if their reported plan rate exceeded the national Medicaid mean and 2 points if their reported plan rate exceeded the applicable regional Medicaid mean, for each available year, for each available state. The respondent will be awarded an additional 2 points for each measure rate where the second year’s rate is an improvement over the first year’s rate, for each available state.

An aggregate score will be calculated and respondents will receive a final score of 0 through 150 corresponding to the number and percentage of points received out of the total available points. For example, if a respondent receives 100% of the available 360 points, the final score will be 150 points (100%). If a respondent receives 324 (90%) of the available 360 points, the final score will be 135 points (90%). If a respondent receives 36 (10%) of the available 360 points, the final score will be 15 points (10%).

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 SRC# 7 – HEDIS Measures (Statewide):

In addition to providing HEDIS measure data, describe any instances of failure to meet HEDIS or Contract-required quality standards for the measures listed below and actions taken to improve performance. Describe actions taken to improve quality performance when HEDIS or Contract-required standards were met, but improvement was desirable.

- Adults’ Access to Preventive/Ambulatory Health Services (Total);
- Child and Adolescent Access to PCPs (all 4 age bands reported as separate rates);
- Medication Management for People with Asthma (75% - Total);
- Controlling High Blood Pressure;
- Comprehensive Diabetes Care – HbA1c Control (<8%);
- Follow-up after Hospitalization for Mental Illness (7 day);
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation – Total);
- Antidepressant Medication Management – Acute Phase; and
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia.

Response:

OVERVIEW

As the current serious mental illness (SMI) specialty plan, Magellan Complete Care began accepting enrollees living with SMI for delivery and management of fully integrated physical health and behavioral health care in July 2014. Our SMI enrollees who came into the health plan at its inception were not previously in a comprehensive physical and behavioral managed care plan. As a result, these enrollees were not as familiar or comfortable with the concepts of comprehensive integrated care management. This resistance to engagement and compliance is well known for individuals with SMI.

Recognizing these population characteristics, Magellan Complete Care has developed an SMI-specific approach to targeted interventions, placing heavy initial emphasis on initiating engagement, identifying enrollee risks, developing individual and population-wide plans for management, and beginning the process of continually improving outcomes for enrollees. We have also placed specific focus on clinical risks that are known to be higher in SMI populations. That includes issues of access and conditions tied to many of the metrics of focus in this response. Our own internal analyses of our enrollees shows the much higher rates of chronic illnesses among our population, which require an even more concerted effort to target outcome improvements for these conditions. Our enrollees have diabetes incidence rates that are 2.6 times higher than in the general Medicaid population. They experience hypertension at 2.2 times and asthma at 1.6 times the rate in the general Medicaid population. Those rates are elevated in part by the effects of psychotropic medications and higher rates of smoking. Our enrollees also have higher rates of substance use disorder (16 percent) and lower rates of primary care utilization, although Magellan Complete Care enrollees are engaged with primary care at more than double the rate of the general SMI population.

All of Magellan Complete Care’s enrollees are living with at least one SMI, while 50 percent also have at least one physical health comorbidity and more than 30 percent have two or more physical
health comorbidities. Engagement in prevention and wellness programs, as well as more intensive forms of care management, pose additional challenges for individuals with SMI since many of our enrollees also experience housing and food insecurity, unemployment, and incarceration. Recognizing the issues posed by the SMI population, Magellan Complete Care has developed numerous targeted programs and interventions in addition to quality monitoring, data capture, and management aimed at taking advantage of multiple enrollee touchpoints for engagement to drive improved outcomes.

Magellan Complete Care’s efforts to enhance engagement and adapt to the unique characteristics of the SMI population have yielded results. Though some of our quality and outcome metrics may not currently meet AHCA’s minimum 50th percentile target for National Medicaid, we can report that all HEDIS measures listed within this SRC reported for HEDIS 2016 and HEDIS 2017 have improved. This improvement is not limited to the HEDIS measures listed within this SRC. Rather, this level of improvement is indicative of the effort Magellan Complete Care has invested in quality initiatives in 2016, which has yielded improvement in 90 percent of the 30 measures reportable to AHCA in 2017. Furthermore, the level of improvement per measure is on average seven percentage points per measure. As a basis for comparison, we analyzed the HEDIS scores for the top three Florida managed Medicaid plans for HEDIS 2016 versus HEDIS 2017 using Quality Compass data for the same 30 measures. Competitor measures with a NR (not reportable) designation for either year were excluded from the count. Comparative performances was as follows:

> Format of the following data: Florida MMA Plan, number and percentage of measures improved, average percentage point improvement per measure:
>> Magellan Complete Care of Florida, 27 of 30 (90 percent) measures improved, <<6.67 average per measure point improvement>>
>> Wellcare of Florida, 16 of 30 (53 percent) measures improved, 0.95 average per measure point improvement
>> Sunshine Health Plan, 15 of 28 (54 percent) measures improved, 1.46 average per measure point improvement
>> Amerigroup Florida, 16 of 30 (53 percent) measures improved, -0.12 average per measure point improvement

The 30 measures included in this analysis are outlined in [General SRC #07, Attachment 1: HEDIS Improvement 2016-2017].

We monitor and act on our clinical outcomes data, in addition to our HEDIS measures, and are achieving reductions in inpatient utilization, ER costs, and polypharmacy, as well as increases in total hospital days avoided. We have robust systems for quality and outcomes improvement and are committed to continuing these trends of improved care management and enrollee outcomes for this complex and vulnerable population.

CRITERIA 1: THE EXTENT TO WHICH THE DESCRIBED EXPERIENCE DEMONSTRATES THE ABILITY TO IMPROVE QUALITY IN A MEANINGFUL WAY...
Magellan Complete Care first received enrollees as a managed Medicaid specialty plan for individuals living with serious mental illness (SMI) starting on July 1, 2014. Our HEDIS performance for reporting years 2015, 2016 and 2017 (for the service period 7/1/14 – 12/31/16) is provided below for all of the measures identified in this SRC, and benchmarked against NCQA’s
2016 Quality Compass Medicaid, All Lines of Business 50th percentiles. Because of our partial year of operation in 2014, only HEDIS Follow up after Hospitalization is reportable for HEDIS 2015. Furthermore, the HEDIS Medication Management for People with Asthma, and the Children and Adolescents’ Access to Primary Care Physician measures require two years of continuous enrollment and were therefore reportable for the first time for HEDIS 2017.

>Adults’ Access to Preventive/Ambulatory Health Services (Total), HEDIS 2015=NR, HEDIS 2016=75.98, HEDIS 2017=77.29*

>Child and Adolescent Access to PCPs (12-24 months), HEDIS 2015=NR, HEDIS 2016=NR, HEDIS 2017=NR. Magellan Complete Care enrollees begin at age 5, due to the need for a SMI diagnosis, which is not clinically relevant until age 5.

>Child and Adolescent Access to PCPs (25 months-6 years), HEDIS 2015=NR, HEDIS 2016=NR, HEDIS 2017=64.29

>Child and Adolescent Access to PCPs (7-11 years), HEDIS 2015=NR, HEDIS 2016=NR, HEDIS 2017=70.55

>Child and Adolescent Access to PCPs (12-19 years), HEDIS 2015=NR, HEDIS 2016=NR, HEDIS 2017=66.26

>Medication Management for People with Asthma (75 percent - Total), HEDIS 2015=NR, HEDIS 2016=NR, HEDIS 2017=52.22

>Controlling High Blood Pressure, HEDIS 2015=NR, HEDIS 2016=39.17, HEDIS 2017=56.20*

>Comprehensive Diabetes Care – HbA1c Control (<8 percent), HEDIS 2015=NR, HEDIS 2016=7.50, HEDIS 2017=39.17*

>Follow-up after Hospitalization for Mental Illness (7 day), HEDIS 2015=15.90, HEDIS 2016=26.18 increase, HEDIS 2017=27.30*

>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation –Total), HEDIS 2015=NR, HEDIS 2016=49.91, HEDIS 2017=50.93*

>Antidepressant Medication Management – Acute Phase, HEDIS 2015=NR, HEDIS 2016=46.74, HEDIS 2017=49.05*

>Adherence to Antipsychotic Medications for Individuals with Schizophrenia, HEDIS 2015=NR, HEDIS 2016=52.01, HEDIS 2017=67.78*

*= year over year improvement

For HEDIS 2017 (based on 2016 data), Magellan Complete Care met or exceeded the 50th percentile for 4 of the measures listed in this SRC. Of note, Magellan Complete Care met or exceeded the 90th percentile in two measures critical for management of SMI, meaning that on both of these measures, our performance exceeded that of 90 percent of all Medicaid health plans, none of which are composed entirely of Medicaid enrollees living with SMI. These included:
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

>Initiation of Alcohol and Other Drug Dependence Treatment (Initiation – Total)
>Medication Management for People with Asthma (75 percent - Total)

We met the 75th percentile for Adherence to Antipsychotic Medications, which is particularly relevant for our enrollees living with SMI. We met the 50th percentile for Controlling Blood Pressure, which is critical from a clinical outcomes perspective. Among the measures below the 50th percentile, all measures for which we had at least two years of reported rates, improved. The percentage point increase for each measure when comparing HEDIS 2016 to HEDIS 2017 is captured in parentheses:

>Follow-Up after Hospitalization for Mental Illness (increase=1.12 percent)
>Antidepressant Medication Management (Effective Acute Phase) (increase =2.31 percent)
>Adults’ Access to Preventive/Ambulatory Health Services (increase =1.31 percent)
>Comprehensive Diabetes Care HbA1c Control (increase =31.67 percent)

Child and Adolescent Access to PCPs was also below the 50th percentile. As stated earlier, the CAPS measures have only one year of performance available (HEDIS 2017) due to the continuous enrollment period; so comparative rates are not available to assess improvement.

As noted in the introduction, significant improvements were made across a broader set of HEDIS and CHCUP/EPSDT measures. Across 30 reportable HEDIS measures, which include those listed in this SRC, 27 (90 percent) improved when comparing HEDIS 2016 against HEDIS 2017, see [General SRC #07, Attachment 1: HEDIS Improvement 2016-2017]. Additionally, CHCUP/EPSDT participation, CHCUP/EPSDT screening, and Preventive Dental Services (PDENT) also improved. Our goal at Magellan Complete Care is to meet and exceed HEDIS and CHCUP/EPSDT benchmarks for our enrollees through continual improvement year over year. Individuals with SMI are known to experience much poorer health outcomes and experience much shorter lifespans than individuals without SMI. We are committed to demonstrating the value of a fully integrated health plan solution to reverse those trends.

The clinical and related needs of our enrollees living with SMI are extensive. SMI populations are often hard to consistently engage, and when analyzing our entire Florida enrollee population against the HEDIS algorithms in 2016, we found that more than 70 percent of our enrollees (32K of 44K enrollees) had at least one gap in care mid-year, with the majority of enrollees showing multiple gaps in care. In addition to presenting with higher physical and behavioral health acuity levels, we have identified additional challenges linked to SMI in our population, including housing instability and a higher incidence of homelessness. Our internal analysis shows that relative to the national homelessness average of 18 per 10,000, our SMI enrollee homelessness rate is 200 per 10,000 individuals. Many of our enrollees also experience unstable housing, making it difficult to ensure that addresses and other contact information are accurate for purposes of closing gaps in care.

****Trade secret as defined in Section 812.081, Florida Statutes****
By the end of 2016, we had:

****Trade secret as defined in Section 812.081, Florida Statutes****
Though Magellan Complete Care has shown continual improvement in key AHCA metrics and is committed to continuing that trend, we endorse the University of Southern Florida’s recommendations that enrollees living with SMI require intensive community-based and specialized services (citation: “Access, Integration and Quality of Care for Individuals with Serious Mental Health Challenges Enrolled in Florida’s Managed Medical Assistance Program: Project #3"
Final Report Deliverable #3.4", University of Southern Florida, June 21, 2016.). Of note, the USF research indicates that it is unrealistic for a plan that works specifically with enrollees living with SMI to generate similar performance levels relative to Florida-based plans supporting a more traditional Medicaid enrollee population (primarily TANF) or national standards that do not recognize the low starting point for engagement and management, and the unique care complexities and management requirements of individuals living with SMI.

We have invested the time, effort, and resources to understand our enrollee population, and we have built and implemented a comprehensive program that will continue to improve given our commitment to program outcome monitoring and measurement for our enrollees who are living with SMI. As our data shows, Magellan Complete Care is fully, and aggressively committed to improved HEDIS, AHCA and other outcomes for our enrollees. Our model is consistent with the USF findings that enrollees with SMI require intensive community-based and specialized services.

While many of our clinical programs are aligned with that recommendation, to further bolster our capabilities, Magellan Complete Care is partnering with Shared Health, a wholly-owned subsidiary of Blue Cross Blue Shield of Tennessee with 24 years of experience covering 1.3 million members. Magellan Complete Care is leveraging Shared Health’s expertise to bring a greater focus to sub-populations through data-driven analyses and a more developed community-based outreach strategy. Shared Health has developed many algorithms through their population health approach to identify health disparities and focus specifically on sub-populations. Additionally, Blue Cross Blue Shield of Tennessee has a rich history of working within the communities they serve and conducts greater than 500 community events a year to reach their Medicaid population across the state. An important area of focus for Magellan Complete Care in continuing to achieve population health improvements is to leverage similar data-driven strategies to create tailored programs and to increase our community presence to reach a greater percentage of our enrollees.

Magellan’s partnership with Shared Health began in 2016, as we partnered with their organization to successfully bid for the managed Medicaid Long Term Services and Supports (LTSS) contract in the Commonwealth of Virginia. Magellan Complete Care of Virginia was awarded that contract and has collaboratively been working with Shared Health for the past year to leverage their Medicaid expertise to build to the systems, frameworks, and strategies to successfully launch their plan as of August 1 of this year. In addition to their collaboration with Magellan Complete Care of Virginia, Shared Health has also joined the Magellan Complete Care team as a consultative partner in developing our population health management framework, and as an expert advisor for HEDIS quality improvement.

Our quality strategies continue to be successful. Based on claims data submitted through June 30, 2017, our in-period rates for HEDIS 2018 show that 29 of 36 (81 percent) measures are improved as compared to this same point last year [General SRC #07, Attachment 1: HEDIS Improvement 2016-2017]. Magellan Complete Care believes in the promise of improved outcomes for both physical and behavioral health through a fully integrated managed care model for enrollees with SMI, and we are committed to demonstrating its value.

CRITERIA 2: THE EXTENT TO WHICH THE DESCRIBED EXPERIENCE DEMONSTRATES THE ABILITY TO IMPROVE QUALITY IN A MEANINGFUL WAY...

For HEDIS 2017 (based on 2016 data), Magellan Complete Care met or exceeded the 50th percentile for 4 out of 8 reportable measures listed in this SRC. Of note, Magellan Complete Care met or exceeded the 90th percentile in two measures critical for management of SMI, meaning
that on both of these measures, our performance exceeded that of 90 percent of all Medicaid health plans, none of which are composed entirely of Medicaid enrollees with SMI. These included:

> Initiation of Alcohol and Other Drug Dependence Treatment (Initiation – Total)
> Medication Management for People with Asthma (75 percent - Total)

We met the 75th percentile for Adherence to Antipsychotic Medications, which is particularly relevant for our enrollees living with SMI. We met the 50th percentile for Controlling Blood Pressure, which is critical from a clinical outcomes perspective.

Although not cited in this SRC, other measures reportable to AHCA for which we met or exceeded the 50th percentile for HEDIS 2017, as compared to 2016 Quality Compass benchmarks are listed below. <<Every measure we reported for two years improved>>.

> Metabolic Monitoring for Children and Adolescents on Antipsychotics, HEDIS 2015=NR; HEDIS 2016=31.21 percent; HEDIS 2017=35.96 percent*, 75th percentile

> Cardiovascular Monitoring for People with CV Disease and Schizophrenia, HEDIS 2015=NR; HEDIS 2016=NR; HEDIS 2017=88.33 percent*, 75th percentile

> Annual Monitoring for Patients on Persistent Medications Total, HEDIS 2015=NR; HEDIS 2016=89.54 percent; HEDIS 2017=90.70 percent*, 75th percentile

> Chlamydia Screening in Women, HEDIS 2015=NR; HEDIS 2016=60.19 percent; HEDIS 2017=63.62 percent*, 75th percentile

> Diabetes Monitoring for People with Diabetes and Schizophrenia, HEDIS 2015=NR; HEDIS 2016=66.25 percent; HEDIS 2017=70.21 percent*, 75th percentile

*= year over year improvement

The broad focus of our HEDIS initiatives in 2016 described earlier in this response, which targeted all Magellan Complete Care enrollees with at least one gap in care, drove improvements in all measures cited in this response, including those measures for which we met the AHCA benchmarks. The significant level of resource we have invested in HEDIS and CHCUP/EPSDT quality initiatives has been inclusive of all enrollees with at least one gap in care, which constitutes 70 percent of our population at any point in time. Magellan Complete Care believes in the promise of improved outcomes for both physical and behavioral health through a fully integrated managed care model for enrollees with SMI, and we are committed to demonstrating its value.
Evaluation Criteria:

1. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way and to successfully remediate all failures for the HEDIS performance measures included in this submission requirement.

2. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way even when HEDIS or Contract-required standards were met, but improvement was desirable, for the HEDIS performance measures included in this submission requirement.

Score: This section is worth a maximum of 10 raw points with each component worth a maximum of 5 points each.
The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

Robert, a 50-year-old man, was diagnosed with chronic obstructive pulmonary disease (COPD) five (5) years ago. His symptoms have been worsening recently, and he has presented at the emergency department three (3) times during the past thirty (30) days. Robert previously smoked twenty-five (25) cigarettes per day for thirty (30) years, but cut down to ten (10) cigarettes per day after his first COPD exacerbation two (2) years ago. He has attempted to quit smoking on several occasions without any success. Robert is prescribed several regular medications for his COPD, as well as for hypertension and hypercholesterolemia. He is pre-diabetic and obese with a BMI of 35. His last appointment with his specialist was ten (10) months ago. Robert has difficulty taking his medications regularly, as he is sometimes unable to get his prescriptions in his rural community and he lacks transportation. After his last visit to the emergency department, Robert was prescribed oxygen treatments and a new medication; however, he has not filled these orders. Robert lives with his 15-year old son and is a single parent. Robert and his son have been on Medicaid for the last four (4) years since he lost his job. Robert has been a member of the plan since December 2016.

The respondent shall describe its approach to coordinating care for an enrollee with Robert’s profile, including a detailed description and workflow demonstrating notable points in the system where the respondent’s processes are implemented:

a. New Enrollee Identification;
b. Health Risk Assessment;
c. Care Coordination/Case Management;
d. Service Planning;
e. Discharge/Transition Planning;
f. Disease Management;
g. Utilization Management; and
h. Grievance and Appeals.

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

Response:

OVERVIEW: MAGELLAN COMPLETE CARE’S OVERALL APPROACH TO COORDINATING CARE FOR AN ENROLLEE WITH ROBERT’S PROFILE
Magellan Complete Care approaches Care Coordination/Case Management (CC/CM) according to a pathway that begins with new enrollee identification and flows through intake and engagement, health risk assessment (HRA), service planning, care planning, discharge/transition planning, disease management (DM), utilization management (UM), grievance and appeals, and ongoing quality monitoring and evaluation. Florida Medicaid enrollees, like Robert, have higher healthcare utilization due to the presence of multiple chronic conditions. This challenges Magellan Complete Care in the best sense to develop, implement, and enhance CC programs (including
UM and CM programs) that fit this reality – and at the same time focuses on taking care of Robert; and enrollees like him.

As the Serious Mental Illness (SMI) Specialty Plan, we engage our enrollees using a flexible, person-centered approach ranging between less intensive to very high touch engagement; customized to the specific, often complex needs of individuals with SMI, serious emotional disturbance (SED), substance use disorders (SUD), and often co-occurring illnesses and comorbid chronic physical health conditions. We offer access to specially trained clinical staff 24 hours every day. Consistent with our daytime staff, our after-hours CareLine staff are specially trained in triaging calls and answering questions from enrollees who have SMI, SUD, and SED, as well as physical health issues.

Robert’s vignette may be fictional, but it resonates in a very real way with Magellan Complete Care. This is not a unique situation for our enrollees, who count on us for our partnership, assistance, and support with all aspects of the CC/CM process. Robert presented with multiple concerns and problems ranging in priority and severity. The Magellan Complete Care CC/CM team partnered with Robert to sort out and address each area of concern and maximize his strengths. We were privileged to help Robert through his challenges. We took his circumstances as seriously as he did and went the extra mile to support him and his son; assuring that our partnership was supportive, seamless, and results-oriented as possible.

We focus our efforts on integrating behavioral and physical health services, and psychosocial supports to holistically address each of Robert’s various, separate, yet related needs. We not only focus on partnering with Robert to meet traditional behavioral and physical health needs, but also explore the services and supports that Robert may need in addressing social determinants of health, including assisting him in parenting activities for his son. We ask Robert what is important to him at all times. To that end, Magellan Complete Care has well-designed and effectively operating programs and processes to make a meaningful difference in Robert’s life and those like him. For Robert’s vignette, we demonstrate examples and application of Magellan Complete Care’s core programs and processes, including the following:

- a. New Enrollee Identification
- b. Health Risk Assessment
- c. Care Coordination / Case Management
- d. Service Planning
- e. Discharge / Transition Planning
- f. Disease Management
- g. Utilization Management;
- h. Grievance and Appeals; and
- i. Quality Performance* (including HEDIS and Gaps in Care) – *Magellan Complete Care’s addition

Throughout our response that follows, we stayed focused on completely answering each of the seven Evaluation Criteria. In addition, we include the notable points in the system with three asterisks (***).
CRITERIA 1: THE ADEQUACY OF THE RESPONDENT’S APPROACH IN ADDRESSING THE FOLLOWING:

1.a. Identification Processes for Enrollees with Complex Health Conditions or Who Are in Need of Care Coordination; and ***A. New Enrollee Identification

In 2016, Robert, a 50-year old male, was diagnosed with worsening chronic obstructive pulmonary disease (COPD). He was auto-assigned by AHCA to Magellan Complete Care’s SMI Specialty Plan and received on AHCA’s X12-834 enrollment file. Magellan Complete Care loads AHCA’s enrollment file daily into CAPS, our eligibility system. We also received the COPD “MC Special Conditions Indicator” for Robert on AHCA’s daily panel roster file. Both the enrollment file and panel roster file data are fed downstream to a variety of systems including TruCare, our care management system and viewable by our Health Services team. Our sophisticated technology infrastructure is flexible so our operational teams can quickly access and leverage information to assist Robert with his needs. Enrollees such as Robert who have complex physical, behavioral, and social needs are identified appropriately and quickly to ensure timely engagement and assistance by the care coordination/case management (CC/CM) team.

Integrated Care Case Manager (ICCM) selection and assignment, including protocols to ensure new enrollees are assigned to an ICCM, occur immediately. All new enrollees are prioritized for outreach via a Welcome Call. Enrollees with high risk indicators, like Robert, receive outreach by an ICCM.

Once Robert was loaded into CAPS an automated process runs issuing Robert a Magellan Complete Care Medicaid Welcome Kit including the Member Handbook, Provider Directory, ID card, and PCP assignment. This automated process ensures that new enrollee materials are sent within five days of receipt of AHCA’s X12-834 enrollment file.

At any point when Robert contacted the Magellan Complete Care Customer Service team or CC/CM staff, the Magellan Complete Care team verified Robert’s identity to ensure privacy and for obtaining appropriate consent and privacy authorizations. For Robert, the Magellan Complete Care “Member Journey” always included a warm hand off from the Customer Service team to the assigned CC/CM staff to ensure immediate follow up. Attention to Robert’s Special Conditions Indicator was prioritized and he was referred to the Complex Case Management (CCM) program. The Regional Clinical Manager assigned Robert to an Integrated Care Case Manager (ICCM), “Evelyn”, for further assessment and follow up. During this assessment, information was collected from Robert about his health status, imminent challenges, and anything else he wanted to contribute.

1.B. Description of the Sources of Data/Information That Would Be Utilized in the Assessment Process, Including Timeframes for Completion

As a Specialty Plan, we engaged Robert using a high touch, person-centered approach, customized to his specific, complex needs, taking into account his social, as well as physical and behavioral health, and the social determinants of health. This also included a review of social factors and the physical condition of Robert’s environment. Other sources of data/information used in the assessment process include historical claims data, HRA data, census track data, utilization data, and pharmacy data, if available. The outputs of the data result in a risk score and identification of care gaps.

Since Robert’s risk stratification triggered as a High Risk level, he was assigned to Evelyn, who contacted Robert by phone to set up a face-to-face visit to conduct an HRA and a more
comprehensive health assessment. For High Risk enrollees like Robert, the HRA and a comprehensive Initial Clinical Assessment is conducted along with other branching condition specific assessments if needed. Robert agreed to meet Evelyn face-to-face at his home where Evelyn conducted the HRA and Initial Clinical Assessment within 30 days of his identification of High Risk.

This timeframe was in compliance with NCQA CCM assessment timeframe standards. Evelyn immediately determined that Robert not only had multiple physical and behavioral health conditions, but also several social issues. Evelyn confirmed Robert’s assignment to a High Risk stratification level.

Methods to screen Robert and identify risk(s) included the HRA process and scoring, utilization data, and Rx reports and patterns, direct referral, having special high-risk conditions, or social dynamics. Enrollees that have multiple chronic conditions, or are medically, behaviorally, or socially unstable, are designated as High Risk or Ultra High Risk, and receive complex and enhanced CC services. The CC team was also focused on educating Robert to identify triggers and to seek healthier ways to avoid health conditions escalating to a crisis level. The CC team encouraged Robert to understand that good health improves functioning and reduces exacerbation of his health symptoms. Robert was also encouraged to work closely with his providers to increase services, if considered medically necessary, to prevent hospitalization. In Robert’s situation, with his written permission, Evelyn communicated with both his primary care provider (PCP) and pulmonologist to ensure Robert’s plan of care and needs were communicated and addressed appropriately.

Magellan Complete Care has developed a stratification and segmentation model that is uniquely designed for our complex SMI population that uses data from many sources. For Robert, there were critical components of information that can only be provided by self-report. This includes Robert’s health habits, living situation, and social connectedness, which are all important predictors of outcomes for Robert. Our Model of Care utilizes clinical judgment and team inputs to assist with appropriate risk level assignment. In Robert’s situation, the face-to-face assessment was carried out within the first 30 days or less of his identification as complex, High Risk and referred to the complex case management program. The face-to-face assessment was essential to effectively and accurately determine Robert and his 15-year old son’s needs.

The cultural diversity of our employee team also allowed us to understand the specific needs that Robert had particular to the region he lives in which is a remote area. Our Model of Care for Robert reinforced and prioritized recovery, stabilization, health maintenance, optimal safety and quality, and independence through partnering with him, his natural supports, and providers.

Our recovery expertise and sound evidence-based practice approaches have been utilized in the development of our integrated behavioral health and primary care program approaches. The elements of our approach to the CC/CM of high need enrollees like Robert, include identifying his health risks, biopsychosocial and chronic care needs, assessment, designing an individualized plan of care to proactively address his most immediate needs, engaging the Interdisciplinary Care Coordination Team (ICCT), and proactively identifying and monitoring Robert’s changes or triggers that might destabilize his condition.
Magellan Complete Care has developed targeted screenings, assessments, and interventions specifically focused on the types of conditions and problems Robert faced each and every day, including:

- Specialized high risk complex diseases, including COPD, hypertension, and diabetes
- Population health and DM approaches focused on diabetes and hypertension
- Health and wellness approaches focused on smoking cessation, weight management, and stress reduction
- Care transitions
- Excess ER utilization

Magellan Complete Care’s innovative predictive modeling tools are a critical element for ongoing stratification and segmentation of enrollees, like Robert, for CC/CM interventions. We use a customized version of the ImpactPro predictive modeling tool modified to capture behavioral health, social support factors, and other issues that are unique to population living with SMI, enrollees like Robert, and important for identifying risks. Our predictive modeling tools use data from multiple sources (claims, utilization, gaps in care, HRA, Rx, etc.), and are specifically focused on enrollees like Robert, demonstrating increasing risks for inappropriate utilization including:

- Inappropriate ER utilization in place of PCP or specialist visits, including a pulmonologist
- Potentially preventable events
- Inappropriate or lack of ancillary service utilization, including oxygen equipment obtainment, other supply needs, transportation,
- Patterns that may indicate destabilization, including food insecurity, lack of prescription obtainment, medication adherence, obesity, etc.

In Robert’s case, our goal was to identify and engage him in self-management and support before indicators of decomposition translated into poor clinical outcomes or inappropriate use of services. In addition to the more traditional predictive modeling described above, Magellan Complete Care recognizes the complex drug regimen that Robert was on, and the many potential issues that can arise from drug-drug, drug-food, and drug-environment interactions. For that reason, we performed regular analyses of pharmaceutical data through Magellan Rx Management (Magellan Rx). These analyses focused on identifying patterns of inappropriate or harmful subscribing; risks of drug-drug interactions; and, under- and over-utilization.

Robert’s medication list was reviewed by the team at the ICCT meeting where expert advice was provided and then recommendations were shared with Robert’s PCP; with Robert’s consent. This analysis of Robert’s medications and predictive modeling was used as part of our Medication Therapy Management (MTM) program to work with the CC/CM team, providers, and Robert to educate on appropriate use and to make changes to Robert’s therapy regimens. This information was particularly important and useful in identifying increased risk for Robert due to unfilled required prescriptions, risks of drug-drug interactions, or inappropriate use.

Magellan Complete Care’s Enterprise Data Warehouse collects information that included Robert’s clinical data, authorizations, claims and encounters, provider-based information, membership-related data, financial information, and products and services data. In addition to Magellan Complete Care’s analytic capabilities, there was no substitution for real-time, face-to-face assessment and interaction with Robert to best engage and obtain the most accurate identification and risk level assignment.
Because of Robert’s ER visits and diagnosis of COPD, he was stratified as High Risk; therefore Evelyn conducted the HRA and comprehensive Initial Clinical Assessment, along with other branching DM/condition specific assessments. The HRA and Initial Clinical Assessment was performed in Robert’s home, accompanied by a visual inspection of the home environment to ensure that Robert’s plan of care could be tracked for positive outcomes.

Evelyn conducted additional, more detailed condition-specific branching assessments based on best practice guidelines and focused on the individualized needs that Robert had, including his COPD and Hypertension. This assessment, problem list creation, and plan of care process is described later in detail within this vignette. Globally, the HRA and Initial Clinical Assessment resulted in Robert’s self-disclosure of his circumstances, including verification of privacy and appropriate consents, review of his COPD, obesity, hypertension, nicotine dependence, stress as a single parent, and/or lack of mobility. The branching assessments included COPD, hypertension, and cardiovascular disease assessments.

b. Health Risk Assessment
The HRA is administered within 30 days or sooner of enrollment for new enrollees; on an as needed basis when significant changes in condition arise; annually for existing enrollees; and for re-enrollees if they have been out of the plan for more than 30 days. Our HRA is SMI-tailored and identifies key areas of risks and the unique needs of the SMI population who are also presenting with other complex physical and social health needs. In addition to basic clinical information, the information captured includes health habits, living situation, and social connectedness, which are important predictors of outcomes for individuals with SMI.

For Robert, the HRA and Initial Clinical Assessment were completed within 30 days or less of his identification as High Risk and enrollment into our CCM program. An example of some of Robert’s key Initial Clinical Assessment findings revealed the following:

>COPD: Robert had moderate to severe COPD with recent decompensation and ER visits. He smoked 10 cigarettes per day and wanted to stop smoking. Robert had tried to quit smoking several times with no success. When posed the question of trying a different way to stop smoking, Robert was very interested and willing to try something different. Evelyn explained Magellan Complete Care’s Smoking Cessation Program; including the potential use of nicotine replacement along with the Clickotine® program and Smartphone application. Clickotine is a cutting edge digital therapeutics™ solution designed by scientists and doctors to help Robert quit smoking. The program is based on published science, and is personalized via the company’s proprietary Clickometrics adaptive data science platform. Through the powerful combination of science and technology, Magellan Complete Care was able to provide this support to assist Robert to quit smoking and create a healthier life. Clickotine delivers personalized components of the U.S. Clinical Practice Guidelines in a user-friendly app. Features include telephonic coaching, controlled breathing, social engagement, digital diversions, personalized messaging, financial incentives, and medication adherence.

Robert expressed concern regarding using a Smartphone application, yet decided to have his son help with the application if needed. Evelyn explained that she could also help him with the Clickotine application. At the time, Robert had a new order for PRN (when needed) oxygen; however he had not received it and was concerned about getting it due to his smoking status. Robert was using his respiratory medications and carrying out his breathing treatments as ordered. He had new medications that needed to be filled and needed assistance of Evelyn to get
them filled. Robert stated that he did get relief from the PRN use of his breathing treatments. Robert also reported using the ER because he had difficulty in locating a PCP and was in need of a pulmonologist. When posed the question regarding participation in a pulmonary rehab regime, Robert was very interested and willing to try pulmonary rehab to eventually not have to use oxygen.

>High Blood Pressure (Hypertension): Moderate hypertension – Robert was taking anti-hypertensive medication which was keeping his blood pressure at 142/88. Robert was obese and did not always eat healthy. He liked salty and fast food because it was easier and cheaper than cooking. Robert did not like to exercise.

>Pre-diabetes: Robert’s fasting blood sugars and HbA1c had been elevated and he understood that he needed to follow a better diet.

>Hypercholesterolemia: Robert understood that he needed to eat healthier and reduce saturated fat consumption.

>Insomnia: Robert woke frequently during the night and sometimes had trouble falling back to sleep.

>Psychosocial: Robert expressed concern about his son and wanted to make sure his son was attending school; along with being successful in school.

During the face-to-face visit with Evelyn, Robert asked for assistance to find a PCP and pulmonologist and scheduling appointments; as he was unsure about getting his appointments made, scheduled on the same day, and obtaining transportation.

Evelyn assisted Robert by arranging appointments at the local Federally Qualified Health Center (FQHC) where Robert could see a PCP, and where his son could obtain care as well. Evelyn also helped Robert in scheduling a pulmonology appointment at the nearest medical center. Evelyn explained Magellan Complete Care’s Integrated Health Neighborhood approach and reassured him that she and the Clinical team would assist him in finding as many providers and resources within his geographical area. Robert expressed an interest in losing weight and stopping smoking. Evelyn conducted a medication review and adherence assessment along with an assessment of supply and equipment needs. In addition, she assisted Robert in obtaining his new medications and asked him if it was okay to discuss his oxygen therapy order with his PCP before arranging it; due to Robert’s continued smoking and safety concerns while smoking. Robert gave permission for Evelyn to speak with his PCP. Additionally, Evelyn worked with Magellan Complete Care’s Clinical Pharmacist to reconcile any potential negative drug interactions, overuse and/or effectiveness.

1.c. Application of the Respondent’s Case Management Risk Stratification Protocol; and ***C. Care Coordination/Case Management
1.c.1 Health Risk Assessment – New Enrollee and When Significant Changes Occur
We use our analytics and assessment information, clinical judgment, and team input to assign enrollees, like Robert, to a level of CC/CM that is most appropriate based on enrollee need, risk, and complexity. Both the HRA, ongoing clinical assessments, regular data capture, and predictive modeling, allow us to gather in-depth clinical information about enrollees that is used to identify and prioritize both short- and long-term CC/CM needs. The different levels of CC/CM are: Wellness and Prevention, Low, Moderate, High, Ultra High, and Monitor Risk. Each of the CC/CM risk levels provide a different type of intervention and a different level of intensity of the CC/CM services based on enrollee need. Evelyn utilized Robert’s identification and assessment information when developing Robert’s problem list and plan of care.
Magellan Complete Care has designed its CC/CM model around a “no wrong door” approach for our enrollees, like Robert, who are able to access CC/CM services throughout their partnership with our health plan. Robert can be referred for any of the Magellan Complete Care CC/CM at any time. Robert, who experienced a critical event, exacerbation of his illness and complex diagnosis, was treated by us as prime candidate for timely integrated, CCM services. To minimize the time between when Robert’s need was identified and when he received services, we had multiple avenues for him to be considered for CC/CM services, ranging from input from nurses on the telephonic CareLine, to hospital and ER discharge planners, providers, and to Robert’s own self-referral.

Our Analytics team reviewed Robert’s available diagnostic information as well as available claims data to proactively sort Robert’s and the current Magellan Complete Care membership based on prioritized needs whenever possible. One of the alerts coming out of the data analysis for Robert was a predictor for hospitalization in the next 90 days. Due to Robert presenting at the ER three times during a 30 day period and due to his exacerbation of his COPD, Robert was prioritized for assignment and engagement to his primary ICCM, Evelyn, within the CCM program. Our SMI Specialty Plan experience has shown us that many individuals like Robert, who present with multiple chronic physical conditions, are at a higher risk of developing depression and anxiety. Details of the CC/CM program risk levels are described within 1.c.2.

Evelyn assessed and monitored Robert closely for signs or symptoms of a new onset of depression and/or anxiety due to his chronic conditions. An essential element to our CCM approach for Robert was using an individualized assessment and planning process initially focused on his unique needs. For Robert, screening for behavioral health, SUD, social determinants of health, and physical health concerns, began at the time of his enrollment using a standardized HRA, which we have customized, nationally vetted for reliability and reproducibility, and fully-integrated in an expanded Magellan Complete Care Initial Clinical Assessment. Robert experienced a significant change in condition and there was a utilization trigger, therefore an additional HRA was carried out along with a more comprehensive assessment to further assess his needs. This assessment tool is SMI-tailored incorporating key HRA elements, identifying key areas of risks and needs of the SMI population. The core domains of the HRA components include the following:

- Living situation / social determinants of health
- Hospital / office visit history
- Substance use history
- Social activity / social connectedness
- Preventive test history / gaps in care
- Chronic physical and behavioral health condition history and potential for complications and exacerbations of both
- Rating of health
- Medication review and adherence
- Supply and equipment needs.

This HRA, along with additional data, were used to screen Robert, score his level of risk, document those risks and stratify him for assignment to the High Risk CCM and for planned interventions. We also employed enhanced, branching assessments for Robert that covered a broad range of situations and conditions, including COPD, hypertension, diabetes, and other
medical, and psychosocial conditions to broaden the scope of the assessment and to ensure a comprehensive and personalized plan of care. Evelyn had access to Milliman Care Guidelines (MCG) chronic care guidelines, which are evidence-based, nationally recognized guidelines offering current and accurate assessment and care planning information to further augment the assessment and care planning process. For example, Evelyn utilized the COPD, Diabetes, Weight Management, and Hypertension Chronic Care Guidelines when assessing Robert and developing his plan of care.

Robert’s assessments were used to develop his “problem list” where each problem identified is mapped to appropriate goals and interventions; specific, actionable, and measurable.

An example of some of the components of Robert’s problem list were as follows:

> Crisis – COPD exacerbation; unstable respiratory status
> Access and availability – difficulty in accessing health providers; lived in a rural area and required assistance in finding PCP and specialist access
> Adult health promotion – contributing symptom management factors; smoking cessation; weight management; stress reduction; parenting assistance
> Support complex care arrangements – lack of identified support system
> Medications – difficulty in getting prescriptions filled
> Medication adherence – once prescriptions are filled, ensure adherence

Robert’s choice and self-determination is incorporated into his service and care planning. Examples of some of the key domains included in Robert’s Initial Clinical Assessment are as follows:

> Medication adherence
> Assessment of life planning and self-directed care activities
> Physical, psychosocial, cognitive, and functional needs
> Comorbidities
> Cultural needs assessment
> Ability to perform ADLs / functional ability
> PCP and specialists
> Behavioral health and substance abuse screening
> Clinical history, including condition specific issues and medications
> Mental health history and potential for development of depression or anxiety due to a chronic illness
> Long term care (LTC) needs and services currently receiving
> Evaluation of caregiver resources and social supports
> Utilization history
> Fragility
> Supply and equipment needs
> Gaps in care and Quality (HEDIS) gaps.

Robert’s level of complexity of his conditions and presenting symptoms demands that we regularly monitor indicators of his health and stability, as well as utilization patterns and trends, pharmaceutical data, and lab data. Evelyn and the team conducted administrative reviews weekly within the Trucare system to ensure they identified any service utilization that Robert may have
experienced. In addition, they contacted Robert weekly to review the activities and services that he was receiving.

1.c.2 Health Risk Assessment – Ongoing Segmentation/Stratification for Enrollee CC/CM Assignment
For Robert, Evelyn and the CC team monitored, assessed, and reassessed Robert’s needs on an ongoing basis. Along with this assessment process, Magellan Complete Care has licensed ImpactPro to enhance its predictive modeling capabilities to identify the top tier risk population on a monthly basis for possible referral to our CCM program. We have modified ImpactPro to incorporate behavioral health conditions, social support status, and other issues that were unique to Robert, and enrollees like him. ImpactPro assesses Robert’s potential for future utilization, and assigns him a likelihood of hospital admission and other health service utilization based on his previous claims and other data, including his self-reported information. ImpactPro relies on the use of a more robust data set than most models, including:

- Enrollment information (age, gender)
- Medical and behavioral claims (diagnoses, costs of care, events)
- Outpatient pharmacy claims
- Lab results
- Information from clinical systems
- Selected HRA data
- Tracking and trending outcomes through Magellan Complete Care’s proprietary dashboards.

ImpactPro also identifies gaps in care used to improve clinical care and outcomes and mitigate the risk of increased unnecessary utilization. Evelyn and the team were trained in gaps in care and specifically those which were pertinent to Robert’s individual situation. Evelyn reviewed these gaps in care with each contact with Robert and documented the information within the customized template within the TruCare documentation system.

Based on the results of these analyses and ongoing CC/CM activities, enrollees, like Robert, are stratified into several different levels of risk, with the level of support and intervention varying depending on that enrollee’s classification. The CC/CM program risk levels range between Very Low Risk to Ultra High Risk. It is important to note that enrollees are anticipated to move between stratification levels, although our goal is to move toward stabilization and sustainable management of the enrollee’s health. Enrollees “graduate” to less intensive intervention levels as those goals are achieved.

As mentioned, Magellan Complete Care utilized TruCare, the care management system to coordinate care for Robert. TruCare is Magellan Complete Care’s application providing clinical systems support for UM, CM, health promotion, care transitions, DM, and CC tasks. TruCare integrated with our claims processing and provider data applications to enable our clinical staff to assess Robert’s needs, complete his plan of care, and authorize his services.

All contact with Robert was documented in TruCare and notes were made on all elements of the CCM processes and services. Information sent to us by Robert’s providers, facilities, and other treatment teams was uploaded and attached to his record. This provided for a comprehensive tracking of all activities, information, services, treatment plans, discharge plans, etc., related to Robert.
System support for Robert’s case operated seamlessly within TruCare, establishing a single platform for Magellan Complete Care staff across the whole continuum of care (both behavioral and physical), and encompassing all care settings. TruCare effectively tracked Robert’s CCM program participation and case artifacts in one place. When baseline assessments were completed for Robert, the TruCare system provided the ICCM with prompts to create the plan of care for Robert. The assessments and system branching offered intuitive triggers and alerts to assist Evelyn as she was assessing Robert and planning for his care. The system provided a list of recommended problems and interventions for a user to select from when building the individualized plan of care, based on Robert’s assessment responses. The problems and interventions were based on opportunity areas for Evelyn to focus on when supporting Robert. For instance, in Robert’s situation, he responded on the initial assessment that he often forgot to take his medications, a problem of “medications” was recommended for the user to select when building his individualized plan of care.

Evelyn addressed questions about benefits, transportation issues, provider appointments, and issues he had as a parent. With Robert’s consent, Evelyn assisted Robert with his son’s issues, communicated with the appropriate agencies, school, and the son’s health providers when needed, and as authorized. Evelyn and other members of the care team explored services and resources within the Integrated Health Neighborhood to assist and support Robert and his son. The Integrated Health Neighborhood customizes Magellan Complete Care’s Model of Care by region. Magellan Complete Care’s goal is to improve an enrollee’s care, quality of life, and health outcomes can only be achieved within the context of where the enrollee lives – within neighborhoods and communities. The Integrated Health Neighborhood is Magellan Complete Care’s vehicle to drive close collaboration with community partners, allowing us to customize care for Robert, and to provide a seamless, one-stop system of services and supports. The Integrated Health Neighborhood model naturally bridges language and cultural barriers and more effectively and efficiently facilitates access to services to support Robert and families where they live, work and play.

In rural areas, as where Robert resides, the Integrated Health Neighborhood utilizes the latest telehealth and telemedicine techniques to ensure that Robert receives the care and services needed at all times. Robert could access virtual health care applications at local libraries, agencies, and/or health care offices. Within the ongoing segmentation and stratification activities for Robert, all of the described Magellan Complete Care applications interact, including claims processing, enrollee eligibility, benefits, UM data, the plan of care, Robert’s profile containing a summary of his medication list, recent services, risk score, and gaps in care. Clinical reference tools are accessible to Evelyn from within the system, such as UM guidelines and criteria, chronic condition assessment tools and guidelines, medication management tools, and an analytics package (a Magellan Complete Care-customized version of ImpactPro) used in identifying Robert’s conditions, predicting and stratifying risks, reporting gaps in evidence-based care, and monitoring medication adherence. Robert’s continuity of care documents (CCDs), if available, were also displayed to users.

The full clinical team, including CareLine (24-hour nurse advice line) staff, are able to interact with online health information tools from Healthwise™ designed for enrollees like Robert, and used by nurses for guidelines in triaging health symptoms and providing self-care education to Robert. Evelyn utilized the Healthwise information during each of her contacts and face-to-face visits with Robert. Use of the Healthwise information ensured that Evelyn was able to provide evidence-based disease specific health information at all times. In addition, Evelyn had access to MCG
(formerly Milliman Care Guidelines) chronic care guidelines, which are also nationally recognized and evidence-based tools which guided her through the assessment and care planning process.

The CareLine team utilizes the Healthwise tools with special emphasis on the use of the symptom tracker application, which is able to quickly review and assess Robert’s presenting symptoms, offering immediate advice and/or referral assistance to an alternate type of follow up or care.

We see the continuum of care and the support provided to Robert through CC/CM as a fluid treatment pathway, where he can enter at any level and be moved to more- or less-intensive settings, and different levels of CC/CM, as his changing clinical needs dictate. Our active, and regular engagement with Robert allows us to monitor and adjust his plan of care and the intensity of his engagement and support as his health improves or degrades. Moreover, Robert’s progress over time was tracked to measure outcomes on an on-going basis, with modifications made to improve his care based on achievable metrics.

Magellan Complete Care utilizes this detailed understanding, and ongoing study and analysis of enrollees, like Robert, his patterns of utilization, and his outcomes, to develop a robust and uniquely designed segmentation and stratification model that captures data from multiple data sources, and is uniquely tailored to the specific risk factors for our very complex population. This model allows us to assign Robert to the intervention and CC/CM category that is right for him that affords the greatest opportunity for successful engagement with him and to assist him in reaching optimal outcomes.

Enrollees such as Robert who show High Risk for admission within the next 90 days are considered to be at the highest risk, and most in need of immediate CC. Enrollees, who are not at immediate risk of admission are then stratified by the quantity and nature of their disease burden, and routed into the appropriate eligibility pool of either CC, DM, or population health.

In addition to stratifying the risk level of Robert, our Advanced Analytic team also scores Robert his propensity to enroll in case management. Robert had a score with a high propensity to enroll in the CM program. In this way, the operational and clinical teams receive enrollee referrals when the likelihood of engagement is high. Enrollees with low likelihood to enroll in CM are referred to a pool of interventions designed to eradicate barriers.

1.D. Identification of Service Needs (Covered And Non-Covered) and a Description for Service Referral Processes, and ***D. Service Planning;

Robert’s planned interventions are person-centered, individualized, and disease specific. This approach is part of the larger Magellan Complete Care enrollee experience connecting Robert within our end-to-end system and processes. This approach is built upon identifying and closing gaps in care and access to care, bridging language, cultural barriers, service access, and transportation challenges in communities like Robert’s. Evelyn asked Robert regarding any other insurances he had including disability coverage due to his injury. Evelyn coordinated all care and services covered by other payers, including speaking with the payers or providers.

Interventions taken into account were Robert’s psychosocial status and support system. His plan of care included self-management tailored to his health conditions, preferences, and supports, e.g., caregiver support, peer support, Health Guide, and ICCM support. Evelyn prioritized Robert’s problem list and explained to him the importance of getting his worsening symptoms under control first; along with securing reliable transportation; finding a PCP and pulmonologist; and receiving
pulmonary rehab. Evelyn helped Robert obtain his prescriptions. He requested assistance with diet, exercise, smoking cessation, and blood pressure monitoring. Evelyn assessed these specific areas and incorporated them into Robert’s plan of care, including pre-diabetes and high blood pressure diet instructions, nutrition consult, referral to community supports for an exercise group, and MTM. In addition, Evelyn ordered Robert a home blood pressure monitoring system and made sure he knew how to use it by having him demonstrate the technic and record his results. Evelyn collaborated with Robert’s PCP in establishing the best plan for introducing oxygen into Robert’s home and living situation, including arranging for portable oxygen therapy and a referral for pulmonary rehab. Evelyn and the team incorporated problems and goals specifically related to Robert’s son and his health and wellness needs, school, and social supports.

Our CC team ensured that Robert received the services that were best aligned with his plan of care. Robert’s plan of care incorporated combined interventions addressing his son’s care and safety needs. Our Case Managers and Utilization Management Professionals are knowledgeable and have immediate access to Magellan Complete Care’s list of covered benefits and services. Magellan Complete Care staff understood which services required prior authorization and provided Robert, and his care and service providers, with ongoing education in the area of covered benefits and covered services as needed. Evelyn referred Robert to his hard copy and online Member Handbook as an additional resource to find the list of covered services and benefits. Evelyn also educated and referred Robert’s providers to the same benefit and covered service information on the provider portal.

Evelyn and the CC and UM team had knowledge of and access to third party covered services through specific funding sources such as LTC plans and through Florida’s Managing Entities. For Robert, Evelyn was able to assist him in starting the application process for LTC coverage and services when necessary. Evelyn was also able to offer access to non-Medicaid covered services by coordinating with these points of contacts to arrange for the services or treatment. For example, Evelyn worked with Robert to ensure that he did not receive duplicative services from other sources, providers, or agencies. Magellan Complete Care would not cover the duplicative service and the provider who submitted the claim would have received a denial for non-covered services.

If Robert required a service which was not a covered service, the CC team would review the case with the Magellan Complete Care Medical Director and other members of the CC team to determine how Robert could receive the required service. This can be through other resources within the Integrated Health Neighborhood or through referral to an entity who provides the specific service. These may include, but are not limited to, health care providers, behavioral health providers, Florida Assertive Community Teams, Managing Entities, Department of Children and Families, and homeless organizations/coalitions.

The goal was to link Robert with the appropriate service providers to ensure that the providers address Robert’s ongoing needs. Our CC team assisted Robert by coordinating care when his third party carrier coverage had been exhausted or if he required a non-Medicaid covered service. Evelyn assisted the provider in ascertaining authorization for care if needed. Evelyn also supported Robert by identifying other community resources and community-based organizations for obtaining needed care. If the non-covered service was gravely impacting his health status and exacerbating his other health issues, then Magellan Complete Care could have considered a one-time coverage exception for Robert.
Our Florida and national experience has taught us the value of establishing strong linkages, effective collaboration, and clear communication to effectively coordinate services and support assisting enrollees like Robert to reach health and wellness goals. We have established standard operating procedures to address communication with local Medicare Advantage plans and Accountable Care Organizations that address processes and timeframes for sharing information and coordinating care in compliance with the Medicare Improvements for Patients and Providers Act (MIPPA).

Our approach to coordinating Medicaid and Medicare services includes early identification of enrollees who are dually eligible, comprehensive assessment of individual needs and preferences, and effective coordination and planning of services and supports.

1.E. Description of the Interventions and Strategies That Would Be Used to Facilitate Compliance with the Plan of Care, Including Use of Incentives, Healthy Behavior Programs, Etc.

The complexities of managing the SMI population and enrollees like Robert mean that Magellan Complete Care must use all available touch points to assess Robert’s health and deploy targeted interventions. Our Model of Care reinforces and prioritizes recovery, stabilization, health maintenance, optimal safety and quality, and independence by partnering with Robert, his natural supports and providers. Our recovery expertise and sound evidence-based practice approaches are used to develop our clinical program approaches, including best practice protocols related to complex condition management. We continually adjust interventions based on Robert’s evolving needs and circumstances including indications of decomposition, or instability in Robert’s mental or physical health, which can trigger cascading effects.

The elements of our approach to the management and overall plan of care compliance by Robert included: identifying his behavioral and medical health risk and biopsychosocial and chronic care needs; closely monitoring, assessing, and reassessing Robert; designing a plan of care to proactively address his most immediate needs; engaging the ICCT; and, proactively identifying and monitoring Robert’s changes or triggers that might destabilize his illness and intervene early.

Because Robert lives in a rural area, the Magellan Complete Care clinical team explored and employed other more non-traditional ways to assist Robert in meeting his care goals, ensuring compliance with his plan of care, including:

> Arranged for mail order medications

> Arranged for telemedicine and telehealth to be set up and available in Robert’s home to include coaching in the areas of weight management, COPD management, BP monitoring, and access to a respiratory therapist, nutrition therapy, and his home health nurses

> Arranged for Smartphone applications, including Clickotine (smoking cessation) and Cobalt (cognitive behavioral therapy)

Our CC team strived to fully understand why Robert may be in crisis and identify strategies to assist him on the path to higher functioning. The elements of our approach include identifying his health risks, biopsychosocial, and chronic care needs, assessing and reassessing Robert, and designing a plan to proactively address his most immediate needs. Data from our enrollees, like Robert shows the importance of multiple forms of screening on a regular and ongoing basis to determine appropriate adjustment of the plan of care interventions, leading to higher levels of compliance with the plan of care.
To further ensure Robert’s compliance with his plan of care, Evelyn worked with Robert in reducing and eradicating some of the risk factors which were contributing to his worsening COPD, hypertension, and pre-diabetes. Evelyn enrolled Robert into the Healthy Behaviors Weight Management Program to assist him in losing weight and to help him make healthier choices with his nutrition and food intake. Evelyn referred Robert for a nutrition consult that he received at the FQHC on the same day of his PCP visit.

Evelyn also enrolled Robert in Magellan Complete Care’s Smoking Cessation Program which included nicotine replacement and the use of the Clickotine application on his Smartphone. The Clickotine application offered personalized coaching and nudged Robert throughout the day to check in with his smoking cessation program. Evelyn educated Robert and his son on the use of the Clickotine application and Robert was pleased that his son helped him with the application as well. Because of Robert’s potential to develop depression or anxiety due to his multiple physical health conditions, and while he was trying to stop smoking, Evelyn also offered Robert the Cobalt, cognitive behavioral therapy program and application to further assist him in managing his stress and anxiety. The Cobalt Program and application offered Robert evidence-based treatment instead of being placed on an additional medication. Evelyn referred Robert to pulmonary rehab, which immediately helped him achieve his altered respiratory status goals.

Evelyn worked with Robert to create an individualized plan of care and to collaborate on prescriptive interventions. A sample of Robert’s plan of care, which includes a full problem list, goals, and barriers is available in [General SRC #08, Attachment 1: Robert’s Care Plan].

Evelyn worked with Robert to identify a conveniently located PCP and a pulmonologist, scheduled appointments for Robert, and coordinated his transportation needs. Due to Robert’s limited support system, Evelyn arranged for a Magellan Complete Care Health Guide to accompany him to his appointments as additional support. Evelyn coordinated with Robert’s PCP to also ensure HEDIS gaps in care were addressed and to ensure that specialty care referrals and durable medical equipment (DME) orders were ordered and fulfilled.

1.F. Application Of Discharge and Aftercare Planning Protocols That Facilitate a Successful Transition; and ***E. Discharge Planning/Transition Planning;

The Magellan Complete Care Transitions and Emergency Department Follow-Up Program activities are integrated within each level of the CC program. Our program promotes physical and behavioral comprehensive care transition management both proactively while an enrollee, like Robert, is enrolled in the CCM program, and when his ER visit occurred. The ICCM, Utilization Management Professional (UMP), and Care Transitions Health Guide, worked collaboratively and were actively involved with Robert at times of care transition, including, but not limited to, planned and unplanned admissions, frequent ER visits, transfer to other institutions and facilities, and worked in conjunction with Robert’s Health Guide to ensure plan of care communication between all providers and the CC team.

Discharge planning is a key element of the Care Transitions and Emergency Department Follow-Up Program and specifically focused on safely transitioning Robert from an inpatient admission in an acute care, skilled nursing facility, or ER back to home, community setting, or another site of care. Discharge planning is carried out by Magellan Complete Care’s UMP staff and Care Transition Health Guides who actively monitor inpatient admissions and have established relationships with inpatient and community-based setting staff. The initial evaluation for discharge
planning begins at the time of notification of ER visit and/or inpatient admission and continues along the entire continuum of care, up to and including getting Robert safely placed back home.

In Robert’s situation, each time he visited the ER, our team proactively engaged him as soon as they were aware of his ER visit. Since Robert had multiple ER visits and very complex needs, the CC team closely monitored him and carried out each of the areas of the assessment and care planning process. For Robert, all of his ER post-discharge requirements for DME, home health, community outreach, community agencies, adjunct support systems, medication assistance/reconciliation, and community mental health services were identified as early as possible.

For Robert, his comprehensive transition assessment and plan of care included, but is not limited to, the following:

> Assessment of needs – proactively by the UMP and ICCM when an enrollee is identified by the Magellan Complete Care Analytics team as having a high likelihood of being admitted to the hospital based on previous utilization and presenting chronic conditions (behavioral, physical, and social)
> Assessment of needs – upon hospital admission
> Assessment of needs – when notified that the enrollee is in and is discharged from the ER
> Plan development – determine the behavioral, medical health care, and social discharge needs; plan to meet those needs; confer with PCP/Specialist
> Plan implementation
> Evaluation of effectiveness
> Provision of proactive ongoing or cyclic care
> Follow-up care after discharge
> Formal review of complex cases at the daily case conference sessions.

The Magellan Complete Care CC/CM and UM teams utilizes best practice care transition checklists which are embedded within the TruCare system. In addition, the team reviews and provides discharge planning information included in the Magellan Complete Care Passport to Care handout and the CMS “Your Discharge Planning Checklist” booklet. In addition to planning for Robert's transition, he was evaluated for level of behavioral health and physical health complexity and risk, and was stratified into the appropriate level of CM based on complexity. More importantly, Magellan Complete Care understands the impact of social determinants of health that Robert faced each day. These social determinants, along with other behavioral and physical health factors, impacted Robert’s transition of care and were managed as an integrated element in his overall CM process. For Robert, these social determinants were paramount and required in depth assessment to determine services and supports.

Any planned or unplanned care transition that enrollees experience, including Robert’s ER visits, require diligent planning and follow up to avoid further unnecessary ER utilization, potential readmissions to acute care settings, and hasty placements into potentially inappropriate institutions. The care transitions approach utilized with Robert, and all enrollees, aims to accomplish the following:

> Ensure continuity between settings while including Robert’s choice, preference, and goals
> Assist Robert, his son, and his caregivers to improve health literacy and learn self-management skills to ensure that his safety, behavioral, and physical health needs are met
>Provide adequate support for Robert and his son when he returns home
>Reduce preventable readmissions, institutionalizations, and adverse outcomes
>Prevent unplanned care transitions for Robert.

We provided proactive CC/CM interventions for Robert, including the following:

> Ongoing assessment of Robert to further identify if he is at risk for any type of transition
> Collaboration with the analytics team to identify enrollees, like Robert, who may be at risk of a transition
> Setting enrollee-specific, prioritized goals with Robert to promote coordinated care
> Addressed social determinants, medical, and behavioral risk factors affecting Robert
> Provided Robert and his family / caregivers one point of contact / accountability
> Made and kept specific tasks / appointments / calls / follow up with Robert
> Created a communication process for involved providers
> Facilitated Robert’s self-management capabilities and closing gaps in care
> Worked with existing community transition programs to support a safe transition plan
> Educated Robert on use of the 24/7 CareLine and Customer Services Staff
> Established a physical and behavioral health home if one does not exist
> Built a circle of support with Robert within his community or neighborhood
> Worked closely with Robert to develop a plan for any type of transition
> Modified Robert’s existing home to ensure a safe, affordable place to live
> Arranged for in-home supports (e.g., home portable oxygen, equipment and supplies, medications and home-delivered meals).

Evelyn communicated with all relevant parties involved in Robert’s transition and ensured that his plan of care supported him in the least restrictive and safest environment. We recognized the highly complex nature of Robert’s situation and with our population and their specific vulnerabilities in managing transitions from different care settings, levels, locations, and from one health plan or delivery system to another. Transitions from one care setting to another require diligent assessment, planning and follow up to avoid unnecessary ER utilization, potential readmissions to acute care settings, hasty placements into potentially inappropriate care settings, or destabilization of physical health or behavioral health comorbidities.

Our care transition approach was focused on the goal of limiting risks for Robert’s health and plan of care, jointly addressing his son’s needs, and successfully transitioning him safely back into the community. Activities were integrated within each area/level of the CCM program and provided by various members of the CC team, including the ICCM (RN and Social Work Case Managers), Health Guides, and UMPs. This team worked within the Integrated Health Neighborhood assisting Robert in accessing necessary supports and services necessary for a safe transfer between health care settings and home.

Magellan Complete Care has designed its Care Transitions and ER Diversion approach, establishing collaboration between the ICCM, UMP, Health Guide, and the hospitals to prevent unnecessary ER visits and hospitalizations and to engage enrollees, like Robert, in the continuum of care. The transition of care planning process started long before Robert had been discharged or transferred from one setting to another; with active engagement with providers and staff in the discharging/transferring site of care, and with his family or caregivers.
The UM Program and UMPs monitored transitions of care including movement of Robert to and from different levels, settings, types of care, and to other health plans or delivery systems. The Care Transitions program is based on a blend of key components from the National Transitions of Care Coalition and Eric Coleman Care Transitions Program. Outreach and enrollment activities were based on Robert’s needs. Specific criteria are developed and used by each of the enrollee-facing areas to offer ease of placement and referral to the appropriate CC program. In Robert’s situation, we incorporated key elements specifically related to jointly addressing Robert’s son and his care and safety needs, as part of Robert’s transition’s plan.

Magellan Complete Care has developed a comprehensive process for the assessment and development of transition of care plans for enrollees moving between levels of care, to new care settings, or into the community. Our program includes the development and maintenance of written CC, UM, CM, and continuity of care protocols.

1.G. Application of Coordination Protocols Utilized with Other Insurers (When Applicable), Primary Care Providers, Specialists, Other Service Providers, and Community Partners Particularly When Referrals Are Needed for Non-Covered Services;
Our CC and UM teams adhere to detailed desktop procedures and processes to ensure that enrollees like Robert are able to receive necessary services from non-covered PCPs, specialists, other service providers, and community partners. Evelyn and the UM team adhere to the Magellan Complete Care Coordination of Benefits (COB) and Magellan Complete Care Single Case Agreement (SCA) desktop procedures which clearly outline each step in the COB and SCA process. Magellan Complete Care supports a “hassle free and easy to follow” approach when communicating and collaborating with non covered providers/entities or those who may require a referral, ensuring that timely authorizations and services are facilitated. The Magellan Complete Care team strives to remove barriers and roadblocks that either providers or enrollees may potentially experience; when faced with a non-coverage situation.

Evelyn and the UM staff ensure that the appropriate and necessary referrals are in place for Robert’s non-covered services. The team coordinates obtaining referrals whenever necessary. Through our fully integrated Model of Care, if we identify a service need (covered and non-covered), through the Integrated Health Neighborhood approach, our CC team coordinates with service providers and community organizations to meet Robert’s needs. Our Clinical staff establish SCA and encourage direct contracting and formal integration of the non-covered providers and community partners into our Integrated Health Neighborhood approach.

In Robert’s situation, Evelyn and the CC team worked closely with him to establish both covered and non-covered services and resources available within his neighborhood. Robert obtained his medical care through the local FQHC and medical clinic near his home. He attended COPD support group and smoking cessation group at the FQHC as well. Evelyn arranged transportation for Robert to and from his support groups and visits whenever necessary. In addition, the Social Worker on the Magellan Complete Care Clinical team assisted Robert with obtaining food at the local food bank and helped him attend his son’s school events and meetings. Robert was active within his church where he also accessed support and services for both himself and his son. The church volunteers were available to assist Robert with home repairs and helped his son with teen social activities and support groups.
1.H. Description of the Assessment of Provider Capacity to Meet the Specific Needs of Enrollees

Magellan Complete Care’s primary focus was to preserve Robert’s existing provider relationships whenever possible allowing for seamless continuation of care. In order to assure effective and efficient PCP “connections” for enrollees, Magellan Complete Care maintains written policies and processes to assign and change a PCP, to assess provider capacity, and to ensure that we maintain an adequate level of specialized service providers. Our processes meet all applicable regulatory and contractual requirements of AHCA; however, our approach goes beyond core requirements as we cast a wide net with our community-based staff who are in constant review of the services and provider capacity we need.

Our approach to Robert’s PCP and specialist assignment was to link him to the PCP, specialist, and community partners who were best suited to meet his needs and able to offer the highest quality of care. Evelyn and the Clinical team had access to updated provider panel lists which were assessed and updated on an ongoing basis by Magellan Complete Care’s provider network teams to ensure that we had the right specialized services providers to meet Robert’s complex needs. Evelyn kept in constant contact with Magellan Complete Care’s Provider Support Specialists who are out in the neighborhoods collaborating with all types of providers, ensuring that provider capacity and specialized network was meeting Robert’s needs and the needs of the broader population.

When Evelyn identified a specific provider need or gap, she communicated directly with the provider network team and/or Provider Support Specialist who engaged the provider in the contracting process. For example, in Robert’s situation, Magellan Complete Care successfully matched him with a PCP within a nearby FQHC. In addition, we coordinated his respiratory care by matching him with a pulmonologist at the hospital medical clinic near his home. Robert also had difficulty finding a dentist nearby and Evelyn assisted him in finding a dentist he liked.

The Magellan Complete Care provider assignment, network capacity assessment, and network expansion process aligns with our commitment to achieve the Institute of Healthcare Improvement’s Triple Aim. In support of the Triple Aim, our clinical Model of Care and quality programs support improving the enrollee experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of healthcare. In addition, Magellan Complete Care has broadened the Triple Aim by adding a fourth element, the provider experience (including quality and satisfaction), resulting in the “Quadruple Aim.” We believe provider participation is an integral and essential addition to this comprehensive framework. In support of the Quadruple Aim, Magellan Complete Care’s goal was to ensure that Robert received the right care, in the right setting, at the right time, and by the right provider.

1.I. Identification of Strategies That Promote Enrollee Self-Management and Treatment Adherence; and ***F. Disease Management

Magellan Complete Care is committed to the philosophy of providing individualized and person-centered treatment in the most appropriate, least-restrictive level of care necessary to provide safe and effective treatment to meet enrollee’s biopsychosocial needs while supporting improved health outcomes and a pathway to recovery. Our system of care, including our CC/CM programs, reinforced and prioritized recovery, stabilization, health maintenance, optimal safety, quality, and independence through a partnership with Robert, his natural supports and providers. Our company-wide recovery expertise and sound evidence-based practice approaches have been utilized in the development of our self-management and treatment adherence approaches.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Magellan Complete Care provided an ICCM, Evelyn, and other support staff who met with Robert and his son face-to-face and telephonically, to review the CC program, identify self-management goals, contact information, including name and information for reaching Evelyn and other members of the care team. This same information was included in Robert’s Welcome Kit received upon enrollment.

Evelyn and the CC team identified Robert’s barriers to care, including language, transportation, and family barriers. Next, they instructed Robert to place the Magellan Complete Care contact information in an easily accessible place for him, his son/family, and caregivers to locate. Magellan Complete Care worked closely with Robert to ensure that he agreed with his ICCM and CC team assignment. Evelyn and the CC team used a person-centered approach when engaging Robert about available services and support to assist him in adhering to and achieving optimal health, wellness, and self-management goals. Evelyn and the CC team provided Robert with information and support in the area of self-direction and self-management.

At all times, Evelyn and the CC team circled back with Robert and his son to ensure that barriers had been removed and that he was satisfied. In addition, that our “Member Journey” was helping him reach his goals. As mentioned earlier and with the case of Robert, the CC team utilized the Integrated Health Neighborhood approach to assist Robert with self-management; accessing necessary resources within the community and health care system in order to remove barriers and to maximize treatment adherence. Ongoing engagement and communication with Robert and his support system was essential to the success of Robert reaching optimal self-management and adherence. Evelyn included Robert in his self-management goal setting and Robert expressed repeatedly that he needed assistance in trying to manage his conditions; as he was trying to be healthier and to be a good parent. Evelyn and the assigned Social Worker assisted Robert in obtaining parenting classes at the local library.

Evelyn focused on health education in the area of diabetes prevention with Robert. Evelyn consulted the Magellan Complete Care Wellness Specialist who is an expert in diabetes who offered additional support for Robert’s diabetes prevention. Robert agreed to attend a diabetes prevention education class at the local FQHC. Robert attended the classes and was able to meet new friends who also had similar health issues. They all shared tips of how to eat better and follow simple self-care interventions for pre-diabetes. Robert received a nutrition evaluation and worked with his PCP to follow a weight management and exercise program after his PCP established that it was safe to do so. Robert began to participate in Magellan Complete Care’s Smoking Cessation Program as he knew it would help symptoms he was experiencing with his COPD exacerbation.

Robert was worried that if he did not stop smoking, his son may start smoking as well. Robert kept a notebook of his health information and self-management plan. Evelyn reviewed Robert’s self-management plan during each contact and visit with Robert. Other members of the CC team also reinforced different aspects of Robert’s plan during their contacts and visits.

Evelyn explained more about Magellan Complete Care’s Cobalt services (cognitive behavioral therapy), which could help him with stress management and the prevention of depression and anxiety. Robert was very interested in participating in these programs as he felt he may be at risk to become depressed or anxious due to his multiple physical health conditions.
Magellan Complete Care’s UM Program and approach is built around the unique requirements of our population, delivery system, and providers.

For Robert, Magellan Complete Care ensured that applicable evidence-based guidelines were utilized with consideration given to characteristics of the local delivery systems, as well as enrollee-specific factors, such as Robert’s age, co-morbidities, complications, progress in treatment, psychosocial situation, and home environment. We made appropriate medical management and authorization decisions based on nationally recognized guidelines and ultimately in the best interest of Robert. Our UM Program’s purpose is to support optimal use of healthcare services for the evaluation, treatment, and integration of medical and behavioral health conditions and safeguard against unnecessary and inappropriate medical care delivered to enrollees like Robert. His medical services and/or records were reviewed for medical necessity, quality of care, appropriateness of place of service, and length of stay (inpatient hospital).

Magellan Complete Care has a strong UM program, including experienced staff, evidence-based guidelines, and expeditious and transparent processes. Magellan Complete Care brings the following strengths to the SMI Specialty Plan for authorization of Robert’s services:

>Corporate support and UM experience with similar contracts and populations – enhances the experience

>Our Model of Care is unique with collaboration between all departments, including physical and behavioral health staff working together

>The UM team assisting Robert was made up of a unique blend of clinicians who have medical and behavioral health backgrounds e.g., Social Workers, LPN, RNs, doctorate level professionals, who all understand both physical and behavioral health and the SMI population

>Our integration/collaboration between the UM team and the hand off to the CC team to manage our enrollees is also unique as both teams focus on quality of service together

>The intensive training that staff receives addresses medical, psychosocial, and behavioral health services, coordination of benefits, SCAs, service authorization protocols, community-based services, transitions of care, end of life issues, and palliative care

>Infrastructure to approve and support the creation and application of evidence-based guidelines and criteria for use in determining medical necessity:
>>These criteria are created and applied based on the unique needs and conditions found within the population in Florida
>>Authorization determinations are made by licensed reviewers based on medical necessity and appropriateness and reflect the application of our approved review criteria and guidelines.

Magellan Complete Care’s UM Program and dedicated UM staff use our Florida experience as a strong foundation to develop models and approaches to UM that are not only based on standardized and compliant UM guidelines and review criteria, but also reflect the provider community, provider capacity, and a detailed understanding of services, interventions, and
outcome goals that best meet the needs of delivering medically necessary services and quality of
care for this very complex population, including Robert.

In addition to compliance with the Florida Medicaid Handbooks, Magellan Complete Care used
developed or adopted clinical criteria that served as the primary decision support tools for Robert’s
care and services. We adopted MCG guidelines as a set of national standardized criteria for the
management of Robert’s physical and behavioral health services.

We also use proprietary diagnostic services criteria for imaging, sleep studies, and certain pain
management procedures that Robert may need. These criteria sets are based on sound scientific
evidence for recognized settings of care and used to decide the medical necessity and clinical
appropriateness of services. If state law requires additional criteria, it is adopted into policy and
used.

Criteria were utilized with consideration given to characteristics of Robert’s Integrated Health
Neighborhood and local delivery system available as well as Robert-specific factors, such as his
age, co-morbidities, complications, progress in treatment, psychosocial situation, and home
environment. Magellan Complete Care’s medical necessity criteria are listed on our website and
were also available to Robert’s providers by hard copy upon request. The criteria used for the
basis of an individual service determination for Robert was in the notice of action letters and also
available upon request. The CC team who helped Robert had access to the Florida Medicaid
Handbooks, MCG Guidelines, and the Magellan Healthcare Guidelines; all embedded in TruCare
under “resources”.

As in the case of Robert for his dental procedures, if the need goes beyond the UM clinical
decision support tools, we request review from our Medical Directors. Magellan Complete Care
has and will continue to ensure continuity of care, particularly as it relates to special needs
populations. Magellan Complete Care has developed continuity of care policies and standard
operating procedures for all UM approaches. The goal of these guidelines is to establish a uniform
process for Prior Authorization Reviews performed by Licensed Clinical Reviewers for the Prior
Authorization subdivision of the Magellan Complete Care UM/Health Services Department.

Magellan Complete Care is responsible for coordination of care for new enrollees transitioning
into the plan. In Robert’s situation when he came onto the specialty plan, he was receiving prior
authorized ongoing treatments with multiple providers. Magellan Complete Care was responsible
for the costs of continuation of such course of treatment, without any form of authorization, and
without regard to whether such services are being provided by participating or non-participating
(non par) providers.

Magellan Complete Care reimbursed Robert’s non par providers at the rate they received for
services rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of
30 days, unless said provider agreed to an alternative rate. In addition, the UM team initiated a
SCA with Robert’s non par providers and coordinated with the Provider Network team to obtain a
formal contract with Robert’s non par provider. Magellan Complete Care provides continuation of
MMA services until the enrollee’s PCP or behavioral health provider (as applicable to medical or
behavioral health services, respectively) reviews the Robert’s treatment plan, which is no more
than 60 days after the effective date of enrollment.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1.j.1 Ensuring Continuity of Care for a Newly Enrolled Enrollee or an Enrollee Disenrolling
Magellan honors any and all continuity of care requests for a new enrollee, including Robert. We honor the authorization for 60 days. We contact the provider to ensure that no delay in services occurs. If we cannot find an in-network provider, we utilize our SCA process to ensure continued services.

When Magellan Complete Care was notified of Robert’s enrollment, at minimum, the following was carried out:

> Obtained appropriate consent from Robert to share demographic and healthcare information
> Collaborated with Robert, the health/service provider, and the receiving or sending health plan to obtain/provide enrollee information related to the respective program assessments and plan of care information
> Requested/shared the most current assessment and plan of care with documentation of same in the TruCare clinical documentation system
> Assisted Robert in finding in-network health and service providers whenever possible
> Documented continuity of care assessments, HRAs, and plan of care and/or other information is scanned/entered into the TruCare clinical documentation system.

1.j.2 Ensuring Continuity of Care upon Provider Termination
Magellan Complete Care provides for continuity of care for the course of treatment in the event a provider agreement terminates during the course of Robert’s treatment. One of Robert’s providers terminated from Magellan Complete Care and we notified Robert within 30 days of the effective date of provider termination without cause. This process is utilized for all enrollees, like Robert, who are in a course of active treatment with the provider, assigned to the provider as a PCP, or has prior authorized care with the provider.

We allowed Robert, who was getting active treatment with the terminated provider, to continue to receive care from the provider until the course of treatment was completed. Other situations would include continued authorization until another provider was selected, or during the next open enrollment period—not to exceed six months after the termination date. If providers are terminated for cause, notification occurs as soon as practicable (not to exceed five business days, but immediately if the enrollee is in imminent danger) and the following continuity of care provisions do not apply. All services provided under the continuity of care provisions are reimbursed at the rates included in the last active contract.

Magellan Complete Care ensures that any limits on services are made on the basis of medical necessity, as defined by the State, or for utilization control, consistent with the terms of the Contract, provided the services furnished can be reasonably expected to achieve their purpose. Decisions for approved services are based only on appropriateness of care and service and existence of coverage. We are clearly aware that one of the biggest issues challenging health plans today is the lack of integrated systems to closely monitor the health care experience of its enrollees, like Robert.

Magellan Complete Care uses the comprehensive TruCare system as the medical management platform to break down these barriers. The TruCare system is fully integrated and serves as the eligibility system, claims system view, provider management and credentialing, Customer Services CRM (Call Tracker), authorization system, and CC/CM/DM system (Case Management Module).
As such, all relevant departments work within the same system. Given our “all services under one roof” approach, authorization staff or clinical staff had everything at their fingertips to fully assess Robert’s situation and needs to deliver the best possible service for Robert and his providers.

For example, staff have the ability to view the following information for Robert in one system:

- Complete and up-to-date demographics
- Complete and up-to-date claims and encounter history
- Customer Service notes relevant to the requested authorization / assessment / intervention
- Authorization request and approval / denial history
- Any HRAs performed by the CM / DM department
- Gaps in care
- Provider contracts and demographics
- Financial payment records for claims and encounters
- Any other clinical or quality notes entered in the system.

Magellan Complete Care has adopted the TruCare technology solution; it has almost no limitations of ensuring Magellan Complete Care staff work in one system and have access to all relevant and timely data to perform critical functions. Our protocols for developing, reviewing, adopting and annually evaluating clinical criteria is based on a formal and systematic review of nationally recognized standards, and takes into consideration local practice patterns. Every change is communicated to providers through fax blasts, bulletins, and posted online to make sure the provider has sufficient time to adapt to the new process.

One of our biggest improvements in 2017 to enhance the service authorization process for the SMI Specialty Plan, was to allow providers to submit enrollee authorizations through our website into our internal automated authorization system. Prior authorization requests can be submitted electronically via Magellan Complete Care Provider Portal, as required in s. 409.967(2)(c)3., F.S. The authorization request is transferred to our automated system (TruCare) where it is reviewed for medical necessity. This improvement in submitting authorizations via our website, improves ease of submittal and viewing of status for providers.

1.K. Application of Strategies To Integrate Enrollee Information across the Plan and Various Subcontractors When the Respondent Has Delegated Functions;

Magellan Complete Care utilizes the TruCare care management system to coordinate care for all enrollees, including those who have the most complex health needs like Robert. TruCare is the Magellan Complete Care application providing clinical systems support for UM, CM, health promotion, care transitions, DM, and CC tasks.

TruCare integrates with our claims processing and provider data applications to enable Health Services staff to assess enrollee needs, complete CC plans, and authorize services. In addition, our Customer Service area utilizes the TMR (Call Tracker) system.

All enrollee contacts, including those contacts made with Robert, are documented in the system and notes are made on all elements of CC.CM processes and services. Information sent to us by Robert’s providers, subcontractors, facilities, and other treatment teams are able to be uploaded and attached to his and each enrollee’s record. This provides a comprehensive tracking of all activities, information, services, treatment plans, and discharge plans, etc., related to an enrollee.
System support for enrollees operates seamlessly within TruCare, establishing a single platform for Magellan Complete Care staff across the whole continuum of care (both behavioral and physical), and encompassing all care settings. TruCare effectively tracks enrollee programs and case artifacts in one place. Each time Robert calls Magellan Complete Care, he is assisted by either a Customer Service Representative or his assigned ICCM. These employees have access to the TMR and TruCare systems at all time.

We view our subcontractors as essential partners, working with us to serve Robert. Magellan Complete Care’s goal is to work with both providers and subcontractors to ensure that Robert received the very best care and services. We deeply value our provider and subcontractor partnerships and have developed meaningful relationships to support them in the care and service provision for Robert. Magellan Complete Care firmly commits to improving the provider and subcontractor experience through a high-touch provider engagement model and continuous improvements to streamline provider management processes. Our integrated provider engagement model offers a hybrid of onsite, personalized support within each Florida region, as well as virtual, self-service and technology-based support capabilities.

We believe that ongoing provider support fosters healthcare integration at the system- and service-level by ensuring collaboration and communication with all providers and caregivers across Robert’s entire care continuum. Magellan Complete Care has developed a robust statewide provider and subcontractor network to support Robert’s unique needs. Over this same period, we have developed successful approaches to engaging, supporting, and communicating with our providers and subcontractors.

We offered Robert, his providers, and his subcontractors’ access to specially trained clinical staff 24 hours each day. Our teams were able to access Robert’s information 24 hours each day to ensure optimal communication with Robert, his subcontractors, and his providers. Robert and his providers/subcontractors were able to access information via secure sign on to the respective enrollee and provider portals. Each of these portals provides a wealth of information for all who securely access it. Robert accessed the member portal at least weekly.

CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT’S WORKFLOWS/NARRATIVE DESCRIPTIONS INCLUDE TIMEFRAMES FOR COMPLETION OF EACH STEP IN THE CARE PLANNING PROCESS.

Magellan Complete Care adhered to the NCQA assessment and care planning standards and timeframes for Robert and his enrollment in the CCM program. Evelyn and the CC team followed a defined and prioritized process for each step in Roberts’s assessment and care planning process. Magellan Complete Care adheres to NCQA standards for plan of care development utilizing prioritized goals and corresponding timeframes. These timeframes for completion are outlined within Robert’s plan of care.

The following outline describes Robert’s High Risk CCM process which encompassed identification, assessment, care planning, and ongoing monitoring with associated timeframes for completion:
Robert was identified as High Risk through the analytics, HRA, and assessment process and scoring, utilization reports, predictive modeling and by having special conditions, including COPD, HTN, etc.

Robert was identified as High Risk and the Regional Manager assigned Robert to his primary ICCM, Evelyn within the same day of identification.

Evelyn became Robert’s case owner and enrolled him into the CCM program, and completed the referral screens within 24 hours of Robert’s case assignment.

Evelyn completed Robert’s HRA, ICA, branching assessments (COPD, HTN, Diabetes), obtained authorizations as appropriate, and completed the plan of care within 30 days of CCM program enrollment.

The CCM program open date in TruCare became the trigger date from which the timeframes for Robert’s outreach, engagement, assessments and care planning was based on and measured.

Robert’s plan of care included prioritized physical health/behavioral health goals, considered Robert’s son and caregiver goals, preferences, identified barriers to meeting goals, and developed with Robert a plan for self-management and a plan for a schedule of communication and follow up.

Evelyn documented Robert’s information in TruCare assessments/notes, uploaded all documents to Robert’s case within 24 hours.

Robert’s CC monitoring timeframes:

Evelyn conducted the required monthly reviews of Robert’s case as evidenced by completion of the CCM Monthly Review Note in TruCare.

Evelyn conducted as appropriate, weekly ICCT meetings with the Health Services staff, Robert and providers.

Evelyn conducted ad hoc case conferences with Robert’s care team in-between the formal ICCT meetings.

If Robert admitted to an inpatient setting, Evelyn and Robert’s Health Guide followed the Discharge Planning desktop procedure.

Evelyn assisted Robert and his family in accessing health services including coordination of transportation, DME and supplies on an ongoing basis and no less frequent than weekly.

Evelyn maintained and updated Robert’s plan of care at minimum, on a monthly basis during the CCM monthly review.

Evelyn documented all of Robert’s activity in TruCare by updating the plan of care when a change occurred and at minimum monthly; additional updates were made as needed, documenting case conferences using the Case Conference/Care Review Note type on the day the service occurred.
>Evelyn completed the CCM Monthly Follow-Up Note to summarize activities for the month, including Robert’s progress toward his plan of care goals and updated the plan of care accordingly

>Evelyn monitored the predictive modeling screen, at minimum weekly, in TruCare to identify Robert’s HEDIS gaps in care and followed the process for closing Robert’s gaps in care.

Examples of other CC activities for Robert include the following:

>Robert requested a new PCP and had a demographic change, Evelyn followed the desktop process for PCP/Demographic Change requests. Evelyn completed the requested update within 24 hours.

>Robert had authorization needs from previous providers, therefore Evelyn notified the UM department by tasking the UM Clinical Review queue for prior authorizations and the UM Concurrent review queue for concurrent requests on a daily basis

>With each contact with Robert, Evelyn worked to assure he had a provider for all of his healthcare and service needs

>Evelyn’s contact frequency was determined by Robert’s High Risk acuity and coordination of care needs

>The frequency of Robert’s contacts occurred no less than 1x/month

>Robert’s Health Guide worked with Robert, as needed, in conjunction with Evelyn, conducting home visits and other community visits based on Evelyn’s direction.

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT DEMONSTRATED...

Our Model of Care is built on the active involvement and coordination of all of Robert’s providers involved in his care. The Magellan Complete Care Clinical team recognized their important role in assisting Robert’s treating providers in efforts to monitor and improve the quality of healthcare and service delivery for Robert. We did not delegate any of the CC/CM functions for Robert. However, we did share Robert’s clinically relevant information for CC/CM purposes with Robert’s providers and subcontractors in various ways and on an as needed basis. We shared Robert’s information with providers and subcontractors in a manner that complies with State and federal confidentiality regulations based on our Medical Records Policy and Procedure to ensure compliance with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA), and the confidentiality of medical/case records in accordance with 42 CFR Part 431, Subpart F.

We made sure that Robert signed and dated a release form before any clinical/case records were released to another party. Clinical/case record release occurred consistent with State and federal law.

We encouraged ongoing engagement through direct and indirect information sharing to support all of Robert’s providers, including:

>ICCM communication (Evelyn reached out directly to Robert’s care providers and subcontractors, including his pharmacy and DME oxygen provider)

>Prior authorizations

>Reconciliation of medication regimens and treatment s (oxygen), especially at care transitions

> Care planning

>ICCT meeting notes and agendas

>Other case conference and case review notes

>Referrals to necessary services, including his pulmonologist.
Magellan Complete Care maintains provider self-serve tools including the ImpactPro Connect Portal to support clinical communication. The Connect Portal assists and informs providers in improved care management, identification of enrollee gaps in care, and performance comparisons to quality benchmarks.

Sharing of Robert’s information through the Provider Portal occurred as follows:
> Robert’s interactions were captured on the portal ensuring each member of the ICCT, including primary care and specialty health providers, had access to up-to-date information about Robert’s care
> Case summaries
> HEDIS care gap information
> AHCA related updates.

Sharing of Robert’s UM Concurrent Review included the following:
> Hospital admission lists daily
> Admissions and discharge notification
> Transition of plan of care
> ER department notification.

CRITERIA 4: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES Magellan Complete Care has enhanced its predictive modeling activities to specifically identify specialty plan enrollees like Robert who are likely to go to the ER, to admit to the hospital within specific timeframes, those who present with complex disease specific indicators, including COPD and HTN. The predictive modeling data identified Robert with the highest probability of inpatient admission risk. Robert’s admission probability and disease condition indicators from the claims predictive model were used to guide his stratification into a High Risk case type with referral to the CCM program. Evelyn, who was primarily assigned to Robert, focused on ensuring that Robert receive all of the supports and services he needed, along with coordinating his services in the most appropriate setting.

In addition, we have developed specialty condition specific programs and employ subject matter experts and leaders who carry out the components of these programs on a daily basis. For example, Evelyn is specially trained in CCM, specifically for individuals who present with COPD. Robert was enrolled in the CCM program with special emphasis on the respiratory disease program which is specifically focused on coordinating care and services for individuals with COPD. Each of the specialty condition programs utilize the core basic CCM approaches in addition to specific nuances and tools pertinent to each of the designated conditions, including COPD and diabetes. In Robert’s situation, Evelyn was careful to assess him for the possibility of HTN and COPD complicating his overall health status and worsening into an additional heart failure diagnosis. Our teams utilized the MCG modules, including chronic condition guidelines, and CarewebQI, etc. Evelyn had daily access to the Magellan Complete Care Medical Directors who are available for consultation on complex cases.

Magellan Complete Care is committed to the philosophy of providing individualized and person-centered treatment in the most appropriate, least-restrictive level of care necessary to provide safe and effective treatment to meet the individual’s biopsychosocial needs; while supporting improved health outcomes and a pathway to recovery. Our Model of Care, including our CC/CM programs, reinforces and prioritizes recovery, stabilization, health maintenance, optimal safety, quality, and independence through partnership with the enrollee, their natural supports and providers. Our company-wide recovery expertise and sound evidence-based practice approaches
have been utilized in the development of our health program approaches, including best practice protocols in the area of COPD and diabetes management.

CRITERIA 5: THE EXTENT TO WHICH THE RESPONDENT DEMONSTRATES EXPERIENCE IN PROVIDING SERVICES TO ENROLLEES...
Magellan Complete Care’s CC/CM and DM programs are informed by input from those most closely involved for Florida residents like Robert who experience multiple illnesses. Input includes assessments of COPD, insomnia, diabetes, and HTN, their families and supports, and the professionals who provide behavioral and physical health treatment.

As we have gained even more experience with our enrollees, including Robert, his providers and community stakeholders, we have worked collaboratively with them and with AHCA to evolve our Model of Care in support of the unique needs of the population we serve. This collaborative, person-centered approach to develop effective solutions to manage the health of our complex enrollees continues and grows to the present day. This Florida-specific experience with enrollees as complex as Robert differentiates us from any other health plan.

As Magellan Complete Care has grown, our data analytics and understanding of enrollees and intervention effectiveness has also become more sophisticated, allowing us to drill down further into subpopulations with unique or very specific needs. This has allowed us to continually improve and optimize clinical programs and develop targeted, new clinical initiatives to meet the needs of individuals and specific subpopulations, including COPD and diabetes.

Magellan Complete Care embeds and operationalizes analytics in all parts of our programs to create insight that leads to the evaluation of changes that we make to enhance CC/CM. Some results of the data analytics have led to paradigm shifts within the CC department, leading to better outcomes and more effective programs overall for the enrollees. Examples of refinements we have made to our programs include the following:

> Targeting High and Ultra High Risk enrollees like Robert focusing on his specific high risk conditions
>> Expanded and defined services to meet the specialty needs of those groups of enrollees
>> Enhanced predictive modeling and ER diversion
>> Utilization of financial models to identify and target high cost enrollees, like Robert
>> Focus on Robert, who we identified through Predictive Machine Modeling with a likelihood to admit to an inpatient facility within a 90 day period. The predictive modeling allows Evelyn the opportunity of early intervention and prevention of an unnecessary inpatient admission for Robert
>> Decreased ICCM caseloads create more capacity for Robert to receive high touch CC and follow up

For Robert and our current membership, individuals continues to present with complex medical, behavioral health, and psychosocial condition. We have established detailed key performance metrics and clinical dashboards for all of our programs. Our dashboards are monitored and used as a key management tool in our ongoing program management.

Robert’s utilization history, and information about his demographics and the social economic vulnerabilities of where he resides, were all examined by the Advanced Analytics teams through use of machine learning models, which generated a risk score that told clinical staff how likely Robert was to be admitted to the hospital in the next 90 days. Based upon Robert’s complex...
medical comorbidities and his history of utilizing the ER for breathing problems and for behavioral health concerns, he was identified to be at an 85 percent risk for hospitalization. In addition, the quality measure engine was identified that Robert does not often see a PCP, and does not appear to regularly take his behavioral health medications, or fill his breathing medications on time.

In addition, he appeared to be taking suboptimal doses of breathing medications given his condition. Robert's case was sent to the CCM team, where Clinical staff, Health Guides, ICCM, Clinical Pharmacist, and others, reached out to enroll him for CC. Robert enrolled and began receiving care. After participating in the program, Robert had developed a relationship with his PCP, whom he now sees to obtain medications to manage his breathing problems and blood pressure. Robert was on a weight management program and has his BMI regularly checked. He has decreased his utilization of the ER breathing emergencies, and has not been admitted into the hospital in four months.

5.1 Practice Guidelines
Evelyn utilized applicable national evidence-based guidelines (EBG) as a basis for Robert's assessment, evaluation, quality management and improvement, identification of care gaps, his education, provider education, key interventions and outcomes measures. Evelyn had additional resources available to her including:

> Magellan Health, Inc., (“Magellan”, parent of Magellan Complete Care) proprietary, evidence-based integrated care guidelines and medical policies fully reviewed and vetted through the Magellan corporate policy and procedure committee
> Magellan’s proprietary behavioral health medical necessity guidelines
> MCG medical necessity guidelines currently in use
> Healthwise and MCG Chronic Care Guidelines for health education materials in English and Spanish

Examples of Magellan Complete Care guidelines utilized for Robert included:
> Diabetes – American Diabetes Association (ADA) guidelines
> Congestive Heart Failure – American Heart Association/American College of Cardiology (AHA/ACC) guideline
> Hypertension – National Institutes of Health (NIH) Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7)
> Chronic Obstructive Pulmonary Disease (COPD) – the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines
> Immunizations – the Advisory Committee on Immunization Practices (ACIP) recommendations
> Preventive care – United States Preventive Services Task Force (USPSTF)

CRITERIA 6: THE EXTENT TO WHICH THE RESPONDENT DEMONSTRATES A SYSTEM OF COORDINATED HEALTH CARE INTERVENTIONS...; AND ***i. QUALITY PERFORMANCE
6.1 Specialized Quality Improvement Program
Magellan Complete Care utilizes an enterprise-wide and fully integrated approach to carrying out key quality improvement, HEDIS, clinical performance measure, and cost of care activities. Evelyn and her Manager collaborated with the Quality team to ensure that the quality improvement (QI) and HEDIS initiatives specific to Robert were fully integrated with Robert’s clinically appropriate/CCM programs. Evelyn and Robert's CC team were educated on targeted quality, HEDIS, quality measures, and cost of care activities. Current and new initiatives were discussed at the cross-functional oversight and operational meetings to determine key initiatives for focus to
improve the key measures. Outcome measures were determined by the results of the HEDIS and state specific performance results. The quality, HEDIS, performance improvement, and cost of care strategy utilizes a multi-faceted approach incorporating clinical, data, and provider-based efforts.

Evelyn carried out HEDIS and quality measure initiative activities encouraging and assisting Robert in obtaining care and preventive services he needed to improve his overall health, and to establish a medical health home.

Magellan Complete Care has a unique Model of Care that supports the needs of individuals like Robert with complex care needs and has been able to demonstrate savings for the time period of 2014 to 2016:

-15% reduction in total care expense PMPM;
-27% reduction in Emergency Room care cost PMPM;
-7% reduction in aggregate PMPM pharmacy expense;
-18% reduction in total Inpatient hospitalizations; and
-18% reduction on 30-day readmission rates (all causes) / 1,000.

To further the point, Magellan Complete Care’s unique approach reduced the high costs of complex enrollees like Robert (from 2014, 2015, and 2016, respectively):

- PMPM, total costs: $901, $857, $762
- PMPM, total ER costs: $67, $66., $49
- PMPM, total pharmacy costs: $196, $186, $181
- Total inpatient hospital admissions, per 1,000: 709, 657, 584
- Total inpatient hospital readmissions in a 30-day period, per 1,000: 233, 222, 192

Additionally, through our tenure as the current Specialty Plan provider, we have been able to demonstrate the value of our CC/CM and DM interventions in improving enrollee outcomes. We present major findings from a study of outcomes associated with both participants and non-participants in these programs. For purposes of this analysis, enrollees, similar to Robert’s profile, were grouped as follows:

- Those enrolled in CC/CM, DM (treatment)
- Those who were unable to contact/never touched (control).

We analyzed data from 1/1/2015 through 9/15/2016 (to allow time for completion of program for the enrolled group and six months of post discharge claims including three months of claims runout). Only enrollees who were continuously eligible for the duration of the study (12 months for the not enrolled/engaged group or 12 months plus time in CM for the enrolled/engaged group). We studied adults (21+) and studied children/youth independently.

We operationalized the study design based on the following criterion:

- RISK: High Risk (2+ comorbid conditions and 3+ any cause admissions)/Moderate Risk (either 2+ comorbid conditions or 3+ IP any cause admits)/Low Risk (< 3 IP any cause admits) – Similar to Robert’s situation

- COMORBID CONDITIONS: Sum of clinical indicators included in this analysis:
>>Use of DME, sickle cell, cancer, hypertension, CHF/cardiovascular disease, SUD, alcohol use disorder (AUD), asthma, schizophrenia, transplants, HIV/AIDS, bipolar, eating disorder, major depressive disorder, congenital birth defects, diabetes, and COPD

>ENGAGED/ENROLLED: To count as enrolled, an enrollee must have had a plan of care, received contact from Case Managers at least 10% of the time they were enrolled in their CM program, and had an outcome of “Goals Met” or “Change in Clinical Status or Condition” for one of these reasons: Program Completed, Reached Maximum Gain, Change in Clinical Status/Condition, Pregnancy-Terminated, or Pregnancy-Delivered.

In adults, inpatient (any cause) admissions were reduced more for the engaged/enrolled group than the not engaged and enrolled group, including:

>Any cause admissions for the enrolled group were reduced by 49%:
>>This reduction was statistically significant (over time and between enrolled and not enrolled enrollees)
>>This reduction was present at all risk levels:
>>Low Risk admissions for the enrolled / engaged enrollees decreased by 47%
>>Moderate Risk admissions for the enrolled / engaged enrollees decreased by 36%
>>High Risk admissions for the enrollee / engaged enrollees decreased by 38%
>>All readmissions were statistically significant (over time and between enrolled and not enrolled).

In adults, similar to Robert, all-cause ER use decreased for both the engaged/enrolled group and not engaged and enrolled group, but these groups were not statistically, significantly different:

>Any cause admissions for the enrolled group were reduced by 34%.

Rates of ER use for physical (non-trauma) causes decreased more for the enrolled/engaged enrollees than for not enrolled/engaged enrollees, including:

>Low Risk admissions for the enrolled / engaged enrollees decreased by 82%
>Moderate Risk admissions for the enrolled / engaged enrollees decreased by 85%
>High Risk admissions for the enrolled enrollees decreased by 68%
>All reeducations were statistically significant (over time and between enrolled and not enrolled).

Individuals like Robert who were enrolled and engaged in CM had longer periods of community tenure than any other group (those not enrolled, those who were enrolled but had staff contact 0 or less than 50% of the time during their enrollment):

>The hazard rate for enrolled and engaged enrollees is statistically significantly lower than the other groups (enrolled enrollees spend more time in the community)
>The health rate for those enrolled and engaged is 37% lower than those who are not enrolled.

CRITERIA 7: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES INNOVATIVE AND EVIDENCE-BASED STRATEGIES...

For Robert, the Magellan Complete Care team utilized several different innovative and evidence-based strategies, utilizing technology and Smartphone applications connecting Robert to the care and services he needed; in addition to facilitating meeting his care goals. As described earlier, the Magellan Complete Care team offered Robert telemedicine and telehealth applications as he
lived in a rural area. Robert and his team were able to utilize videoconferencing technology to conduct visits and contacts in-between face-to-face contacts. Coaching related to health promotion, BP monitoring, COPD management, and medication adherence were addressed using the telehealth and telemedicine technology. Virtual visits could be made, offering frequent contacts for Robert and his son; ensuring plan of care compliance and enhanced health outcomes. Smartphone apps including Clickotine for smoking cessation and Cobalt cognitive behavioral therapy were used by Robert as part of his plan of care to assist him in meeting his care goals. Magellan Complete Care was able to also coordinate with Magellan Complete Care pharmacy system, Magellan Rx to offer additional support to Robert in the area of medication adherence.

Magellan Complete Care innovatively utilizes its TruCare care management system to connect the other applications mentioned above into one seamless system. This seamless approach enhanced the team’s ability to coordinate Robert’s care and services. TruCare is the Magellan Complete Care application providing clinical systems support for UM, CM, health promotion, care transitions, DM, CC tasks, and the tie-in of other applications and services. TruCare integrates with our claims processing and provider data applications to enable Health Services staff to assess enrollee needs, complete CC plans, and authorize services.

All of Robert’s contacts were documented in the system and notes were made on all elements of CM processes and services. Information sent to us and connected via applications, including providers, facilities, and other treatment teams, was uploaded and attached to each enrollee’s record. This provided for a comprehensive tracking of all activities, information, services, treatment plans, and discharge plans related to the enrollee.

System support for Robert in the CCM program operated seamlessly within TruCare, establishing a single platform for Magellan Complete Care staff across the whole continuum of care (behavioral, physical, and psychosocial), and encompassing all care settings. TruCare effectively tracked Robert’s programs and case artifacts in one place. When baseline assessments were completed for Robert, the TruCare system intuitively provided Evelyn with prompts to further assess or to create a CM plan of care for Robert.

The system also provided a list of recommended problems and interventions for Evelyn to select when building Robert’s plan of care, based on his assessment responses. The problems and interventions were based on opportunity areas for CM to focus support. For instance, if Robert responded on the Initial Clinical Assessment that he was more short of breath, a problem of “crisis” or “altered respiratory status” popped up and recommended Evelyn to select from respiratory specific assessments and interventions to further build Robert’s individualized plan of care.

To most effectively identify process improvements and problem solve when necessary, Magellan Complete Care structures its analytic functions to provide daily enrollee-level information to the Operational team related to Robert’s risk, clinical characteristics, health segmentation, and gaps in care spanning all types of service coverage (medical, pharmacy, behavioral health, transportation, vision, and dental). For example, we have real-time access to our internal pharmacy benefit management for enrollee utilization data, through our data warehouse / repository, which enables us to use our data analytical tools to quickly identify and manage early risk indicators, such as those associated with Robert’s medication over- and under-utilization.

Daily extracts of Robert’s claim information, vendor claims, provider information, eligibility and pharmacy claims were extracted into an input file which was fed into a clinical rules engine and
predictive model. The model generated Robert’s risk scores meant to predict the likelihood of admitting to a hospital within 90 days. The models predict disease-specific admission risk, potentially preventable admissions (ambulatory sensitive conditions), and all-cause admission risk. Clinical prioritization logic was employed to select the causal driver of Robert’s "highest risk". The risk status is then joined to the rules engine results to extract Robert’s clinical and pharmacy gaps in care, his HEDIS-like measure compliance status, his DM segmentation, and clinical profile information. The information is converted to a daily file which is transmitted to the Cm and UM application (TruCare), the provider Connect Portal, the HEDIS intervention application, and to reporting dashboards used by Robert’s Clinical and Health Services team within Florida, and reported to the Executive teams within Florida, as well as to the Magellan corporate executive team.

Biweekly meetings between the Magellan corporate analytic teams and Robert’s local Florida clinical, quality and health services team served to examine performance of the risk stratification, health segmentation and gaps in care for Robert. The teams review current enrollment of enrollees, including Robert, into CM, identify areas of emerging risk, and review analytic data related to drivers of inappropriate clinical utilization patterns. Performance of Robert based upon clinical and operational designated outcomes was tracked via Tableau or Qlikview dashboard, and was also reviewed bi-weekly with the Clinical and Operational teams, and monthly at the Magellan Complete Care Executive team meeting.

Building on the deep experience we have gained by providing integrated care for Robert and all of our enrollees in the SMI Specialty Plan, our integrated, flexible, and comprehensive system of care continues to evolve to further expand and define services to meet the specialty needs of our highest-risk enrollees. This model reflected Robert’s unique needs as well as the understanding of Florida providers’ capabilities, services, and resources that we have gained since the launch of the program.

Recognizing these unique needs and requirements, we have recently implemented a paradigm shift in our CC/CM approaches, focusing on the establishment of CCM and disease state specialty teams. The paradigm shift focuses on our integrated biopsychosocial CC model, which also includes providers as active, engaged participants in Robert’s care team; allowing for the easy exchange of information important for the success of Robert’s plan of care and his successful achievement of improved health outcomes. Our enhanced Model of Care, including our CC/CM processes, is built upon the following components:

> Multivariate, data-driven assessment of Robert’s risks, complexity and need

> Stratification and assignment of Robert to the appropriate level of support based on his risks and complexity

> Person-centered planning process built around concepts of shared decision-making

> Multi-level, evidence-based, fully integrated biopsychosocial CM that includes:

  >> Prevention and wellness

  >> Self-management and self-directed care, built around concepts of recovery and resiliency

  >> DM/condition management (COPD, HTN, diabetes, insomnia)

  >> CM

  >> Care transition management and supports

  >> Complex medical, behavioral and psychosocial CC
An important element of managing Robert’s care and health plan experience was the Integrated Health Neighborhood customized by region, was an integral part of Robert’s CC/CM team. Our goal to improve Robert’s care, quality of life, and health outcomes could only be achieved within the context of where he was – within his neighborhood and community. Our Integrated Health Neighborhood team lives and works within the communities where Robert resides and are important participants in supporting his stability and his path to recovery. Our team has first-hand knowledge of Robert’s community’s strengths, resources, services, and service gaps. Robert’s Integrated Health Neighborhood team included Evelyn (his ICCM), Health Guides, and Community Outreach Specialists, supported by Housing Specialists, Employment Specialists, Clinical Pharmacists, Medical Directors, and others.

We created the Integrated Health Neighborhood concept which includes relationships and collaborations with community partners that enable us to effectively coordinate care with the community supports and services that Robert knows and trusts, and which the provider delivery system can easily access.

The Integrated Health Neighborhood is our vehicle to drive close collaboration with community partners, allowing us to customize care for Robert, and to provide a seamless, one-stop system of services and supports. The Integrated Health Neighborhood model also naturally bridges language and cultural barriers and more effectively and efficiently facilitates access to services to support Robert, his son with supports where he lives, works, and plays. In Robert’s rural area, the Integrated Health Neighborhood had the ability to utilize the latest telehealth and telemedicine techniques to ensure Robert received the care and services needed. Virtual health care applications were utilized by Robert at local libraries, agencies, and/or health care offices.

7.1 Population Assessment: Annually of Enrollee Population Characteristics and Needs
No less frequently than annually, Magellan Complete Care assesses the characteristics of its enrollee population and sub-populations to identify changes in underlying enrollee characteristics, disease-burden, and risk levels. Since the launch of the health plan in 2014 and due to the dynamic and complex nature of the Magellan Complete Care enrollment, Magellan Complete Care has conducted more frequent assessments of the population to accurately improve its CC/CM focus. The information is used to refine our CC/CM models, including changes needed in clinical programs, planned interventions, and staffing mix/level.

***h. Grievances and Appeals
We are committed to supporting Robert with his complex needs and conditions in accessing and receiving care and services he needs in an appropriate and timely fashion. Magellan Complete Care sees the complaints, grievance, and appeals process as an opportunity for continuous refinement and improvement for all areas of our operations and those of our contracted providers and vendors. Our goal is to use the invaluable information gathered through these processes to continually enhance our organization, Robert’s experience, and outcomes for our innovative specialty health plan.

Magellan Complete Care worked with Robert and his network providers in a collegial, partnering atmosphere to resolve issues. We leveraged our extensive system capabilities to collect and comprehensively monitor complaint, grievance and appeals data, perform detailed trending and
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

analysis, manage the provider network, and respond quickly to enrollee and provider needs. We also tracked root cause analysis and trending to mitigate future complaints, grievances, and appeals.

We worked to resolve issues quickly to promote Robert’s wellness. We train our employees to not only apply excellent customer service skills, but also to understand the complexities of someone who has complex illnesses, their potential obstacles, behaviors, and how to engage with sensitivity and empathy. Enrollee satisfaction is a critical component of empowerment, and is central to AHCA and Magellan Complete Care’s vision for recovery and health for enrollees like Robert.

We strive to make the complaints, grievances, and appeals process as simple and user friendly as possible. Robert was able to communicate a grievance at any time by contacting AHCA or Magellan Complete Care Customer Service in-person or by phone, fax, e-mail, or letter. There is no required format and no wrong way to bring a concern to our attention.

Robert was clearly informed of the grievance and appeals process through a variety of enrollee communication materials including the Member Handbook, enrollee newsletter and on the Magellan Complete Care website. Evelyn educated Robert on the grievance and appeals process with each contact she made. Robert was encouraged to register complaints, appeals, and grievances with Magellan Complete Care when he felt it was appropriate to do so. He was informed of the process that Magellan Complete Care follows in investigating and providing feedback on resolution.

Robert was informed that if he ever needed to report a grievance or participate in the appeal process, he could contact the Customer Service, QI Department, or the Appeals Department, and the staff would take the opportunity to provide further education and to answer questions as needed or requested on a wide range of topics, including the complaint, grievance, and appeals process, the Medicaid Fair Hearing process, Subscriber Assistance Program, benefits and limitations, and our utilization processes. Additionally, Evelyn took the opportunity to inform Robert on how to work with his providers to get needed documents, or to discuss how we can help get documents on his provider’s behalf, if Robert indicated the need for help.

In Robert’s situation, Evelyn reviewed the grievance and appeals process with him initially with the first face-to-face visit and on subsequent calls and contacts with him. Robert had no formal complaints or concerns but expressed a good understanding of what to do in the event that he needed it.

Robert did communicate that in the past he was having difficulty finding a PCP and he thought about filing a complaint. Evelyn reassured Robert that if he did file a complaint, that whomever took his complaint would be able to resolve it within one business day; and it is reported to AHCA as a complaint. If it takes more than one business day, it is considered a grievance and a different timeframe to manage. Our goal was to get Robert what he needed quickly to resolve a complaint or grievance.

There are a number of mechanisms under which Robert could file a complaint/grievance: calling customer service, submitting a letter to a designated address, sending by electronic mailbox, asking a provider (PCP) to submit on his behalf, or asking a Health Guide/ICCM to submit on his behalf.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

All SMI Specialty Plan written materials are at a 4th grade level when possible. Written materials are available in alternative formats and in an appropriate manner that takes into consideration special needs the enrollee may have, including those who are visually limited or have limited reading proficiency. Customer Service Representatives are trained to offer enrollees assistance with filing complaints, grievances, and appeals when an enrollee contacts Magellan Complete Care with a verbal complaint or grievance. Magellan Complete Care has bilingual and multi-cultural staff that speak English and Spanish, as well as use of a telephonic interpreter service for those enrollees who call for services but do not speak English. Magellan Complete Care uses Pacific Interpreters, who provide telephonic translation for 180 languages.

For appeals, all of our Appeals Coordinators function as an ombudsman for our enrollees and are trained to engage and communicate with the SMI population. Appeals Coordinators are culturally aware subject matter experts in the area of SMI behaviors and de-escalation techniques and motivational interviewing. We have no time limits when we receive or carry out calls. When we receive a verbal appeal, we do not require a written appeal follow up. We begin our appeal process based on the verbal appeal and the Appeals Coordinator maintains the documentation trail.

CONCLUSION – RESULTS FOR ROBERT
Within the first month of Robert’s enrollment and CCM engagement with Evelyn and the Magellan Complete Care CC team, Robert was fully assessed and his plan of care was successfully established and implemented. He continued to be engaged with Evelyn and accessed services and supports within his Integrated Health Neighborhood.

First and foremost, Evelyn partnered with Robert to get his COPD under better control, including getting him on a more adherent medication regime; scheduling PCP and specialist appointments; and scheduled transportation to and from appointments. Robert agreed to use PRN oxygen, which was delivered to his home, including portable oxygen, and used the oxygen as needed. Robert fully understood that he could not smoke while the oxygen was in use. Robert agreed to get the Cobalt and Clickotine applications on his Smartphone to begin the process of smoking cessation, and to participate in stress reduction techniques to ease the process. Evelyn coordinated Robert’s care and services and integrated Robert’s son’s care and services as much as possible.

During the first three months of Robert’s engagement with the CCM program, he accomplished the following milestones:
> Experienced no ER visits
> Participated in virtual visits by his care team utilizing telehealth and telemedicine technology
> Received and began utilizing the Clickotine application on his Smartphone to assist with smoking cessation
> Received the Cobalt application on his Smartphone and began utilizing it for stress reduction and relaxation
> Received assistance in getting access to the FQHC near his home and received all of his care there, including his PCP, dental, and financial assistance when needed
> Received assistance in getting an appointment with a pulmonologist at the local medical center who assisted in coordinating his pulmonary rehab services and his sleep study for his insomnia
> Received assistance in getting his pulmonary rehab services at the FQHC
> Accessed services through the FQHC for his son
> Tolerated his respiratory medication adjustments with less side effects and/or symptoms
> Received transportation assistance with successful trips to and from all FQHC appointments –
  the Health Guide accompanied him on occasion to his appointments
> Obtained his PRN oxygen (with a portable tank) for use in the home
> Received nutrition counseling at the FQHC and was tried his best to adhere to a low cholesterol,
  low fat, and recommended ADA diet.

Robert remains active in his church and is accessing services and supports for both himself and
his son – all offered in-kind by the church. Robert attends parenting support groups at his church
and his son is participating in the teen workshops there as well.

Within 3-6 months of Robert’s engagement with the CCM program, Robert accomplished the
following additional milestones:
> Enrolled in the Healthy Behaviors weight management and smoking cessation program and
  reported feeling better; less short of breath
> Scheduled for a sleep study to further evaluate his insomnia issues
> Continued to receive transportation assistance with successful trips to and from all FQHC
  appointments – Evelyn or the Health Guide accompanied him on occasion to his appointments
> Continued communication between Evelyn and the FQHC staff to ensure that Robert’s plan of
care stayed current and he was meeting his goals as agreed upon.

Within 6-12 months of Robert’s engagement with the CCM program, Evelyn and the team
continues to support and communicate with Robert, who has now stopped smoking, has lost 25
pounds, and overall feels much better. He is having less reparatory symptoms and benefitted
greatly from the pulmonary rehab services. His sleep patterns improved once his respiratory
symptoms improved. Robert was afraid that he would need to use an apnea monitor at night,
however he did not need it. Robert and his son jointly participate in church and school functions.
Robert is now exploring the possibility of going back to work when able, and is receiving job
search information through the FQHC Social Worker.
Evaluation Criteria:

1. The adequacy of the respondent’s approach in addressing the following:

   a. Identification processes for enrollees with complex health conditions or who are in need of care coordination;
   b. Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
   c. Application of the respondent’s case management risk stratification protocol;
   d. Identification of service needs (covered and non-covered) and a description for service referral processes;
e. Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;

f. Application of discharge and aftercare planning protocols that facilitate a successful transition;

g. Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services;

h. Description of the assessment of provider capacity to meet the specific needs of enrollees;

i. Identification of strategies that promote enrollee self-management and treatment adherence;

j. Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and

k. Application of strategies to integrate enrollee information across the plan and various subcontractors when the respondent has delegated functions.

2. The extent to which the respondent’s workflows/narrative descriptions include timeframes for completion of each step in the care planning process.

3. The extent to which the respondent demonstrates innovative and evidence-based processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).

4. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.

5. The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provides evidence of strategies utilized that resulted in improved health outcomes.

6. The extent to which the respondent demonstrates a system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.

7. The extent to which the respondent describes innovative and evidence-based strategies to integrate information across all systems/processes into its workflows.

**Score:** This section is worth a maximum of 85 raw points with each of the above components being worth a maximum of 5 points each.
C. RECIPIENT EXPERIENCE

SRC# 9 – Expanded Benefits (Regional):

Based upon the expanded benefits listed in Exhibit A-4-a-2, Expanded Benefits Tool, the respondent shall identify the benefits it proposes to offer its enrollees for all eligible populations (TANF, ABD, dual eligible, and LTC populations). Exhibit A-4-a-2, Expanded Benefits Tool outlines specific expanded benefits, including category, procedure code descriptions and procedure codes. When electing to offer expanded benefits included in Exhibit A-4-a-2, Expanded Benefits Tool, the respondent must offer the benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in Exhibit A-4-a-2.

Response: The respondent shall select the following expanded benefits it will offer, as listed in Exhibit A-4-a-2, Expanded Benefits Tool (Respondent shall check all that apply):

☒ Dental benefits for adults
☒ Over-the-counter benefits
☒ Occupational Therapy benefits for adults
☒ Physical Therapy benefits for adults
☒ Hearing benefit for adults
☒ Vision benefit for adults
☒ Prenatal benefit
☒ Respiratory Therapy benefit for adults
☒ Speech Therapy benefit for adults
☒ Additional Primary Care services benefit
☒ Newborn Circumcision benefit

Evaluation Criteria:

Score: This section is worth a maximum of 190 raw points as outlined below.

(a) Election of the Dental benefit for adults: 50 pts
(b) Election of the Over-the-counter benefit: 25 pts
(c) Election of the Occupational Therapy benefits for adults: 20 pts
(d) Election of the Physical Therapy benefit for adults: 20 pts
(e) Election of the Prenatal benefit: 20 pts
(f) Election of the Hearing benefit for adults: 10 pts
(g) Election of the Vision benefit for adults: 10 pts
(h) Election of the Respiratory Therapy benefit for adults: 10 pts
(i) Election of the Speech Therapy benefit for adults: 10 pts
(j) Election of the Additional Primary Care services benefit: 10 pts
(k) Election of the Newborn Circumcision benefit: 5 pts
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
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SRC# 10 – Additional Expanded Benefits (Regional)

The respondent shall identify each additional expanded benefit that it proposes to offer its enrollees by eligible population (TANF, ABD, dual eligible, and LTC populations). For the purposes of this SRC, the respondent must not select expanded benefits that are included in Exhibit A-4-a-2, Expanded Benefits Tool described in SRC# 9. The respondent shall include the name of the benefit, procedure code descriptions, procedure codes and any limitations (frequency/duration, etc.).

The respondent shall submit documentation that includes the calculations used to determine the per-member-per-month (PMPM) cost and the data source used for the calculations (e.g. previous SMMC experience, commercial experience). The submitted PMPM cost must be developed on a “total member” basis, rather than a “per user” or “per benefit eligible” basis (e.g., if the benefit is for adults only, do not submit the expected monthly cost per adult but rather the expected cost per member; or, if the benefit is for the household, its expected monthly cost must be converted to the expected cost per member) and should exclude administrative costs. The respondent shall submit Exhibit A-4-a-3, Additional Expanded Benefits Template (Regional).

Response:

Magellan Complete Care of Florida was created for the sole purpose of developing, delivering, and managing state-of-the-art integrated medical and behavioral health services for individuals with serious mental illness (SMI). We have leveraged our experience as the current SMI specialty plan to create a set of additional expanded benefits to meet the unique needs of this population.

Magellan Complete Care will offer the following additional expanded benefits. See [Exhibit A-4-a-3] for our complete list of expanded benefits, as well as [General SRC #10, Attachment 1: Expanded Benefits Actuarial Support Summary].

Magellan Complete Care has designed its benefit programs to continue to meet the needs of the very complex SMI population being served. We believe the benefits are medically appropriate to support our fully-integrated biopsychosocial model of care and support the goals of enrollee behavioral and physical health stability and progress toward recovery.

Magellan Complete Care has designed its array of expanded benefits around the following principles:

> Helping enrollees access important health care services not normally covered in the State Medicaid Plan
> Helping enrollees access important over-the-counter medications and related healthcare items
> Facilitating enrollees’ transitions from inpatient settings back to home in a safe and efficient manner
> Promoting healthy nutrition for those with chronic conditions
> Promoting enrollees’ ability to safely live in the community
> Promoting medication adherence and medication safety
> Promoting true integration of care through consistent interdisciplinary treatment team conferences
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

The benefits are based on our regular and ongoing analysis of enrollee patterns of utilization and expense. They support best-practice clinical guidelines as well as improved quality, health outcomes, and lower total enrollee costs. They also reflect a more detailed understanding of the underlying provider capabilities and practice patterns in the communities served by Magellan Complete Care, ensuring that required provider capacity is available to support those benefits.

We have reviewed AHCA’s current approved expanded benefit coverage and limitations for Managed Medicaid Assistance plans. We propose the following additional expanded benefits to more fully meet the unique needs of the SMI specialty population. See [Exhibit A-4-a-3] for additional details on these services.

- Nutritional Counseling
- Post Discharge Meals
- Waived Copayments
- Intensive Outpatient Treatment – Mental Health
- Intensive Outpatient Treatment – Substance Use Disorders
- Collaborative Care (Collaborative Care is currently a Medicare-billable service through codes G0502, G0503, and G0504. Magellan Complete Care is proposing the use of CPT codes 99366, 99367, and 99368 until the American Medical Association releases Medicaid equivalent codes in early 2018).

In addition to the covered benefits, expanded benefits and the expanded benefits listed above, Magellan Complete Care offers several of the in lieu of services outlined in the current contract. These services include:

- Crisis Stabilization Units
- Detoxification or Addictions Receiving Facilities licensed under s 397, F.S.
- Mobile Crisis Assessment and Intervention
- Ambulatory Detoxification Services
- Self-Help/Peer Services
- Partial Hospitalization Services

By offering in lieu of services, enrollees are able to receive some services in a different location, different intensity and different modalities to fit their level of functioning and to help the enrollee get the right services in the right location at the right time.

Magellan Complete Care has learned over the past four years that not all enrollee needs can be addressed through Medicaid covered services and expanded benefits. The SMI specialty membership has unique needs that Magellan Complete Care knows are important to address for the holistic well-being of the enrollee. Our care managers work with enrollees to address the social determinants of health. For instance, we assist enrollees in locating appropriate housing options including shelters, temporary housing and permanent housing. We also work with the criminal justice system to reduce recidivism and increase diversions to care, support enrollees through the internal peer support process, and assist them in locating local community resources to assist with day-to-day living needs. To that end, we have built out a comprehensive community resource guide (by region) to help us address social determinants of health.

Evaluation Criteria:
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

a. The extent to which the respondent identifies the expanded benefits it will provide and the information included in Exhibit A-4-a-3, Additional Expanded Benefits Template (Regional).

**Score:** This section is worth a maximum of 5 raw points with the above component being worth a maximum of 5 points.

**Note:** Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK
The respondent shall describe the provider search function for the online provider directory, including submission of:

a. A description outlining the transparency and accessibility of the online provider directory, including the parameters upon which enrollees may search. Include whether or not the online provider directory is mobile friendly.

b. Screen shots for each mouse click required from the start of the respondent’s home page to actual search results for a provider, using durable medical equipment providers and zip code as the search elements.

c. A list of performance indicators the respondent will include for each provider type listed in its provider directory.

d. A description of the respondent’s process for verification of provider information in the online provider directory, including delegated subcontractor provider information, and the method(s) the respondent uses to ensure the weekly network file submission to the Agency is accurate.

Response:

OVERVIEW
Magellan Complete Care’s roots as an engaged and committed member of the Florida healthcare community go back to the 1990s, when our parent company began providing mental health and substance abuse services as sub-contractor to several large Florida health plans. Our Medicaid experience is deep, through our tenure as the Prepaid Mental Health Plan (PMHP) in Florida Medicaid; to our work helping children and families engaged with the child welfare system across the State, and to Magellan Complete Care of Florida itself – the nation’s very first serious mental illness (SMI) specialty Medicaid plan, and the culmination of our decades of experience supporting vulnerable Floridians with complex needs.

Magellan Complete Care has an existing statewide provider network with specific expertise to support the unique needs of our enrollees who are living with SMI. We have developed a successful working relationship with AHCA on managing and reporting provider-related data and continue to modify and adjust our network based on input/feedback, as well as continuously monitored quality data. One critical component of ensuring seamless service delivery is our comprehensive, searchable, on-line provider directory, which ensures that our enrollees have an easy access point for identifying providers in our network, including PCPs, behavioral health providers, specialists, pharmacies, hospitals, and other provider types.

During the term of our current AHCA contract, we have facilitated numerous enrollee, provider and other stakeholder meetings regarding our online and related plan communications materials. These efforts have further refined our deep understanding about the provider community and how we can support the accuracy of their data. We have used this feedback to revise and improve the transparency and accessibility of our provider search function, including the structure of our provider directory and provider portal. We will continue applying our quality improvement
methodolog to support the gathering of enrollee, our provider council and other stakeholder feedback as one of the many approaches we use to improve our communication methods with enrollees, providers and other stakeholders.

CRITERIA 1: THE EXTENT OF THE RESPONDENT’S SEARCH FUNCTIONS…
Magellan Complete Care’s mobile friendly online provider directory, Find a Provider, is fast and easy to navigate using the enrollee’s zip code and is continuously being enhanced. This Florida-specific site is readily found at both of our websites. Our online directory requires no login, making it universally available to anyone supporting our enrollees. Find a Provider is accessible on all platforms (desktop, mobile technology, and tablet). For ease of access, we use a responsive web design, meaning our truly mobile-friendly technology instinctively adapts to the screen size it is being viewed upon, making it natural and easy to use on mobile phone, tablet or desktop. The site works well on any operating system using any current internet web browser. There is no pinching or horizontal scrolling required by the user.

Information about our provider network is available in real-time and can be easily navigated through a guided search format. This provider search function helps enrollees find Magellan Complete Care providers by searching using any combination of the provider’s name, NPI, license number, provider type, the provider’s distance from the enrollee’s address, ZIP code radius, and the provider’s capacity to accept new patients. For additional transparency, users can also target specific provider based group affiliation, hours of operation, location conditions, level of care, ethnicity, ages treated, hospital affiliations, and languages spoken, including English and non-English languages. We also provide Google Maps links in our search function, which enable users to view a map of their provider’s location and obtain driving directions. Additional icons in the provider search results enable users to easily identify and compare providers who are handicap accessible or are located near public transportation. This search engine includes features such as the provider’s picture, a list of self-designated attributes, a personal statement, education and board certification and the ability to compare providers.

Enrollees can rate a provider and provide feedback to Magellan Complete Care on issues encountered while trying to contact a provider such as incorrect address, provider deceased or provider not accepting new patients. Viewers can benefit from other enrollees’ experience and ratings for an individual provider as they view provider information returned from the search. The search provides the ability to change location for providers who practice at multiple locations, and the simple click of a button displays a map with all the provider locations identified. Screenshots of the provider search function and resultant display are shown in [General SRC #11, Attachment 1: Provider Search Screens].

To ensure enrollees and other stakeholders have immediate and easy access to the information they need, Magellan Complete Care enrollees can receive free smartphones and messaging services through the SafeLink program. We deliver the free smartphones with a pre-installed default link to our website, which displays in a mobile-friendly format on any mobile platform using an up-to-date browser. We believe this approach and service helps enable our enrollees to understand what providers are available to them, allowing them to play an active role in their own healthcare decisions.
CRITERIA 2: THE EXTENT TO WHICH THE NUMBER OF CLICKS IT TAKES...
Magellan Complete Care’s online provider search is detailed in [General SRC #11, Attachment 1: Provider Search Screens] and outlines the number of clicks it takes to access the final search results, using the process of searching for a durable medical equipment provider by zip code as an example. Starting from our enrollee website homepage, a user would have to click five times to access the resulting provider list.

1. Click #1 “Find a Provider” – This takes you to the provider search page where the user would initiate a provider search

2. Click #2 “Search for a Provider” – This Provider Search screen is where a user would initiate a provider search, by clicking on the “Search for a Provider” link

3. Click #3 “Choose Provider Type and Zip Code” – This Provider Search screen allows the user to enter a provider type, based on a set of options in the drop-down box, as well as the user’s zip code and desired distance relative to the zip code.

4. Click #4 “More Filters” – The Find a Provider screen allows the choice of more filters by the click of a button to expand the choice of criteria used to identify providers.

5. Click #5 “Search” – This Provider Search screen identifies the complete list of ancillary providers and allows the user to refine their search for a category such as “Durable Medical Equipment” specialty providers within the referenced zip code.

CRITERIA 3: THE EXTENT AND RELEVANCE OF THE PERFORMANCE INDICATORS AVAILABLE IN THE RESPONDENT’S PROVIDER DIRECTORY FOR EACH PROVIDER TYPE LISTED.
As part of Magellan Complete Care’s PCP assignment process, we identify preferred providers for membership assignment; however, enrollee choice is always the first criteria. When an enrollee performs a provider search, providers are sorted in the order of distance from the enrollee’s address, then ranked by preferred provider status. We continue to advance our methodology toward establishing preferred providers based on quality and cost. Quality metrics used will align with our AHCA performance measures, our provider incentive programs, and Value Based Purchasing (VBP) agreements.

Viewers benefit from other enrollees’ experience and ratings of providers. We upload these ratings into the Provider Search after a quality validation and provider notification. Enrollees are able to rate a provider based on their clinical, quality, and utilization experience with that provider including:

>Provider’s ability to understand enrollee’s concerns
>Provider’s treatment plan was adequate
>Satisfaction with the provider’s treatment and care
>Ease of scheduling an appointment
>Friendliness and courtesy of staff
>Comfort and safety of office environment
>General satisfaction of overall experience of care and services with the provider
>Would the enrollee recommend this provider
We also provide enrollees with a link to the national organizations Quality Check®, Hospital Compare, and The Leapfrog Group about the quality of hospitals and other facilities. These links are displayed prominently in the Qualifications section of the provider detail page. Quality Check is hosted by The Joint Commission. Hospital Compare is hosted by Medicare.gov, and The Leapfrog Group is a nonprofit organization that serves as a voice for health care purchasers by using their collective influence to foster positive change in U.S. health care. Leapfrog is the nation’s premier advocate of hospital transparency—collecting, analyzing and disseminating hospital data to inform value-based purchasing.

By maintaining a network that offers the appropriate mix of specialists, we are able to respond quickly to changing demographics and provide an adequate choice of providers. We support these provider network capabilities by monitoring and leveraging various performance indicators to meet enrollee needs, including:

> GeoAccess and population density data
> Internal communication with Care Coordinators and the care team, current and anticipated enrollment and penetration data
> Enrollee demographic data, including cultural and linguistic needs
> Stakeholder feedback
> Input from satisfaction surveys and quality committees
> Review of complaints and grievance information regarding service access
> Results of on-site reviews and surveys of appointment availability
> Authorization and claims data comparing authorized services to delivered services

CRITERIA 4: THE EXTENT OF THE RESPONDENT’S EFFORTS TO ENSURE INFORMATION...

4.1 Data Integrity of Magellan Complete Care’s Provider Information

Magellan Complete Care’s provider data is captured and maintained in the Integrated Provider Database (IPD). This IPD database is the core repository for the data displayed on our online directory, and is updated daily, in real time. We have adopted a Network Provider Data Maintenance and Data Integrity policy and related set of procedures, which describe our policy and standards for collecting, entering, maintaining, and validating provider information in the provider database. Our Network team ensures completeness of all provider data entry by adhering to specific rules designed to capture required data entry points contained in the online provider directory. To ensure accuracy, monthly data audits are performed on all entries and provider types in the provider database to ensure completeness and alignment with documented data requests and state requirements. Inaccurate provider data is updated following verification of the correct information.

Timely and accurate information about each provider is essential for enrollee access to care. We use provider information to support provider directories, claims payment, authorizations, and enrollee referrals to providers. Examples of these data include: provider demographic information, provider availability, provider credentials, and provider billing information. We confirm the accuracy of provider data by comparing the data to a valid, credible source. We use a number of
methods to perform this validation, including credentials verification, provider attestation and periodic audits.

4.2 Information Sources, Data Validation, Monitoring and Updates
We use the following data sources and data validation steps to confirm and validate the accuracy of provider data:

4.2.a Information Sources
Provider data is obtained from the following sources:

1. Magellan Complete Care’s Provider Gateway application for providers interested in joining our network
2. The provider’s credentialing/recredentialing application
3. Materials supplemental to the application as submitted by the provider
4. Primary and secondary verification sources queried at credentialing events and when new information is received from the provider
5. Online Provider Data Change Form available on our provider website (magellanprovider.com) for providers to update information to ensure accuracy
6. Appointment availability information which may be obtained from random outreach calls (as required by customer or regulatory body)
7. Provider interaction with our field network staff and provider support specialists, who on a regular basis are verifying and validating provider data
8. Enrollee services staff validate information as they interact with providers in arranging appointments for enrollees
9. Enrollee feedback regarding inaccurate provider practice and provider availability information
10. Written communications from providers indicating changes to their practice data

4.2.b Data Validation
Provider directory information is validated through a combination of primary and secondary source verifications performed by Magellan, provider self-report and attestation.

1. Practitioner qualifications gathered during the credentialing process match these listings. Verification using primary sources is performed on: education, training, licensure, and specialty board certifications.
2. Facility/organizational provider accreditation status is verified via primary source or provider-supplied copy of accreditation report, letter, or certificate.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
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3. Data validated via providers’ self-report: demographic information, office locations, contact
information, office hours, hospital affiliations (as applicable), other areas of specialty practice or
expertise, languages spoken, and whether accepting new patients.

4. Provider information is revalidated at recredentialing (at least every thirty-six (36) months), and,
as required, whenever provider submits new information.

5. Practitioners are requested to review and attest to the accuracy of information displayed on the
online provider directory on a quarterly basis

4.3 Monitoring
4.3.a Provider Directory
Before uploading any provider data to our online directory, we perform a three-step process to
ensure enrollees have access to covered services through online and/or paper provider directory
and are using the most up-to-date and validated provider data available.

4.3.b Customer Service Center
Our Customer Service Center team validates provider information by conducting periodic and
semi-annual audits. The provider data we validate includes, but is not limited to:

>Practitioner
>>Name and gender
>>Provider type/discipline (professional level) – Psychiatrist, Psychologist, Registered Nurse,
Social Worker, Substance Abuse Professional or Therapist;
>>Professional degree;
>>License type;
>>Specialty and any subspecialty qualifications;
>>Hospital/organizational affiliations (admitting/attending privileges);
>>Medical/practice group affiliations;
>>Board certification(s), if applicable;
>>Languages spoken by the practitioner or clinical staff;
>>Office locations and phone numbers: address, phone numbers and office hours for primary
services locations, as well as secondary and tertiary service locations (if applicable); and
>>Whether accepting new patients.

>Facilities/Organizations
>>Facility name;
>>Facility location(s) and phone number(s);
>>Facility accreditation status;
>>Practitioners included within the facility (as required by client or regulation);
>>Office hours;
>>Specialties;
>>Available services (as required by client or regulation); and
>>Hospital quality data from recognized sources.

>Groups
>>Group name;
>>Group location(s) and phone number(s);
>>Practitioners included within the group;
>>Office hours;
>>Specialties of practitioners; and
>>Available services (as required by client or regulation).

4.3.c Network Team
The Network team ensures that information accurately aligns with ACHAs Provider Master List (PML) for License Number, Medicaid ID, and NPI by reviewing the weekly Provider Network Verification (PNV) submission response files. For each data point the Network team researches any discrepancies and makes the necessary changes to ensure accuracy of our data.

The Network team and provider support specialist partner to ensure data accuracy and completeness by capturing accurate provider data updates directly with the provider during regular provider visits.

To ensure accuracy, validation of inaccurate provider information is identified through random audit sampling as well as pended claims by the claims staff.

Our Network team also conducts internal “secret shopper” outreach to providers to validate that phone numbers and addresses listed in the directory are correct. This process ensures that contact information for providers is reviewed and corrected if needed to support a positive enrollee experience.

4.3.d Online Services
Our online services allow providers to submit updates and changes, which we emphasize during provider orientation and on-site visits. Our online provider portal allows some provider types to update information regarding their practice information such as:

>Service location addresses and phone numbers
>Office hours
>Whether they are accepting patients, appointment availability and access
>Submit a W9 to change their billing TIN
>Name, gender, ethnic origin, degree, CAQH ID
>Add a new professional license
>Practice age limitations
>Behavioral health areas of clinical interest
>Languages spoken
>Mailing and financial addresses
>Enroll in EFT

Group practices can perform all of the above activities and maintain their roster of professional providers in their practice.

The provider must review their information and attest that it is accurate for each change that is submitted.

CRITERIA 5: THE EXTENT TO WHICH THE RESPONDENT’S ONLINE...
Magellan Complete Care’s provider data is captured and maintained in the Integrated Provider Database (IPD), which contains provider demographics, credentialing, and contract-related...
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

information. This IPD database is the core repository for all the provider data displayed on the website, and is updated in real time, exceeding the requirement that changes be made daily. Using IPD, we capture provider information such as clinical expertise, which is critical to providing services to our SMI enrollees.

Magellan Complete Care reports its full provider network to AHCA weekly via the Provider Network Verification (PNV) file. This file is pulled from the same source data that populates the daily directory updates and aligns closely to the AHCA’s PNV layout specifications, especially with regard to specialty and provider type classifications. Upon each weekly PNV submission, we review the response files to identify any records that require correction for successful transmission to AHCA.

Evaluation Criteria:

1. The extent of the respondent’s search functions for the respondent’s online directory and ease of access for enrollees’ navigation of the online provider directory, including whether or not the online directory is mobile friendly.

2. The extent to which the number of clicks it takes recipients to access the search results, as indicated by the screen shots provided, is less than five (5).

3. The extent and relevance of the performance indicators available in the respondent’s provider directory for each provider type listed.

4. The extent of the respondent’s efforts to ensure information in the respondent’s online provider directory is accurate, including type and frequency of monitoring activities, and delegated subcontractor provider information. Include the frequency of outreach efforts to remediate incorrect provider demographic information and accepting new patient status.

5. The extent to which the respondent’s online provider directory updates are performed daily and the extent to which the updates are communicated to the Agency as required to ensure the information the respondent displays on its website align with the Agency’s information.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 12 – Enrollee Grievance and Appeal System (Statewide):

The respondent shall provide a flowchart and written description of how the respondent will execute its enrollee grievance and appeal system, including identifying, tracking and analysis of enrollee complaints, grievances, appeals and Medicaid fair hearing data. The respondent shall include in the description detail regarding how data resulting from the grievance and appeal system are used to improve the operational performance of the respondent.

Response:

OVERVIEW
Magellan Complete Care embraces the complaint, grievance, and appeals process as it offers an opportunity to evaluate performance and continually improve services offered to members. We treat any expression of dissatisfaction by or on behalf of an enrollee, provider, or a representative on the enrollee’s behalf consistent with the formal requirements of the complaint, grievance, and appeal process. We comply with all aspects of Florida State law, including s. 641.511, F.S., and with Federal laws and regulations, including 42 CFR 431.200 and 438, Subpart F, Grievance System.

Magellan Complete Care definitions for complaints, grievances, appeals, and actions are consistent with AHCA requirements. We use well-established processes to resolve and manage grievances, appeals, and requests for fair hearings. Grievances or appeals may be filed by an enrollee or by a provider acting on behalf of an enrollee and with the enrollee’s written consent. Grievances or appeals may be filed orally or in writing.

Magellan Complete Care administers a fair, efficient, and responsive complaint, appeal, and grievance processes to ensure timely resolution for our enrollees in support of AHCA’s goal to deliver appropriate care in a timely and efficient manner. The core of the complaint, grievance, and appeal process is ease of navigation and continuous collaboration with enrollees, providers, and advocates to achieve the best outcomes for enrollees. Magellan Complete Care meets or exceeds all AHCA requirements for timeliness in the processing and resolution of complaints, grievances and appeals, and the reporting of those results.

CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT’S GRIEVANCE AND APPEALS SYSTEM FLOWCHART...
We are committed to supporting our enrollees with complex needs and conditions in accessing and receiving care and services they need in an appropriate and timely fashion. Magellan Complete Care sees the complaints, grievances, and appeals process as an opportunity for continuous refinement and improvement for all areas of our operations and those of our contracted providers and vendors. Our goal is to use the invaluable information gathered through these processes to continually enhance our organization, enrollee experience, and outcomes for our innovative specialty SMI health plan.

Magellan Complete Care works with enrollees and network providers in a collegial, partnering atmosphere to resolve issues. We leverage our extensive system capabilities to collect and comprehensively monitor complaint, grievance, and appeals data, perform detailed trending and analysis, manage the provider network, and respond quickly to enrollee and provider needs. We also track root cause analysis and trending to mitigate future complaints, grievances, and appeals.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

We work to resolve issues quickly to promote enrollee wellness and support enrollees in their recovery. We train our employees to not only apply excellent customer service skills, but also to understand the complexities of someone who has Serious Mental Illness (SMI), their potential obstacles and behaviors and how to engage them with sensitivity and empathy. Enrollee satisfaction is a critical component of empowerment, and is central to the Agency for Health Care Administration’s (AHCA) and Magellan Complete Care’s vision for recovery and health for enrollees.

We strive to make the complaints, grievances, and appeals process as simple and user friendly as possible. Enrollees may communicate a grievance at any time by contacting AHCA or Magellan Complete Care Customer Service in-person or by phone, fax, e-mail, or letter. There is no required format and no wrong way to bring a concern to our attention.

Enrollees are clearly informed of the grievance and appeals process through a variety of enrollee communication materials including the enrollee handbook, enrollee newsletter and on the Magellan Complete Care website. They are encouraged to register complaints, appeals, and grievances with Magellan Complete Care when they feel it appropriate to do so and are informed of the process that Magellan Complete Care follows in investigating and providing feedback on resolution.

When an enrollee contacts Customer Service, the QI Department, or the Appeals Department, the staff will take the opportunity on those calls to provide education and answer questions as needed or requested on a wide range of topics including the Magellan Complete Care complaint, grievance, and appeals process, the Medicaid Fair Hearing process, Subscriber Assistance Program, benefits and limitations, and our utilization processes. Additionally, the team may, and has in the past taken the opportunity to educate the enrollee on how to work with their providers to get needed documents or to discuss how we can help them get documents on their behalf if the enrollee indicates the need for assistance.

All written materials are in an easily understood language (including Spanish) and are written at a 4th grade level when possible. Written material are available in alternative formats and in an appropriate manner that takes into consideration special needs the enrollee may have including those who are visually limited or have limited reading proficiency. Customer Service Specialists (CSS) are trained to offer enrollees assistance with filing complaints, grievances, and appeals when an enrollee contacts Magellan Complete Care with a verbal complaint or grievance. Magellan Complete Care has bilingual and multi-cultural staff that speaks English and Spanish as well as use of a telephonic interpreter service for those enrollees who call for services but do not speak English. Magellan Complete Care uses Pacific Interpreters, providing translation for more than 180 languages, to provide telephonic translation services for all enrollees who do not speak English.

[General SRC #12, Attachment 1: Complaints, Grievances and Appeals] provides graphical depictions of our current processes.

CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT’S TIMELINES FOR ACKNOWLEDGING...
Upon receipt of either a complaint, a grievance, or an appeal, the Complaint and Grievance Coordinator or the Appeals Coordinator logs the complaint/grievance/appeal into the applicable
Tracking System, notifies the enrollee in writing upon receipt within five business days acknowledging receipt of the enrollee’s compliant/grievance/appeal, and immediately forwards the complaint/grievance/appeal to the appropriate staff person for investigation and resolution. For example, quality issues are referred to the Quality Improvement Director, clinical issues to the Health Services Department, billing/claims concerns to the Network Services Department, and customer service issues to the Customer Service Department. Magellan Complete Care’s grievance and appeal processes are expedited under urgent circumstances and resolved no more than 72 hours after receipt of the urgent request, or as quickly as the enrollee’s health condition requires.

The enrollee and all relevant parties are notified in writing of the disposition of the complaint, grievance, or appeal within the appropriate timeframes. The written notification includes the results and date of the grievance or appeal resolution. Additional information includes a notice of the right to a Medicaid fair hearing and how to request one. This includes the AHCA Medicaid Hearing Unit address and contact information; an explanation and instruction on filing an appeal through the State’s Subscriber Assistance Panel (SAP) after exhausting Magellan Complete Care’s complaint, grievance, and appeal process; notice of the right and how to continue to receive benefits pending a hearing; and, notice that if Magellan Complete Care’s action is upheld in a hearing, the enrollee may be liable for any cost of any continued benefits.

Magellan Complete Care ensures that decision makers on grievances and appeals were not involved in previous levels of review or decision making. All decision makers are health care professionals with clinical expertise in treating the enrollee’s condition for any grievance or appeal involving a clinical issue. Magellan Complete Care provides AHCA a copy of any grievance or appeal disposition upon request. In all grievance, appeal, and fair hearing cases, Magellan ensures that no punitive action is taken against the enrollee, or the provider who files on an enrollee’s behalf or supports an enrollee’s case. Magellan Complete Care’s policies and procedures clearly specify that the quality and quantity of care received by an enrollee will not be adversely affected, nor can providers be penalized. We will monitor adherence to this policy through analysis of the reasons for filing grievances and the provider complaint and review processes.

Magellan Complete Care has timelines, policies, and procedures that meet or exceed all AHCA standards and requirements. We notify enrollees in writing within five business days acknowledging receipt of an enrollee’s compliant/grievance/appeal, and immediately forward the grievance/appeal to the appropriate staff person for investigation and resolution. Magellan Complete Care’s grievance and appeal processes are expedited under urgent circumstances and resolved no more than 72 hours after receipt of the urgent request, or as quickly as the enrollee’s health condition requires. Our grievance and appeals process flows, coupled with our first-call resolution process and pledge to a 60-day turnaround time for 100 percent of all grievances, reflects our deep commitment to enrollee satisfaction and exceeds the AHCA requirements.

Magellan Complete Care recognizes that AHCA has separate requirements for the processing of enrollee complaints and grievances, and medical/benefit appeals. To ensure a timely, responsive process, Magellan Complete Care has a dedicated complaint and grievance team within the quality management department and dedicated appeals staff within the Compliance Department, to receive and respond to issues. In both departments, we give hiring preference to and employ individuals who are bilingual, and have dedicated Spanish-speaking staff available. We also deploy interpretative services (providing translation for more than 180 languages) and maintain a
TTY line (as required by AHCA) as well as 711 for use when needed by the enrollee or their authorized representative. We provide an overview of the processes in each area, and the required workflows for each, separately below.

2.1 Complaints and Grievances
Magellan Complete Care staff are available via a toll-free telephone number by which enrollees, or someone on their behalf, can file complaints, grievances and appeals. Enrollees can also file complaints and grievances online, by written mail, or in-person. All departments, including Customer Service and Care Management are trained to capture and document verbal complaints, and enter them into our electronic Resolve Complaint System (Resolve) for resolution by our Quality Department. Magellan Complete care provides both translation services, TTY and 711 services to afford enrollees the opportunity to make complaints in instances in which they may require those special supports. If needed, we also will send Health Guides, or other support staff to the enrollee’s home to take a complaint verbally if necessitated by enrollee circumstances. Complaints may also be received from external vendors. Vendor complaints that can’t immediately be resolved by the vendor, are flagged as a grievance and entered into Resolve for resolution by Magellan Complete Care staff.

Magellan Complete Care has a quality improvement department, Quality Director, Quality Manager and two Complaint and Grievance Coordinators on-site in the Miami Office. We also have a Quality Coordinator who does most of the analysis and reporting for AHCA and NCQA purposes. Those reports go through our Quality Committee structure. We also have a Data and Reporting Manager who assists with reporting and analysis and is responsible for all AHCA required reporting of enrollee complaints and grievances.

All departments are trained to try to resolve the enrollee’s complaint at the first contact, through our call handling process. (See [General SRC #12, Attachment 2: Call Handling Process] for more detail). If an enrollee complaint or grievance cannot be immediately resolved, it is forwarded to the Quality Department, where it is documented in our Resolve Vendor Complaint System, for resolution by one of our Quality Improvement Coordinators by close of business (COB) the day after receipt. Verbal complaints are primarily captured by customer service call center representatives and entered directly into our Resolve System daily. Every morning, the quality team runs a report from the Resolve System to capture the previous day’s complaints/grievances and processes them through to resolution. Case managers can also capture a verbal complaint and route it through the same system and workflow. If the complaint cannot be resolved by COB, it is reclassified as a grievance in our system and it is escalated for resolution. The enrollee is also sent an acknowledgement letter within 5 days. The Quality Improvement Staff then works both complaints and grievances that have been logged in the Resolve system every day, and escalating as appropriate, until the issue has been resolved. See [General SRC #12, Attachment 3: Complaints and Grievances Desktop Procedure] for more detailed descriptions of these activities, and [General SRC #12, Attachment 1: Complaints, Grievances and Appeals].

Issues that arise out of consumer forums, whether they are complaints or grievances, are documented and resolved as such. There are times that enrollees will choose to not file a complaint, but the concern or issue brought to our attention warrants further evaluation and consideration. In these circumstances, the Florida-based Magellan Complete Care Quality Improvement Director reviews the concern and determines the appropriate next steps.
Where the concern may be a quality of care issue or could result in a provider quality of care issue, the follow up involves activities such as a random chart review or a site visit. If complaints indicate that there are contractual compliance issues, the Compliance Officer is notified. In these situations the identity of the enrollee will remain confidential due to the enrollee’s decision not to file a complaint or grievance or if the enrollee wishes to remain anonymous. This system, coupled with our first-call resolution process and pledge to a 60-day turnaround time for 100 percent of all grievances, reflects our deep commitment to enrollee satisfaction and exceeds the AHCA requirements.

Magellan Complete Care developed and maintains a dashboard that provides a real-time inventory and aging of complaints and grievances. This tool is used for active and ongoing management of all complaints and grievances and has resulted in Magellan Complete Care achieving turnaround time at or below 60-days for more than one-year. Complaints are managed real-time, upon receipt and must be resolved within one business day. Therefore, there is never a designation of urgent or emergent. A grievance can be managed as expedited, with a 72 hour turnaround time, when the enrollee requests that it be managed as an expedited grievance. However, Magellan Complete Care has had very few of those per year, since its inception.

The data provided in [General SRC #12, Attachment 4: Turnaround Times Summary and Trends] demonstrates our timely resolution process to complaints and grievances and performance on key metrics.

2.2 Appeals
Medical and benefit appeals follow a separate process and are managed within our Compliance Department. The appeals process is managed by a dedicated Appeals Department. To ensure that the volume and contractual requirements are managed effectively, the Appeals Department is sufficiently staffed and has accountable processes to ensure that all enrollee calls are answered promptly, timelines are met, documents received are correctly processed and all letters are appropriate and in compliance with the contract. The Appeals Department has a proactive escalation workflow that includes notifying the Compliance Officer when appeals are close to internal deadlines and other compliance issues such as, but not limited to incorrect denials. The Compliance Officer takes immediate action to mitigate or address the issue.

The Appeals Department is comprised of an Appeals Manager, five Appeals Nurses and three Appeals Coordinators. The team brings a wealth of experience and knowledge. The clinical staff are experienced in the management of physical health and mental health issues, as well as issues that are related to both physical and mental health. The Appeals Nurses prepare and staff complex clinical cases with the Medical Directors and discuss decision points to ensure that enrollees’ needs are met. The non-clinical staff have claims experience and customer service experience. Non-clinical staff receive training on the SMI population as part of their onboarding process with the team. This wealth of experience and knowledge allows the team to address and process each enrollee appeal or provider dispute efficiently and effectively. They are also technically skilled and manage multiple databases to identify, investigate and process the requests appropriately.

Each appeal is recorded and tracked in the appeals database. As part of the team’s daily process, in the morning and at the end of day, a fully detailed appeals report is pulled and used to manage new appeals and appeals already in process. They also account for all appeals and ensure that no notice or letter is missed and each is sent out in accordance to the contractual timeframes.
The team meets daily for a quick status call and the appeal nurses coordinate with physician reviewers at least weekly to discuss the details and timeframes of their assigned appeals and provider disputes. The two workflows included [General SRC #12, Attachment 1: Complaints, Grievances and Appeals] provide additional detail of the process followed in managing appeals received by Magellan Complete Care, as well as those managed through the Medicaid State Fair Hearing process.

To ensure that contractual timeframes are met, the team operates with internal timeframes that are within contractual timeframes and maintains contingency plans if an unforeseen situation occurs rendering any team enrollee or physician reviewer unable to complete their activities. The Magellan Complete Care Appeals staff reviews and manages all appeals on a daily basis through our Appeals database. [General SRC #12, Attachment 5: Appeals Resolution Performance] provides our outcomes for processing and resolution of appeals.

An appeal may be filed within 60 days of the date of the adverse benefit determination and Magellan Complete Care confirms receipt within five business days. Magellan Complete Care ensures that all oral inquiries received to appeal an action are treated as appeals and confirms all inquiries in writing, unless the enrollee or provider requests expedited resolution. Magellan Complete Care acknowledges all appeals in writing within five business days of receipt unless the enrollee requests an expedited resolution. Each letter is provided to the enrollee in a culturally and linguistically appropriate manner. The appeal resolution is written at or near the 4th grade reading level to ensure that resolution in the letter is easy to understand for all readers.

Magellan Complete Care provides a reasonable opportunity to present evidence and testimony and allegations in person and in writing. The enrollee and their representative are also afforded sufficient opportunities before and during the appeal process to examine the enrollee’s case file, including medical records and any other documents and records. If the enrollee or their authorized representative requests a copy of the case file, it is provided to them free of charge.

We understand that our specialty population may require more individualized and supportive assistance than other health plan populations may require. We often receive calls from enrollees requesting assistance in helping them understand not only the appeals process but the utilization management process as well. We provide whatever assistance is needed including information not related to the appeal in some cases. As an example, there is an enrollee who contacted the Appeals Department regarding an adverse benefit determination letter and wanted to request an appeal. She did not know what to do so the Appeals Coordinator spoke with her at length and talked her through the process and provided her with answers to her multiple questions. That enrollee called a number of times after that initial call. Only two of her follow up calls were related to a denied service while the others were just to call that particular Appeals Coordinator to talk and check in with her. This type of interaction that goes beyond health plan processes, rules and requirements, and personally reaches the individual we care for, are not atypical throughout Magellan Complete Care.

We resolve each appeal and provide notice as expeditiously as the enrollee’s health condition requires or no later than 72 hours for expedited appeals and within the State timeframe of 30 days from the date of receipt for standard appeal requests. We process expedited appeals on average within 48 hours of the request (24 hours less than the contractually required 72 hours) and the average standard appeal is completed within 20 days of the request (10 days less than the contractually required 30 days). The plan has not had to extend the standard appeal process but
does have processes in place in case there is a need to seek an extension. If the extension is needed, Magellan Complete Care has procedures in place to ensure that an extension would be in the enrollee’s best interest. [General SRC #12, Attachment 1: Complaints, Grievances and Appeals] includes additional detail outlining the criteria applied to make that determination. If an extension is taken, Magellan Complete Care will notify the enrollee of the extension within two calendar days of the determination.

The enrollee’s benefits are continued when the appeal is filed in a timely fashion by the enrollee or their authorized representative. The appeal must also involve the termination, suspension, or reduction of a previously authorized course of treatment, must have been ordered by an authorized provider, and the authorization period must not have expired. If Magellan Complete Care continues or reinstates enrollee benefits while the appeal is pending, the benefits continue until either of the following occurs:

> The enrollee withdraws the appeal
> The enrollee fails to request a fair hearing and continuation of benefits within 10 calendar days after Magellan Complete Care sends the notice of plan appeal resolution that is not wholly in the enrollee’s favor

Upon receipt of each appeal, it is fully investigated, including review of any evidence, testimony, or allegations submitted by the enrollee or their authorized representative. Documentation of the appeal includes substantive information such as the enrollee’s reason for the appeal and any additional information that was provided with the appeal request. The appeal review does not give deference to the denial decision, but is focused on the clinical information and collateral information provided to reach the final decision. The appeal reviewer is a physician who has the same or similar-specialty and has the appropriate training and experience in the field of medicine as the physician who was involved in the adverse benefit determination denial case. The physician appeal reviewers are different reviewers than those who made the original adverse benefit determination. This ensures that the review is conducted without prejudice and with independence. The physician who conducted the original review and the physician who will conduct the appeal review are recorded in the appeals database.

If the final resolution of the appeal is adverse to the enrollee, Magellan Complete Care may recover the cost of the services furnished while the appeal was pending, to the extent that they were furnished solely because of contract or regulatory requirements. Magellan Complete Care will authorize or provide any disputed services promptly and as expeditiously as the enrollee’s health condition requires if the services were not furnished while the appeal was pending and the disposition reverses a decision to deny, limit or delay services. Magellan Complete Care will pay for disputed services in accordance with State policy and regulations if the services were furnished while the appeal was pending and the disposition reverses a decision to deny, limit, or delay services. Magellan Complete Care informs the enrollee of their rights and the process to request a State Fair Hearing if they do not agree with Magellan's appeal resolution.

2.3 Expedited Appeal Process
Magellan Complete Care has an established procedure for expedited review within 72 hours or sooner when it is determined that taking time for routine resolution could seriously jeopardize the enrollee’s life, health, or ability to attain, maintain, or regain maximum function. The enrollee or their authorized representative may file an appeal either orally or in writing, and no further action on their part is required unless they wish to submit evidence to the fact or other documentation.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Timeframes for resolution begin on the date Magellan Complete Care receives the request for appeal, written or oral. At the time of receipt of the expedited appeal and if the enrollee or their authorized representative wants to submit documentation, the Appeals Coordinator assigned to the case will inform the appellant of the limited time available for the enrollee to present their evidence and allegations of fact or law, in person and in writing. When an enrollee has expressed issues or concerns about their ability to get what they need for their appeal from the provider and they request our help, we assist the enrollee by contacting the provider on their behalf.

Each expedited appeal request is reviewed for appropriateness. The Appeals Nurse reviews all medical documentation provided in support of the expedited request along with the date(s) of the service in question. If the service was already provided, the expedited request is transferred to a standard review. Pre-service requests are then referred to the medical directors for review and will make the determination that the expedited request is medically warranted. If the appeal request is for a concurrent service, the request is processed as an expedited appeal. If Magellan Complete Care denies the request for expedited appeal, it is immediately transferred to the timeframe for standard resolution and we will notify the enrollee. If the enrollee asks for an extension, Magellan Complete Care treats their request as a denial for expedited appeal and immediately transfer the appeal to a standard appeal status and follow the timeframes for same unless there is a need to resolve the appeal expeditiously due to the enrollee’s health status.

Upon receipt of an expedited appeal, the Appeals Coordinator logs the appeal into the Appeal Database and the Appeals Nurse summarizes the case and immediately forwards it to a physician reviewer or an appropriate peer advisor for review. Following resolution of the appeal, the appeals coordinator sends a notification letter to the enrollee and others involved in the appeal. We make every reasonable effort to provide prompt oral notification of the reason for the denial to the appellant. Written notification of the denial dissent within 72 hours of the request. We process expedited appeals, on average within 48 hours of the request. The average standard appeal is completed within 20 days of the request.

2.4 State Fair Hearing
Enrollees have the right to a state fair hearing if they are dissatisfied with the health plan’s appeal resolution. The enrollee must complete Magellan Complete Care's appeal process prior to requesting a State Fair Hearing. A State Fair Hearing must be requested in writing within 120 days of the date of the notice of the appeal determination. At the enrollee’s request, Magellan Complete Care will provide transportation and/or interpreter services.

Magellan Complete Care has cooperated and complied with the Medicaid State Fair Hearing process. Magellan Complete Care understands that we are a party to the hearing and attend as scheduled. Magellan Complete Care prepares and sends the evidence package to AHCA, the Department of Children and Families, Office of Appeals, and the enrollee, free of charge, within the ten business days as indicated in the contract and the notice of hearing request letters. The evidence packages include the original adverse benefit determination, the appeal resolution letter and all documents including any medical records considered or relied upon by Magellan Complete Care to make our decisions. Magellan Complete Care will provide the corresponding Notice of Adverse Benefit Determination and the Notice of Plan Appeal resolution letter to AHCA within two business days from the notification of the Fair Hearing request.

Magellan Complete Care maintains a dedicated email box for receiving notifications on the State Fair Hearings and tracks all timeframes and document submissions in the database dedicated for
the aforementioned process. The email box and the database are monitored at least once a day to ensure that all notifications are reviewed and acted upon timely.

If Magellan Complete Care continues or reinstates enrollee benefits while the Medicaid Fair Hearing is pending, the benefits are continued until one of the following occurs:

> The enrollee withdrawal the request for the Medicaid Fair Hearing

> Ten days pass from the date of the adverse plan appeal decision and the enrollee has not requested a Medicaid Fair Hearing with continuation of benefits until a Medicaid Fair Hearing decision is reached.

> A Medicaid Fair Hearing decision adverse to the enrollee is made.

Magellan Complete Care will authorize and provide services promptly but no later than 72 hours from the date we receive the State’s notice reversing the determination. Magellan Complete Care will pay for services in accordance with State policy if the services were provided while the Medicaid Fair Hearing was pending and the fair hearing officer reverses a decision to deny, limit or delay services.

Magellan Complete Care will support and participate in the appellate process if an enrollee should appeal the Medicaid Final Order. We understand that we will bear all costs associated with completing the record including transcribing the audio recording of the Medicaid Fair hearing proceedings and will provide a copy of the record to the enrollee, or the enrollee’s authorized representative, and the Agency Appellate Section. Magellan Complete Care’s Compliance Officer will contact the Agency’s Appellate Section to discuss the appeal within five business days after an appeal of a Medicaid Fair Hearing is filed with the District Court of Appeal. We will also provide a copy of the case record to the Office of Fair Hearing within five days of receipt of the case record. A copy of the draft briefs are provided to the Agency’s Appellate Section for review no later than 10 business days in advance of the filing deadline.

2.5 Training

The Quality Improvement (QI) staff, including the Complaint and Grievance Coordinator receive rigorous training in the specific policies and procedures for complaints and grievances. The Complaint and Grievance Coordinator receives training in the use of the Resolve Complaint, Grievance Tracking System, how to use the monitoring and timeline compliance reports, and the use of the Complaint, Grievance, Tracking System used for data analysis. Additionally, all Magellan Complete Care staff receive training on the concepts of complaints, grievances, and their importance to contract compliance and enrollee and provider satisfaction. All staff are also trained in how to receive a complaint or grievance, and the steps to follow as outlined in Magellan Complete Care complaint, grievance procedures.

As part of the initial orientation of network providers, training about the complaint, grievance, and appeal processes is presented and discussed. Information is also included in the provider manual and on our website. Information on these processes and procedures is also regularly included in provider newsletters. Providers can also access training modules through the provider portal. Additionally, complaint, grievance, and appeal policies and procedures are explained in the Provider Handbook including phone numbers and web sites to use when registering a complaint, grievance or appeal.
Appeals management staff in the compliance department receive training on specific policies and procedures for medical and benefit appeals and Medicaid Fair Hearings. The team receives training on the appeals database, how to use the full detail appeals report to manage and monitor appeal completion and compliance with contractual timeframes, along with learning how to use the reports for data analysis. Appeals staff are further trained on how to review each appeal for compliance against expected utilization management standards and time frames. They review the case information and supporting documents to verify if the appropriate utilization management criteria was used, applicable contractual time frames were met and denials decisions were made by qualified professional staff. Any process failures are escalated to the Compliance Officer and shared with the Utilization Management Department for correction and re-training if needed. The team receives training on enrollee service skills that focus on ensuring ease of access and handling enrollees who have certain obstacles for communication and identification of needs and issues.

Other impacted departments such as customer service, utilization management, and network management receive training on appeals and the appeals process to ensure that any appeals received by same are appropriately identified and sent to the Appeals Department in a timely fashion, to ensure that the team meets the contractually based timeframes. As part of that training, the impacted departments are instructed to send all requests regardless of terminology used by enrollees, authorized representatives or providers, directly to the Appeals Department. The subject matter experts in the Appeals Department will quickly determine if the request is truly a medical or benefit appeal and manage the case accordingly.

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT’S COMPLAINT, GRIEVANCE AND APPEAL AND MEDICAID...

All communications regarding complaints and grievances are entered into the Resolve system which compiles the intake, documentation and tracks and reports all complaints and grievances. As mentioned previously, all appeals are entered into the Appeals database. The Magellan Complete Care Appeals Coordinator has access to a variety of reports that track resolution progress and compliance with AHCA, Magellan Complete Care and accreditation standards for timelines and documentation. The Resolve system will produce monthly reports that detail all information needed for analysis.

Magellan Complete Care maintains an accurate record of each grievance and appeal including the following information:

> All demographic information (e.g., enrollee’s name, address, phone, and Medicaid ID; provider’s name and address; Magellan Complete Care’s name and address; and filing date

> A complete description of the grievance or appeal, including type (standard or expedited) and category of grievance (i.e., access to care, clinical care, service provision, claims, benefit plan)

> A complete description of Magellan Complete Care’s investigation of the grievance or appeal

> A complete description of our findings and actions pertaining to the grievance or appeal as well as to its final disposition, including the dates of action and notification
The level at which the grievance or appeal is in process and the level(s) remaining before it has been processed through our entire grievance system.

Magellan Complete Care sees the complaints, grievances, appeals and Medicaid Fair Hearing processes as critical to our organization’s processes of continuous quality improvement for the benefit of our enrollees and ACHCA. The Magellan Complete Care Quality Improvement Program places great emphasis on reviewing complaint, grievance and appeal data to identify both individual provider issues and potential systemic concerns. For example, grievance data provides important insight regarding access to care. Quarterly, the Enrollee Advisory Group reviews trended grievance data. Currently, Magellan Complete care elicits enrollee feedback through our innovative Voice to Vision (V2V) model to engage members, family members, and advocates in our quality improvement activities. These town hall-type focus groups are held on a quarterly basis, and are facilitated by our recovery and resiliency team leaders.

The Quality Improvement Committee reviews reports that display grievances by type (standard or expedited), the established category (e.g., access, clinical care, claims), subject of the grievance (e.g., provider, agency, or Magellan), percentage of grievances that meet the resolution timeliness standard, and percentage found to be satisfactory to the enrollee. Complaint and grievance data will be aggregated for reporting and trending purposes. Individual complaint data, while maintained to manage the process of resolution and response, will not be used in reporting or committee to protect enrollee privacy. These reports are analyzed for patterns and trends, such as a disproportionate number of an individual type of grievance or a high or increasing number of grievances related to a particular provider or a particular set of circumstances. When an aberrant pattern or trend is identified, the appropriate committee will conduct a root cause analysis and recommend interventions to be implemented. With regard to the appeals and Medicaid Fair Hearing data analysis, each appeal/fair hearing is used as a source of insight into the enrollee’s experience with the utilization management process and service authorization determinations, their identified needs and whether they experienced any obstacles.

Trended data has allowed the team to present areas of potential improvement to the medical management team, the provider team and the QIC for consideration. An example includes presenting increasing trends for appeals on particular non-covered benefits. Presenting trends allowed the medical management team and the QIC committee to discuss the enrollee impact if the non-covered benefit became an expanded benefit and if by doing so would keep the enrollee from accessing high cost services like hospitalization. This information may also identify the need for additional staff or provider training. As noted previously, in instances in which the data shows a consistent pattern of issues with an individual provider, this may result in a Provider CAP or could result in termination.

This information allows the Quality Improvement Committee (QIC), to quickly identify where to focus improvement efforts. When negative trends are identified regarding access to services in the grievance data, we quickly mobilize interventions to look at causes, implement system changes, and improve access. We review this information continuously so improvements to the system are made on an ongoing basis.

Trended summaries are shared to gain their perspective on potential issues. We ensure a meaningful and effective role for enrollees and their families in the grievance and appeals process through active collaboration as well as consultation with advocacy organizations such as the National Alliance on Mental Illness and Mental Health America. In keeping with Magellan
Complete Care’s use of rapid cycle quality improvement methodologies like Plan-Do-Study-Act (PDSA) or Plan-Do-Check-Act (PDCA), the QIC monitors and modifies interventions as necessary to ensure improved performance and continued incorporation of the changes into our daily operations.

CRITERIA 4: THE EXTENT TO WHICH THE RESPONDENT’S COMPLAINT, GRIEVANCE AND APPEAL PROCESS.
To ensure the integrity of the complaint and grievance process, the Magellan Complete Care Quality Improvement Department conducts routine audits of the process and feedback is given to the coordinator with any corrective actions. Appeals are monitored and managed through our Compliance Department and our Compliance Monitoring and Reporting processes.

The Compliance Department monitors reporting on complaints, grievances, and appeals. The Department also monitors the points in workflow processes to ensure that letters and responses are submitted within the contractually required timeframes. The Compliance Department conducts reviews of complaints and grievances both per individual event (possible enrollee harm or delay in services) by conducting tracer audits and auditing significant trends such as transportation issues to identify enrollee impact and possible harm. The Compliance Department audits the timeliness and responsiveness of appeals and Medicaid Fair Hearings. These reviews not only verify compliance with the contractual timeframes but will also monitor the health plan’s and its subcontractors’ application of utilization management guidelines and criteria.

If corrective action is identified due to any findings related to the above, a corrective action plan (CAP) will be issued to the applicable operational area (i.e. health plan’s internal department(s), Magellan Complete Care’s subcontractors, and network provider) by the Quality Improvement Department with review and approval from the Compliance Department. The activities on the CAP will not be closed until Magellan can validate that the action did occur and performance is maintained for at least three consecutive months.

Magellan Complete Care sees the complaints, grievances, and appeals process as an additional data point to inform our organization’s processes of continuous improvement for the benefit our enrollees and AHCA. The Magellan Complete Care Quality Improvement Program places great emphasis on reviewing complaint, grievance, and appeal data to identify both individual provider issues, potential systemic concerns, and internal opportunities for improvement. For example, grievance data provides important insight regarding access to care. Quarterly, the Enrollee Advisory Group reviews trended grievance data. Currently, Magellan Complete care also elicits enrollee feedback through the Voice to Vision model. The Quality Improvement Program reviews reports that display grievances by type (standard or expedited), the established category (e.g., access, clinical care, claims), subject of the grievance (e.g., provider, agency, or Magellan), percentage of grievances that meet the resolution timeliness standard; and percentage found to be satisfactory to the enrollee.

Complaint and grievance data will be aggregated for reporting and trending purposes. Individual complaint data, while maintained to manage the process of resolution and response, will not be used in reporting or committee to protect enrollee privacy. These reports are analyzed for patterns and trends, such as a disproportionate number of an individual type of grievance or a high or increasing number of grievances related to a particular provider or a particular set of circumstances. When an aberrant pattern or trend is identified, the appropriate committee will
conduct a root cause analysis and recommend interventions to be implemented. If the Quality Improvement Department identifies issues such as enrollee harm, and potential or real or system issues that impact the health plan’s compliance during any of the investigations of complaints and grievances, the Department will immediately notify the Compliance Officer. The Compliance Officer has direct access to and will escalate these issues to the Chief Executive Officer, Chief Operations Officer, the Vice President, National Chief Compliance Officer of Magellan Complete Care and to the Magellan Complete Care Board of Directors.

CRITERIA 5: THE EXTENT TO WHICH THE RESPONDENT IS ABLE TO ENSURE ALL COMPLAINTS.

As noted previously, all departments within Magellan Complete Care are trained on how to identify, document and resolve the enrollee’s complaint at the first contact, through our call handling process. This means the complaint is resolved to the enrollee’s satisfaction on the initial call or by close of business (COB) the day after receipt of the complaint. Verbal complaints received by customer service call center staff are entered directly into our Resolve system, or may be forwarded by Customer Service or other department staff to the Quality Department, where it is documented in the system. This ensures tracking and documentation from the time of receipt.

A daily report is run from the Resolve System to capture the previous day’s complaints/grievances and Quality Coordinators process them through to closure including acknowledgment and resolution letters as required. All enrollee complaints on the daily report are reviewed by Quality Coordinators as first order of business the next business day to verify the status of the resolution or, if needed, support an expeditious resolution process so the complaint can be closed within one business day of receipt. At this time the Quality staff also screens every complaint/grievance to ensure it is categorized appropriately for subsequent reporting and trending. This screening also looks for any potential quality or risk issues and when identified appropriate referrals are made within Magellan Complete Care for management beyond the complaint/grievance process. When a complaint cannot be resolved by close of business, it is reclassified as a grievance in our system and it is escalated for resolution. All enrollee complaints/grievances whether received through Magellan Complete Care staff, from AHCA or from a sub-contractor are entered, documented, resolved and tracked using this process and the Resolve system.

When complaints are reclassified as grievances, Quality Coordinators immediately forward the grievance to the appropriate staff person or subcontractor/vendor contact for investigation and resolution. For example, clinical concerns are referred to the Health Services Department, billing/claims issues to the Network Services Department and customer service needs to the Customer Service Department. The Quality Staff works both complaints and grievances that have been logged in the Resolve system every day, and escalating as appropriate, until the issue has been resolved.

The Quality Department has a complaint and grievance dashboard that includes a real-time aging report. We control the risk of a complaint/grievance falling through the cracks or exceeding the 90 day turnaround time requirement through weekly management level review. Every Monday the Quality Manager and Quality Director review the aging report to prioritize and support the resolution of any grievance that is getting close to or at 60 days and is still open. Any challenges or barriers to the resolution process are addressed by management at this point in the grievance’s resolution cycle. Quality Coordinator’s use the aging report daily to prioritize their follow up with
the Magellan Complete Care staff or subcontractor/vendor contact involved in the resolution. Every grievance on the aging report receives a minimum of a weekly follow-up email from Quality to ensure the resolution is on track.

There are other audit processes in place at Magellan Complete Care that ensure we are using systems and processes effectively to capture of all complaints and grievances, have comprehensive documentation of resolutions and outcomes, and produce accurate and timely reporting. The Magellan Internal Audit team conducts an annual audit of Magellan Complete Care’s complaint, grievance and appeals process. The auditors review programmatic documents such as training tools, desk top procedures, work flows, and policies. They receive access to the Resolve system to allow them to run reports and case audit documentation. Findings and recommendations from the Magellan Internal Audit team for provided in a written report and shared with Magellan Complete Care leadership management. The Quality Director responds with an action plan that is tracked by the audit team from 90 to 180 days for completion.

The Magellan Complete Care Quality department has a data and reporting analyst who conducts audits on all complaint/grievance/appeals data on a monthly basis in anticipation of monthly reporting to AHCA. He uses queries on the data and works with Magellan Complete Care staff in quality, operations, and appeals to reconcile the data and ensure consistency and accuracy from month to month. He also supports the Quality Coordinator’s audit of all sub-contractor/vendor complaint data to ensure all the data is in the Resolve system and consolidated into the monthly report.

Through comprehensive training, use of the Resolve system and aging reports as well as multiple levels of oversight and auditing, Magellan Complete Care ensures that all complaint and grievances are tracked and resolved within our established complaint, grievance and appeals process.

CRITERIA 6: THE EXTENT TO WHICH THE RESPONDENT’S GRIEVANCE AND APPEAL SYSTEM DATA...
This information allows the Quality Improvement Committee (QIC), to quickly identify where to focus improvement efforts. When negative trends are identified regarding access to services in the grievance data, we quickly mobilize interventions to look at causes, implement system changes, and improve access. We review this information continuously so improvements to the system are made on an ongoing basis.

Trended summaries are shared to gain their perspective on potential issues. We ensure a meaningful and effective role for enrollees and their families in the grievance and appeals process through active collaboration as well as consultation with advocacy organizations such as the National Alliance on Mental Illness and Mental Health America. In keeping with Magellan Complete Care’s use of rapid cycle quality improvement methodologies like Plan-Do-Study-Act (PDSA) or Plan-Do-Check-Act (PDCA), the QIC monitors and modifies interventions as necessary to ensure improved performance and continued incorporation of the changes into our daily operations.

Magellan Complete Care investigates any quality of care concerns that are identified through quality audits or care management processes, including the grievance process, as well as at the request of AHCA. This system is in place in the 8 AHCA regions Magellan Complete Care
currently services. The grievance coordinator logs concerns, which are assigned by category to the appropriate departmental leadership for investigation, review, and resolution. Results are reported to the appropriate QI committees for further action and follow-up. As needed, Magellan Complete Care works with providers to develop corrective action plans intended to address quality of care concerns. In all cases, action plans include a specific timeline for implementation of interventions, completion and follow-up.

Evidence of serious quality of care issues found by the QI department can result in the immediate restriction or exclusion of the provider from participation in the network by way of a referral to the Peer Review and Credentialing committee for review and action. It may also result in the reporting of any concerns to the applicable State licensing board and national data bank. Magellan Complete Care’s policies and procedures describe the processes by which quality of care concerns are addressed, up to and including a provider’s appeal of a network termination decision.

6.1 Example
The following example, which recently occurred under our current contract with the state of Florida, highlights how using complaints is an effective mechanism to improve enrollee services, experience, and overall well-being.

Enrollee concerns related to Attitude and Service showed the highest volume during a recent reporting period. 59 percent of those concerns were related to the transportation service provided by our transportation vendor. These concerns predominantly pertain to lengthy pick-up wait times. A detailed analysis of our transportation complaints was completed. Other Attitude and Service issues included unprofessional attitude/behavior from providers or office staff, unsatisfactory treatment experience, and requests for changes in services. Those issues concerning unprofessional behavior by provider/staff were escalated to Network Department staff and/or the Provider Support Specialists Team. When appropriate, research into complaints related to unsatisfactory treatment was conducted internally to see if the issue might be benefit driven or driven by some other Magellan Complete Care policy or procedure. Where the complaint relates to behavior by the provider or provider office staff, the provider’s office was contacted and appropriate follow-up education was provided. An enrollee name was only used with permission, so if an enrollee did not permit their name to be used, the discussion was more general around processes or behavior and how it may appear to enrollees. If an enrollee was dissatisfied with a provider, Magellan Complete Care staff worked with the enrollee to support assignment to a different practitioner. The complaints pertaining to dissatisfaction with treatment were reviewed internally and the enrollee’s medical records were requested for review by clinical staff to determine next steps.

Access issues made up our second highest category. The issues under this category include enrollee concerns related to accessing care with in-network providers and/or inability to locate specialists. A bump in membership of approximately 10,000 enrollees lead to a high number of Continuity of Care requests. To address these complaints Enrollee Services and Health Services Department staff assisted the enrollees with getting a single case agreement over to the provider of their choice or locating a new practitioner or an appropriate specialist within their geographic area. Another issue seen in this category was difficulty obtaining medication. In these instances, the case was forwarded to staff on enrollee’s care team for further assistance. Additionally, staff engaged Magellan Rx to work with both the prescribing physician and enrollee to override/approve the medication that was rejecting in the system.
The appeals department made the following operational changes based on system data trends:

> In the Appeals Department and as above, the team identified trended data that demonstrated a large number of concurrent outpatient targeted case management requests that were being administratively denied due to the providers’ failure to submit timely concurrent authorization requests. This trend was reviewed by the Medical Director and the Appeals Department who determined that these services were medically necessary and approved upon initial request and the only issue was the providers’ failure to submit timely requests. As such, these would be overturned by the Appeals Department upon receipt since our enrollees need these services to improve functioning and grow towards independence.

> The Medical Management team and the Appeals Department improved the appeals review process to include an efficiency created by organizing medical records submitted by provider into logical sections so that important clinical documents such as physicians’ notes, admission and discharge summaries are in Part 1, other supporting like labs in Part 2 and ancillary documents such as admission paperwork in Part 3. Further, the review process includes weekly case staffings on all appeal cases where the Appeals Nurses will present and discuss the clinical overview and summary of the appeal cases with the medical directors and together the team will determine the outcome of the case and any follow up clinical interventions.

Most situations are individual with no trends noted. Based on the findings, the following are some examples of specific recommendations for improvements that have been developed and continue to be followed:

> Continue individual provider education regarding contract requirements as issues are identified

> Continue to address individual enrollee complaints as received and monitor/evaluate for systemic trends/issues that may need to be addressed

> Submit quarterly complaint/grievance analysis and findings for review to Medical Directors, Peer Review Credentialing Committee (PRCC), Enrollee Services Committee (ESC), Health Services Committee (HSC), Vendor Oversight Committee (VOC), and Quality Improvement Committee (QIC)

> Reinforce complaint process at quarterly team meetings to ensure appropriate identification and reporting; incorporate examples of complaints and related outcomes as part of discussion in these meetings to show how the process improves the care and service to enrollees

> Aggregate complaints by practitioner on a quarterly basis to review for potential issues. Individual practitioners meeting review criteria per policy will have a site visit and/or be presented to the PRCC for follow-up recommendations.
1. The extent to which the respondent’s grievance and appeal system flowchart reflects ease of access for individuals with complaints, grievances and appeals, including ease of access for persons with disabilities or who speak other languages.

2. The extent to which the respondent’s timelines for acknowledging and responding to complaints, grievances and appeals are less than those specified in federal and State requirements.

3. The extent to which the respondent’s complaint, grievance and appeal and Medicaid Fair Hearing data are aggregated so that results are actionable, protect enrollee privacy and are reviewed by the appropriate staff or committee for analysis and prioritization of corrective action and/or improvement initiatives.

4. The extent to which the respondent’s complaint, grievance and appeal process imposes deadlines on completion of corrective action plans implemented as a result of verified complaints, grievances or appeals and have set quality controls in place to review outcomes.

5. The extent to which the respondent is able to ensure all complaints (including those submitted to the respondent by the Agency or respondent's subcontractors) are tracked and resolved as part of the respondent’s established complaint, grievance and appeal process.

6. The extent to which the respondent’s grievance and appeal system data resulted in operational improvements of the respondent.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.
SRC# 13 – Social Media (Statewide):

The respondent shall describe its approach for engaging enrollees by using innovative communication methods and technologically advanced resources, including, but not limited to the use of social media, texting and smartphone application platforms.

Response:

OVERVIEW
Magellan Complete Care is dedicated to serving some of the most complex and difficult to engage enrollees in the Medicaid program, individuals living with SMI. As such, we have developed innovative and outside the box solutions to meet the unique needs of these enrollees to ensure optimal engagement in the healthcare process. In addition to dealing with the challenges of managing at least one serious mental illness, our data shows that approximately one-half of our enrollees are also dealing with at least one physical illness. Many are dealing with multiple severe physical and behavioral health conditions, and also face challenging life circumstances such as co-occurring substance use disorder (SUD), homelessness and food insecurity. Effective engagement with our enrollees requires creative strategies and a willingness to use all available touchpoints to influence health behavior and outcomes.

The use of social media and technology assisted engagement and care are important elements of our model. For many individuals with SMI, technology enabled tools help to overcome the stigma associated with their illness, and expand the availability of care. Social media can also create a sense of community and belonging for individuals who may be socially isolated and dealing with complex behavioral and physical illnesses. These platforms can also serve as effective tools in educating enrollees about health, effective use of their benefits, and the importance of preventive and routine care, and management of their illness. Magellan Complete Care is committed to expanded use of these tools to enhance care and outcomes for our enrollees.

CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT DESCRIBED HOW THESE TECHNOLOGY...
1.1 Magellan’s Use of Technology to Improve Health Literacy and Outcomes

At Magellan Complete Care, enrollee engagement represents the foundation of our fully-integrated model of care and is a cornerstone of our enrollee communication strategy. We have developed numerous technologically rich initiatives to actively collaborate and communicate with everyone involved in an enrollee’s care. In practical terms, this means we:

>Employ multiple technology solutions to use every potential enrollee touchpoint to increase health literacy, support enrollees in self-care and health management, and create connections to the community.

>Leverage advanced technologies to alert our internal staff and external partners to ensure each enrollee receives timely access to care and that enrollee’s physical, mental and social health needs are met.

>Use technology platforms and social media resources to enable our customer care staff to notify our health services team about the need for and availability of follow-up resources. They also
communicate with our care coordination team to ensure enrollee inquiries about PCP, specialists, benefits, transportation and other issues are addressed.

>Use multiple forms of technology for employee collaboration in a manner that supports enrollee care and outcomes.

>Partner with each other, and our partners, and share relevant information among team members (within and across all departments) to ensure the enrollee is engaged, complying with provider appointments, and/or using medication reminder services to comply with their treatment plan.

Magellan Complete Care, we has combined its extensive experience caring for individuals living with SMI in Florida and across the country with a strong organizational commitment to using technology to innovate in the engagement and treatment of enrollees through multiple platforms. Though our use of many of these new technologies is still in its early days, or is still being implemented with our Magellan Complete Care enrollees, the clinical efficacy of this approach to engaging and managing enrollees has already been demonstrated. Our deployment of technology solutions generally falls into two major categories specifically tied to improving health literacy and improved health outcomes:

Category 1 - Direct care delivery and care management tools to improve health outcomes, including programs such as:

>Cobalt SmartScreener and Computerized Cognitive Behavioral Therapy (CCBT) platform
>Clickotine, a smoking-cessation tool built on the innovative Click Therapeutics platform
>PsychTrac, an inventive platform to support recovery and hard-to-engage enrollees such as those in jail diversion programs
>Magellan Rx mobile tools
>Telemedicine solutions for primary and specialty care
>mPulse, a smart messaging tool that allows us to send appointment and care gap reminders, and general health and wellness information
>SafeLink free enrollee phones
>Remote enrollee health monitoring (being reviewed for use)
>Self-care health monitoring and management apps (being reviewed for use)

Category 2 - Social media for enrollee and community engagement and health and wellness to improve health literacy, including:

>Microsite
>Facebook
>Twitter
>Blog

Magellan Complete Care is deploying or has already deployed these technologies to support our enrollees, providers, and the communities we serve. With our parent company, Magellan Health, we constantly evaluate new clinically effective technology solutions to support engagement, health management, care delivery, and health literacy. We foster an innovation- and technology-centered culture throughout the entire organization.

This is more than a simple philosophy. We have a dedicated unit inside Magellan, the Innovation Laboratory (iLab), headed by our Chief Innovation Officer, that leverages best practices and
proven technology to solve enrollee and provider challenges. This team meets weekly to discuss project areas for innovation. They communicate their activities in a variety of ways throughout the organization, such as Facebook@Work, for which Magellan was the pilot healthcare company.

In addition, Magellan acquired Cobalt Therapeutics and its leadership, which applies our organization’s cutting-edge, problem-solving mindset to further strengthen our innovative spirit and creativity in the development of technology solutions. One of the overarching themes for all of our strategic priorities is to leverage technology to meet people where they want to be met (including providers and caregivers) and to gather more data for our partners so we know where and how to intervene to more effectively serve our enrollees and provider partners, and where we need to invest more resources.

1.2 Cobalt
Magellan has invested heavily in carefully and deliberately leveraging technology to empower individuals and their primary care teams. This accomplishes short- and long-term goals, improves care and access, and lowers costs. We pioneered several of these in Federally Qualified Health Centers (FQHCs) where we deployed our Cobalt smart screener and CCBT platform to enhance access to behavioral health care and management of that care in a primary care setting. Access to behavioral health care in the primary care setting is a significant barrier to effectively managing an enrollee’s health. A well-designed delivery system and contracting strategy supports regular screening for behavioral health needs, including substance use disorders (SUD), at the most common locations for care.

This solution is built on our Cobalt Therapeutics platform that our company acquired, along with its leadership, in 2014. The Cobalt suite of software applications provides Computerized Cognitive Behavioral Therapy (CCBT) to users via an accessible platform and has been found to be as effective as, if not more than, face-to-face delivery while simultaneously removing barriers to care. Magellan Complete Care is committed to using this platform to dramatically change how enrollees access and manage their care by meeting emerging preferences for today’s health consumers (self-guided, self-driven and self-paced). Through our CCBT programs, we offer an enhancement to traditional telephonic and face-to-face care. This proven, high-quality, web-based platform, which can be accessed on a computer, smart phone, or tablet, has been shown to decrease the need for higher levels of care, increase access to preventive behavioral health programs, and reduce the prescribing of inappropriate (and sometimes dangerous) medications. It has also simplified the behavioral health screening process by placing self-guided tools in the hands of the provider and enrollee. The Cobalt platform provides an innovative, technology-based solution that:

> Addresses the most common behavioral conditions
> Has been clinically demonstrated to be as effective as face-to-face CBT
> Requires no appointment and has no waitlist
> Enrollees can use at their own pace
> Is secure and confidential
> Can be used anytime and anywhere

CBT stands apart from other options for enrollees as it has been shown to be just as effective, or more effective, than prescription medication for long term health outcomes. CBT is a short-term, goal-oriented method that focuses on problem-solving and building skills such as identifying unhelpful thinking, modifying beliefs and changing behaviors. The efficacy and effectiveness of
CBT has been validated and supported in more than 1,000 clinical outcome studies, and it is recommended in treatment guidelines as the first line of care for insomnia, anxiety, phobias, and panic disorder, and as a first-line option for depression and substance use, by The American Psychiatric Association (APA), The American Psychological Association (APA), The American Academy of Sleep Medicine, and The Agency for Healthcare Research and Quality (AHRQ) guidelines.

Recognizing the need to support primary care provider understanding of behavioral health and requirements for screening and treatment, we worked with FQHCs to design and implement a “Virtual Care Solution” (VCS) built around our Cobalt platform that we have made available to primary care providers throughout our organization. This innovative platform, which has won multiple awards from professional societies and governments, accomplishes several things:

>Links enrollees to screening tools so they and their providers know their risks and diagnoses
>Links enrollees directly with proven tools such as CBT, telehealth, text and chat
>Provides new types of useful, real-time data to the clinics that they can act on at the point of care
>Allows for crossing language barriers, since the tools are available in multiple languages, including Spanish

Behavioral health is often the single biggest factor in illnesses including cardiac, diabetes, and sleep disorders. This platform allows us to affect behavior at the moment a problem is identified, with the most impactful solutions. An example is insomnia, a problem that worsens most medical conditions. Our software identifies people with sleep issues and provides them with a proven tool to help, which is the only one of its kind endorsed at the highest level by the Food and Drug Administration (FDA). It is also available with culturally sensitive approaches and languages, helps reduce polypharmacy, and reduces the risk of addiction to habit-forming sleep medications.

Our digital SmartScreener technology, for example, leverages predictive analysis to enable a primary care provider to gather usable, actionable information on an enrollee. For some of the most common complaints seen in medicine such as insomnia, depression and substance use, Magellan Complete Care provides the primary care provider with the necessary tools to treat the enrollee, e.g., telehealth, as well as our CCBT programs. These technologies are endorsed by federal agencies such as SAMHSA, the only software of its kind to receive the highest level certifications.

The CCBT includes multi-channel access, including:

>24/7/365 Telephonic Access to a clinician for assessment, consultation, referral.

>Our Cobalt CCBT apps engage participants with text based reminders and push notifications that drive our participants to participate in activities throughout their interactive sessions which each range from 15 to 30 minutes to complete.

>Instant Live Chat from anywhere on VCS to get assistance with a referral, ask benefits questions, identify community resources and obtain educational materials.

SmartScreener is behavioral health screening software that sits at the front of VCS and is described as “smart” because it uses an algorithm developed to quickly and efficiently screen
individuals for potential problems. Each symptom cluster has a short and long set of questions. The latter is only presented to the user if they score positive on the short set. For example, if behavioral health symptoms (e.g., depression) are not identified on the short version of a scale, such as the PHQ-2, then SmartScreener skips to the next set of questions, such as the GAD-2 (anxiety). Thus the number of questions used in SmartScreener are automatically tailored to the individuals’ condition, from those with no symptoms to those with severe illness. SmartScreener has been in use since 2012 in clinical and non-clinical settings and includes the following, well-validated measures (including the short versions):

>>ISI = the Insomnia Severity Index has seven questions (short version is the first three).
>>PHQ9 = the Patient Health Questionnaire has nine questions (short version is the first two).
>>GAD7 = the General Anxiety Disorder-7 has seven questions (short version is the first two).
>>AUDIT = the Alcohol Use Disorders Identification Test has ten questions (short version is the first one).
>>DAST = the Drug Abuse Screening Test has ten questions (short version is the first one).

The software also provides a results and recommendations page (called “Scorecard”), which uses a color-coded system based on scoring. The colors (green = not clinical; yellow = mild symptoms; orange = moderate or high level of symptoms; red = severe symptoms) allow for quick review of symptoms and severity by the provider. The scorecard can be shared or printed for consultation with a provider or counselor.

1.3 Clickotine
Clickotine is another online therapeutic platform that Magellan Complete Care will deploy to evaluate its effectiveness in driving smoking cessation with our enrollees. As noted elsewhere in our ITN response, SMI enrollees experience much higher rates of smoking, which often exacerbates comorbid physical illnesses. An important part of our integrated care management model is screening for smoking and encouraging engagement in smoking cessation programs. Clickotine offers another effective tool in those programs, and will also support the Healthy Behaviors program directed at supporting enrollee wellness.

As its name suggests, Clickotine is a patent-pending, clinically-validated, fully digital, smoking cessation program that can easily be scaled to the Magellan Complete Care population since it uses an enrollee’s smart phone. It is also extremely effective in supporting enrollees to quit smoking. In 2016, Clickotine was studied in a 416-participant Institutional Review Board (IRB)-approved clinical trial. More than 40 percent of participants had stopped smoking at the end of an eight-week study, and Clickotine was found to be almost 10 percent more effective than Chantix and 20 percent more effective than nicotine replacement therapy. General SRC #13, Attachment 1: Magellan Health Clickotine Overview provides additional, more detailed information on key elements of the Clickotine platform and its performance.

In addition to the current smoking cessation tool, Click Therapeutics, the parent company of Clickotine, is currently developing an additional tool to support enrollees in the management of congestive heart failure (CHF). As with the higher rates of smoking among our enrollees, SMI enrollees also experience higher rates of hypertension which is a risk for CHF. We are excited about the potential for expanding the use of this type of tool to this at-risk category of enrollees, and will be evaluating its use as it becomes available.
1.4 PsychTrac
PsychTrac is a new solution Magellan Complete Care is deploying for enrollees. PsychTrac has developed a mobile-based software and software as a service (SaaS) solution that enables enrollees, providers, court systems, and other key stakeholders to easily direct, communicate, measure and coordinate the treatment of behavioral and chronic mental health conditions. This solution provides an efficient, data-driven case management system for clinicians and consumers of behavioral health care. Specifically, the sophisticated app can be used by the enrollee on any type of smartphone and includes an enterprise back-end solution. This system is already in use in several states, and has proven especially effective for individuals in drug and alcohol treatment programs and drug diversion programs with the criminal justice system. It allows for management of enrollee activity and tracking of behavior by a treatment center, provider, or therapist.

PsychTrac’s technology provides treatment professionals with tools to help monitor behavior, diagnose mental and emotional health, and intervene proactively through a patient-facing mobile platform. This app gives providers mobile technology to gather key behavioral and diagnostic information about enrollees in a readily available and cost-effective way. After identifying a behavioral issue, the provider can intervene directly with the client via any mobile phone to provide clinical tasks, reminders and track follow up.

Much in the same way a diet program tracks food and exercise, PsychTrac monitors the enrollee’s activity, including location. We gather activity information about the individual’s compliance with legal, clinical and recovery assignments. This information is sent back to the criminal justice agent, clinician or treatment provider for review. Support systems and other stakeholders can also be updated real-time by this system.

Magellan Complete Care believes this tool may be particularly effective for assisting in the management of enrollees in drug diversion programs or under the direction of the criminal justice system. We will be testing and evaluating its use and efficacy to assess the broader dissemination for use in managing enrollee health.

1.5 Mobile Pharmacy Access
Our pharmacy program website, www.Magellanrx.com, provides secure sign-on and role-based access to prescription information, health resources, and user-group specific applications for enrollees. Our public site contains basic content such as news and announcements, important documents, and general contact information. Through self-service registration, we improve enrollee literacy by providing them access to plan-specific details, pharmacy information, claims history, and more, 24 hours a day, 365 days per year. Figure 1 in [General SRC #13, Attachment 2: Table and Figures] provides an illustration of our enrollee portal features. Table 1, Enrollee Portal Features in [General SRC #13, Attachment 2: Table and Figures], summarizes the various features of our enrollee web portal.

1.6 mPulse Mobile Smart Messaging
Magellan Complete Care has partnered with mPulse Mobile to use smart messaging with for its enrollees. The mPulse platform, which has been used by Medicaid plans throughout the country, allows for tailored, interactive messaging for HEDIS and other gap in care closure, appointment reminders, and reminders to enrollees about alternatives to high-cost ER utilization, and to understand enrollee engagement and activation to direct targeted messages around health management. The mPulse messaging platform can be used with enrollee phones or with the free
SafeLink phones made available to our enrollees. Magellan Complete Care’s currently planned campaign for the use of the mPulse messaging platform is pending AHCA approval.

1.7 SafeLink Mobile Phones
To ensure enrollees and other stakeholders have immediate and easy access to the information they need, Magellan Complete Care enrollees can receive free smartphones and messaging services through our SafeLink program, and we have established a website dedicated to our current enrollees: www.mccoFL.com. This program’s goal is to make it easier for Magellan Complete Care enrollees to get care, while helping to improve the quality of care enrollees receive. This program includes:

>Free smartphone / Enrollees can choose to bring their own phone

>Free phone services from SafeLink Wireless

>350 monthly calling minutes
>>Free calls to Magellan Complete Care Enrollee Services
>>Free calls to 911 emergency

>Unlimited text messages

>500 MB of data

>Voicemail, caller ID and call waiting

>Free technical support

>In the future, we will provide free health tips and reminder text messages sent from Magellan Complete Care

1.8 Telemedicine
Magellan Complete Care, and our parent company, Magellan Health, also offer remote access to care through telemedicine, with nearly 500 providers currently providing these services to our enrollees in Florida. Magellan Complete Care enrollees are currently able to access telemedicine services through contracted providers whose platform and services have been verified as meeting privacy, reliability and accuracy standards established by the plan. These services are currently used in our Road-to-Recovery program which focuses on post-discharge follow up.

Magellan Complete Care has a robust strategy to expand access, particularly for primary care and select specialty services, as well as in rural communities and regions where access to behavioral health services may be limited. This service is also available in selected CMHC providers. We are currently assessing use of tele-monitoring capabilities to support remote monitoring of enrollees with diagnoses which have been demonstrated to be responsive to this solution, including CHF, hypertension, diabetes, COPD, and asthma. In fact, one of our existing FQHC providers has already approached Magellan Complete Care with proposals to develop a system for diabetes care, which we will be exploring with them.
1.9 Self-Care Apps
Smart phone and online apps are becoming increasingly effective and more broadly used to support enrollees in the monitoring and management of their health and wellness. They can be particularly effective for those illnesses that require logging of medication use, diet, or symptoms. Recognizing their increasing importance, effectiveness, and acceptance, Magellan Complete Care will be evaluating tools for broader use and deployment among our enrollees. In fact, mPulse, the enrollee messaging tool, already in use within Magellan Complete Care, currently supports these capabilities and will be part of the solutions evaluated. As always, Magellan Complete Care will review tools for clinical efficacy with our complex enrollee population.

1.10 Social Media
Magellan Complete Care and our parent company, Magellan Health, use multiple social media applications and other platforms to reach out to stakeholders to:

>Generate Awareness: Create a community call to action to focus on proactive access to services, where and how to find support via system navigation, and stigma reduction.

>Combat the Stigma: Provide accurate literature to educate communities about mental illness and help people to overcome their misconceptions, misinformation and prejudices.

>Educate: Those affected, caregivers and the entire community, enabling everyone to spot mental illness and know how to get help.

>Find Pathways to Help: Provide resources (by way of discussion forums, peer-to-peer recommendations, professional advice, law enforcement perspective, etc.) to those directly affected and their caretakers.

>Build Community: Provide a community platform to highlight mental health, wellness and recovery for those living with serious mental illness and caregivers as well as a promise of hope through sharing stories of lived experience.

1.11 Magellan Complete Care Microsite
Magellan Complete Care’s microsite, unfoldmentalhealth.com, drives our social media campaigns, delivering a message of wellness, acceptance and openness with the recognition that mental illness is a disease state like any other and can be treated as same. The site encourages community: people share their experiences, hopes and fears to bring the discussion of mental illness to light. Success story videos, links to community resources, and tip sheets and helpful hints about wellness and physical and mental health aim to educate and inspire all Floridians through:

>Education: From the many stigmas that exist around mental illness to getting a diagnosis and treatment, Magellan’s role in the mental health community is about helping those that are living with serious mental illness find treatment and educating others around them.

>Treatment: The road to recovery is a long and complex one for many who live with mental illness. The real opportunity in all of this is helping to connect people with the treatment and support they desperately seek. Magellan provides the building blocks and foundation of a better tomorrow.
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>Resources: The motivation behind positioning Magellan Complete Care at the center of the 
conversation of mental health is about making a difference in the lives of those that live in the 
communities we serve. The success of this initiative relies on identifying health literacy resources 
information and sharing it with the community we build together. 

Recent additions to unfoldmentalhealth.com include:

>Tip sheets with information about common mental illnesses and everyday issues such as stress. 
>“Meet Bernadette,” a powerful story of an enrollee overcoming formidable odds. 
>A link to a popular YouTube channel called “My Story of Strength,” where people from all over 
the world talk about their illnesses and how they manage them. 
>A post about Logic’s suicide hotline number song. 
>Highlights of Magellan’s recent work with “To Write Love on Her Arms and the Race for Recovery.” 
>Information about and links to community resources. 

No one likes to feel alone. Social media’s role in today’s society is to build bridges between 
isolated groups of people with like interests and experiences. With over 1,900 visitors since it 
launched a few months ago, our microsite is a community of groups with a single focus: to erase 
stigma to get people the help they need. 

1.12 MCC of FL Facebook Page 
Facebook is one of the most popular social media platforms among groups similar to our 
enrollees. Reaching over 187,275 people, our over 160 posts connect everyone in the community, 
delivering messages about health and wellness. From posts about exercise and healthy eating to 
announcements about free resources available all across the state, we post at least four times a 
week and recently shared the following:

> An announcement about Magellan Complete Care’s huge MY FEST event in Tallahassee on 
October 7th. 
> Information about NAMI’s Latino Multicultural Action Center. 
> A post from Mary J. Blige about the impact that music therapy has had on her life. 
> Details about our sponsorship of and activities at “To Write Love on Her Arms’ MOVE 
Conference.” 
> Information about painting and photography workshops to teach people how to use creativity to 
increase mental health wellness. 

Facebook is customizable and integrated. We can add event pages to our Facebook page for 
different activities like health fairs, benefit and health education sessions, volunteer programs, 
and more. If appropriate, we can link our Facebook page to other social media platforms such as 
Twitter to maximize reach. YouTube is also integrated with our Facebook site, housing our videos 
on a private channel. 

With over 4,495 likes, shares and comments, our Facebook page engages Floridians in the 
discussion to reduce stigma, contributing to improved health literacy and outcomes—physical, 
mental and social.
1.13 Magellan Health Social Media
Understanding that consumers use social media for many different purposes, our parent company Magellan Health uses several different social media channels and platforms, including our own thought leadership blog, Magellan Health Insights, to connect with enrollees, providers, non-profit organizations, and others in Florida and across the country. Our social channels alert followers to specific health tips and observances (i.e., living life in recovery, mental health well-being, early detection of suicidal thoughts, Suicide Prevention Awareness Month, etc.) and allows them to share this content with their friends and followers, as well.
Since June of 2016, Magellan Complete Care has engaged in a sustained campaign to increase the reach of and engagement on its social media channels. Magellan shares an array of content on Twitter, LinkedIn and Facebook. Since June 2017, we have seen 90 percent growth in the level of interaction on social media.

1.14 Magellan Health Twitter
Magellan Health uses Twitter to educate, connect and direct the public to information and services daily and always in times of crises, and we do so very quickly. We also use it to send out quick tips on wellness, such as “5 ways to Improve Your Sleep” and “Healthy Snacks.” We have over 1,200 Twitter followers; Florida is our sixth biggest audience in the United States, making up 4.88 percent of our total audience. Our tweets have had strong performance in the Florida market:

> A June 2067 tweet about the Orlando Pulse Nightclub shooting reached 39,300
> An October 2016 tweet about Medicare coverage for children’s dental exams reached 10,400
> A January 2017 tweet about the Fort Lauderdale airport shooting reached 1,300
> A June 2017 tweet about the Orlando business shooting reached 17,600
> A September 2017 tweet about Hurricane Irma reached 2,300
> A September 2017 tweet about Tropical Storm Maria reached 1,200

1.15 Magellan Health Blog
The Magellan Health Insights blog was launched in August of 2016. Since that time, we have published 65 articles across a wide variety of healthcare-related subjects. While a young web property, the blog is showing strong signs of growth:
> Our current readership averages around 1100 views a month, from three main sources:
>> 49 percent is a combination of organic search (31 percent) and social media (18 percent)
>> 21 percent is from web referrals
>> 30 percent is from direct promotion of our articles

During our first 12 months, Magellan Health Insights featured several articles aimed at the Florida market:
> “The Behavioral Health Impact of Zika”: August 2016; 37 views, 3 organic
> “Helping Members Change Their Lives (and Our Own Lives, Too)”: May 2017; 84 views, 11 organic
> “Strength in the Storm: Thinking about Suicide in the Face of Natural Disasters”: October 3, 2017; 15 views in the first two days

1.16 Social Media and Customer Service
We sometimes get private inbound messages from Magellan Complete Care enrollees and Florida citizens. While not our primary method of customer service, we treat all messages as if they come through our toll-free customer service number. We triage the messages, engage
customer service or our outreach team as appropriate, and respond within the State’s required timelines.

Magellan Complete Care uses social listening tools to capture customer service questions, comments and complaints and addresses them through our corporate social media customer service process. Examples include the need to refill prescriptions, provider billing questions or questions/comments more general in nature. This capability allows us to meet the consumer where they are – in this case – on social media, to quickly and efficiently address the comment, concern or question. Magellan Complete Care monitors its social media channels 7 days a week, several times per day.

1.17 Media During Emergencies
Magellan Complete Care makes the health, well-being and safety of our communities as our top priority. During emergencies, we leverage social media and its external crisis communications capabilities to offer counseling and referrals through our 24-hour crisis line. As an organization committed to the physical and mental health of Floridians, we do not limit access to these services to enrollees only. Every Floridian is able to use our crisis hotline if needed, in keeping with our community engagement, our mission and our commitment to our unique IHN structure.

Before, during and after emergencies, we tweet the information for our 24-hour crisis line and other emergency assistance resources. We tag media and disaster relief agencies so our message is shared on their Twitter feeds, and we share their information as well. We monitor the most-used hashtags during the crisis and add them into our messaging to maximize our reach. Twitter is our primary delivery vehicle during crises; we duplicate the posts on Facebook and LinkedIn. We used Twitter for the Pulse nightclub shooting, the Ft. Lauderdale shooting, the Orlando business shooting, Hurricane Irma, and Tropical Storm Maria, directly sharing our crisis support line with over 61,700 people. We used Facebook for Hurricane Irma and shared information about emergency and community resources with nearly 7,000 people.

1.18 Social Media Policies
Our Social Network policies, which have been reviewed and approved by AHCA, specifically address social networking practices and smartphone applications (apps). Our social media apps include disclaimers that the apps are not private and we do not publish PHI or personally identifying information on them. We also ensure all software applications are obtained, purchased, leased or developed based on secure coding guidelines. Our use of social/electronic media complies with all contractual requirements as well as state and federal law, and we treat all electronic media as we do printed materials. Further, we comply with the following AHCA requirements as they relate to electronic content:

> We ensure that the content complies with the standards for written materials specified in the Contract.
> The content is accurate and does not mislead, confuse or defraud recipients.
> Content has been reviewed and approved by AHCA if required.
> Communication(s) sent to recipients or enrollees describing other health-related lines of business contain instructions that describe how recipients or enrollees may opt out of receiving such communications.
> All of our providers and third party communicators are appropriately trained through provider education, outreach and monitoring.
CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT PROVIDES DATA THAT SUPPORTS THE EFFICACY OF THE PROPOSED APPROACH...

2.1 Data on the efficacy of Magellan Complete Care’s approach
Magellan’s online CCBT programs have been shown to save clinician time. They allow clinicians to reduce face-to-face time with members, without jeopardizing quality of care. One study showed that self-exposure for panic and phobia cuts clinician time per member by 73 percent without losing efficacy when guided mainly by a computer rather than entirely by a clinician.

The programs allow for most of the process to be delegated to member-computer/mobile device interactions, and no training in CBT is required for clinicians to administer the programs. Online CBT also provides individualized guidance to each member while delivering a standardized and well-studied protocol. Furthermore, online CBT programs allow members to work at their own pace, and repeat sessions as needed, without the burden of long wait times between traditional appointments.

Magellan Complete Care’s online CCBT programs are welcomed by members. Medications are costly and can have undesired and sometimes harmful side effects, resulting in low adherence rates. In addition, Cobalt’s programs teach valuable skills for lasting improved wellness; in addition, the effects do not cease as compared to most medications. About 75 percent of individuals actually prefer a non-medication care option when asked.

Magellan Complete Care’s suite of online CCBT programs gives providers readily accessible tools that can be made available to enrollees anywhere at any time over the Internet, thereby optimizing the enrollee experience. It also provides a reliable behavioral health intervention in primary care setting to build their capacity to effectively meet the needs of individuals in need of treatment. The user interface is simple and can be anonymous. Magellan’s CCBT programs are designed for easy administration. They can be modified to integrate into a range of different workflows. These programs do not require clinician administration and can be accessed directly by enrollees. Trained customer service, providers, and care managers can easily provide enrollees a program overview and registration support that takes 60 seconds or less.

The return on investment (ROI) for Magellan’s CCBT programs for providers is more than 300 percent, freeing up funds to direct to other patient services. In addition to increasing practice efficiency through the use of a structured screening, monitoring, and care delivery tool, CCBT saves time and money by providing care online. The programs allow for immediate access for insomnia, anxiety, depression, and substance use. Indirect additional benefits include:

> Reductions in unnecessary emergency visits for the care of these conditions
> Decreased in member readmissions secondary to falls (associated with polypharmacy and side effects)
> Reductions in costly prescription medications often prescribed inappropriately
> Lower utilization of “stepped up care” (i.e., decreased referral to outpatient behavioral care)
> Improvements in co-morbid health conditions
>Provision of a proven, cost effective behavioral health solution to thousands of members that are not currently receiving services
>Additional choices staff can offer enrollees to address anxiety, depression, substance use and insomnia
>Improvement in behavioral health and health outcomes for health plan enrollees

Magellan Complete Care provides Return on Investment (ROI) information based on a current implementation with an independent third party use of online CBT. The assumptions and background provided are those embedded in the third party model. A 30,000-enrollee health plan case example has been extrapolated based on the model assumptions (for depression) using the Cobalt pricing. The ROI information does not take into account the value and savings potential of the additional insomnia program (RESTORE) included in the proposed Cobalt solution.

The infrastructure investments for innovations like CCBT, SmartScreener, and Clickotine systemically change care delivery. They also simplify care and business processes to create administrative and payment efficiencies. As shown above, they are also very effective in encouraging enrollee engagement and self-care.

We have scaled and deployed our set of Virtual Care Solutions (VCS), which at the core drives individuals to our CCBT programs, as well as SmartScreener, and optional wraparound telephonic, chat and text support, for a variety of settings and populations, including statewide and citywide implementations (see philly.ontobetterhealth.com – a project for the City of Philadelphia) covering millions of lives, employee assistance programs (with more than 900 employer clients) covering more than 15 million employee lives, large multi-state health insurance companies (Blues and others) covering more than 5 million lives including Medicaid, and Medicare plans, multiple government agencies, nearly 100 individual practice associations, sleep center, community mental health center, and FQHCs. Magellan’s VCS platform is a virtually-organized, <<multilingual ecosystem of programs and resources>>, which integrates tested and proven online clinical programs such as SmartScreener, CCBT, and Resource Library.

The VCS platform applies to more than 90 percent behavioral health conditions seen in primary care and behavioral settings, including CCBT programs and mobile apps for:

>Inomnia and Sleep Problems: a six-session program (RESTORE) and mobile app that teaches new skills to help improve sleep including sleep restrictions, sleep hygiene, and mindfulness.

>Anxiety, Panic, and Phobia: a nine-session program (FearFighter) and mobile app that focuses on the development of self-management skills to help participants overcome their anxiety.

>Depression and Low Mood: a four-session program (MoodCalmer) and mobile app that teaches skills to recognize unhelpful thoughts, and motivates participants with real life examples.

>Alcohol or Drug Use: a 10-session program (SHADE) and mobile app that includes education on alcohol, narcotics, cannabis, opioids (new opioid addiction pathway coming in Q1 2018) and depression, as well as activities for monitoring mood and triggers.

>OCD: a nine-session program (OCFighter) and mobile app that focuses on helping participants understand ritual impacts, identify triggers, and develop self-management skills.
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>CCBT for Chronic Pain: a seven-session program and mobile app targeted commercial release
is Q4 2017.

One of the things we learned about our company a few years ago was that the unique skills we
had for various populations could be combined and augmented for positive impact in new ways.
Our case study for the opioid crisis and pain is an example of those kinds of combined benefits.
Magellan Complete Care has been a leader in pain management programs that focus on what
happens when people see specialists for pain and also in addiction management and behavior
change. We identified that the opioid crisis was growing due to inappropriate prescriptions and
we brought together multidisciplinary teams to combine our industry leading medical expertise in
musculoskeletal pain management, behavioral expertise, and digital care leadership to create a
comprehensive, multifaceted approach that includes a digital program to help people manage
pain before they need opiates, and in many cases alleviate the need for surgery. We also use our
pharmacy expertise and combine it with big data and Artificial Intelligence (AI) to identify people
at risk earlier and intervene with our traditional behavioral case management, which of course
brings tremendous and proven value.

We took a similar approach with tobacco cessation. It is estimated that approximately 15 percent
of Medicaid spending on healthcare results from smoking, and as noted previously, smoking rates
are higher among individuals with SMI. We decided to design an approach that leveraged
traditional approaches and combined them with new ones. While smoking exacerbates most
major medical conditions it is controlled by a combination of behavioral and pharmacologic
methods [nicotine replacement and tobacco cessation behavior techniques]. We combined our
pharmacy and pharmacy expertise to bring nicotine replacement together with our live coaching
and added Clickotine, which has proven to be far superior to traditional coaching for getting people
to stop smoking.

Clickotine is a clinically-validated, fully digital smoking cessation program that can easily be
scaled to the Florida population as it uses an enrollee’s smart phone. In 2016, Clickotine was
studied in a 416-participant Institutional Review Board (IRB)-approved clinical trial. More than 40
percent of participants had stopped smoking at the end of an eight-week study, and Clickotine
was found to be almost 10 percent more effective than Chantix and 20 percent more effective
than nicotine replacement therapy, as outlined in [General SRC #13, Attachment 1: Magellan
Health Clickotine Overview].

EVALUATION CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES HOW
SOCIAL MEDIA...
The social media apps that we use are available on multiple smartphone and computer operating
systems and have been implemented in a responsive fashion. They automatically adapt to the
screen size as they are being viewed, making them easy to use on mobile, tablet or desktop.
There is no pinching or horizontal scrolling required by the user. Our apps are interoperable with
many of the other technologies currently used by the Medicaid population, which supports our
goal of empowering enrollees and caregivers with the information they need to become active
participants in healthcare, whether he or she is looking for information on providers, conditions,
or covered benefits. Our website will have a login/secure portion through which enrollees can
access some, private information. All new technologies deployed among our enrollees or
providers are evaluated against these same standards of usability.
EVALUATION CRITERIA 4 - THE EXTENT TO WHICH THE RESPONDENT IS ABLE TO PROVIDE ROUTINE PERFORMANCE DATA TO SUPPORT ENROLLEE USAGE TRENDS.

Through the use of social listening software, we are able to monitor Magellan Complete Care and Magellan Health's social media channels to capture trends and reach enrollees. As discussed previously in this section, we also use this software and the application’s messaging features to ensure customer service issues are addressed within State-required timelines. Examples include the need to refill prescriptions, provider billing questions or questions/comments more general in nature. This capability allows us to meet the consumer where they are. In this case, that is on social media, which allows us to quickly and efficiently address the comment, concern, or question. Magellan monitors its social media channels 7 days a week, several times a day.

Since June 2016, Magellan has engaged in a sustained campaign to increase the reach of, and engagement in its social media channels. We share a wide array of different content on Twitter, LinkedIn, and Facebook. We monitor usage and mentions monthly, and since June 2017 we have seen steady growth in the level of interaction on social media. Social media mentions during that period increased from slightly more than 200 per month, to more than 400 an approximate 90% increase. Our social channels have strong performance in Florida, for example:

> A June 6 tweet about the Orlando shooting reached 17,600 impressions
> An October 18 tweet about Medicaid coverage for children’s dental exams reached 10,400 impressions
> A September 13 tweet about Hurricane Irma reached 2,300 impressions

The Magellan Health Insights blog was launched in August of 2016. Since that time, we have published 65 articles across a wide variety of healthcare related subjects. While still a young web property, the blog is showing strong signs of growth:

> Current readership averages approximately 1,100 views a month
> Readership is derived from a number of sources: 49% of traffic over the past year has come from a combination of organic search (31%) and social media (18%). A further 21% has come from web referrals. The remaining 30% has come from direct promotion of our articles by Magellan Marketing and Communications.

Additional data on social media usage:

Facebook is one of the most popular social media platforms among groups similar to our enrollees. Reaching over 187,275 people, our over 160 posts connect everyone in the community, delivering messages about health and wellness.

Our Magellan Complete Care microsite has had over 1,900 visitors since it launched a few months ago. As noted previously, our microsite is a community of groups with a single focus which is to erase stigma to get people the help they need.

We also collect routine performance data for our other direct care applications. As an example, routine performance data for our CCBT system supports enrollee usage trends, which can be reported on a monthly or quarterly basis. Data includes aggregate service utilization and analytics data, such as number of website visitors, dates of enrollment, number of participants enrolled by condition specific program, progress status, number of logins, and outcome metrics. Additionally, all of the programs incorporate success metrics within each session. These metrics are collected
using standardized measurement tools embedded in the programs and mobile apps to measure baseline symptom levels and monitor progress throughout the programs. These standardized tests and questionnaires allow generalization of results across the enrollee population.

Technology solutions employed by Magellan Complete Care to engage enrollees and/or support self-care management and reductions in gaps-in-care are evaluated in the same statistically rigorous manner as all other interventions employed with our enrollees. We will follow the same Plan-Do-Study-Act (PDSA) framework used throughout our organization and in our quality management processes. This process supports clear identification of the issue, planned intervention, and evaluation of pre- and post-intervention efficacy. Magellan Complete Care is interested in ensuring that the solutions deployed are effective in reaching and engaging our enrollees to affect positive change in their health and well-being.

Identification of patients with behavioral health problems has long been recognized as challenging, so the Magellan Complete Care model of integration – called “Screen and Engage” – includes systematic screening as one element to improve care. Our screening tool, SmartScreener, is behavioral health screening software available in English and Spanish that sits at the front of VCS and is described as “smart” because it uses an algorithm developed to quickly and efficiently screen individuals for potential problems.

Importantly, completion and improvement with our programs do not appear to be necessarily related. In addition, Magellan Complete Care compares what individuals achieve when they are referred to our programs to programs using traditional behavioral clinicians and we have seen that the engagement levels are at least as good in terms of depth of progress as they are with traditional CBT clinician access.

At Magellan Complete Care, we regularly demonstrate the value of population data for our partners. Our SmartScreener platform uses a dashboard approach to capture prevalence reports of substance use and mental health conditions (as well as insomnia) across regions and demographics to provide broad population analysis that can be used to track meaningful statistics. Population screening data can be reported on a regular basis. Analyzing this data over time will enable us to allocate mental health and substance use resources in a very efficient and cost effective manner. This data can help improve outcomes (e.g., lower costs and enhance access) over time.
1. The extent to which the respondent described how these technology investments will be used to improve health literacy and promote improved health outcomes.

2. The extent to which the respondent provides data that supports the efficacy of the proposed approach in achieving the intended goals/health outcomes (e.g., increase in appointment compliance) for the target population.

3. The extent to which the respondent describes how social media, texting and smartphone app(s) will be mobile friendly and made available on all operating systems (iOS, Android, Windows, etc.) and interoperable with other technologies currently used by the Medicaid population (e.g., Lifeline).

4. The extent to which the respondent is able to provide routine performance data to support enrollee usage trends.

**Score:** This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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SRC# 14 – CAHPS Results (Statewide):

The Respondent (including respondents’ parent, affiliate(s), or subsidiary(ies)) shall include in table format, the target population (TANF, ABD, dual eligible) and the respondent’s results for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) items/composites specified below for the 2017 survey for its adult and child populations for the respondent’s three (3) largest Medicaid Contracts (as measured by number of enrollees). If the Respondent does not have Medicaid CAHPS results for at least three (3) states, the respondent shall provide commercial CAHPS results for the respondent’s largest Contracts. If the Respondent has Florida Medicaid CAHPS results, it shall include the Florida Medicaid experience as one (1) of three (3) states reported. Respondents shall provide the data requested in Exhibit A-4-a-4, Standard CAHPS Measurement Tool, to provide results for the following CAHPS items/composites:

a. Health Plan Rating;
b. Health Care Rating;
c. Getting Needed Care (composite);
d. Getting Care Quickly (composite); and
e. Getting Help for Customer Service (composite).

Response:

As the current Serious Mental Illness (SMI) specialty plan, Magellan Complete Care began accepting enrollees with SMI for delivery and management of fully integrated physical health and behavioral health care in July 2014. This SMI specialty plan concept was created through a partnership between AHCA and Magellan, as a way to truly focus on those complex health issues that people affected by SMI, and living in poverty, face. We know that these enrollees are super-utilizers within Medicaid, and AHCA was a national leader in developing this approach.

Over the course of the last three years, we have worked to create a new model of care that truly addresses the unique issues our enrollees face day-to-day. It is important to note that no other Medicaid health plans in Florida exclusively serve a similar target population as that served by Magellan Complete Care. In fact, in discussions with NCQA, the organization confirmed that there are no comparators for the population we serve. To that end, we believe this model works for Floridians, is a best in class model, and will ultimately, over time, allow enrollees with SMI to lead healthier lives.

Challenges around consistent engagement and compliance, even on a short-term basis, much less longer-term regimens, are well-known issues for individuals affected by SMI. To address that, the concept of a fully-integrated biopsychosocial care management model, which is relatively new, has been developed, although, there are few examples of having implemented this solution at scale over a broad population. Our SMI enrollees that came into the health plan at its inception were not previously receiving integrated physical and behavioral managed care. As a result, these enrollees were not as familiar or comfortable with the concepts of comprehensive integrated care management.

Given this historic lack of engagement and access to primary and specialty care, and the heavy burden of chronic disease in this population, Magellan Complete Care placed heavy initial emphasis on identifying enrollee physical health and behavioral health risks; initiating engagement; developing individual and population-wide plans for management; and beginning
the process of continually improving outcomes for enrollees. We have also placed specific focus on clinical issues that present risks for persons with SMI populations. We know these enrollees experience higher rates of physical health comorbidities, co-occurring substance use, and social instability; with resulting life spans that are 20 to 25 years shorter than individuals without SMI. Working to stabilize those clinical issues is a primary focus, and serves as a bit of a “gateway” to addressing other physical health issues.

Internal analyses of Magellan Complete Care’s enrollees shows the much higher rates of chronic illnesses among our population. All of our enrollees have at least one SMI diagnosis, while more than 40 percent have two or more SMI diagnoses; approximately 50 percent have at least one physical health comorbidity; and, more than 30 percent have two or more physical health comorbidities. Our enrollees have diabetes incidence rates that are 2.6 times higher than in the general Medicaid population. They experience hypertension at 2.2 times and asthma at 1.6 times the rate in the general Medicaid population. Those rates are elevated in part by the effects of psychotropic medications, higher rates of smoking, and poor nutrition. Our enrollees also have higher rates of substance use disorder (16 percent) and lower rates of primary care utilization, although Magellan Complete Care enrollees are engaged with primary care at more than double the rate of SMI populations in the U.S.

In addition to the kind of enrollee complexity noted above, resistance to engagement and compliance is well-known for individuals with SMI, likely impacting their satisfaction with their overall healthcare, their health plan, and their providers. Many of these enrollees are transient and experience significant housing instability, which makes them more difficult to locate for purposes of conducting satisfaction surveys. Addresses and phone numbers on file are often inaccurate. These factors tend to depress survey results.

However, Magellan Complete Care continues to look for new interventions and programs to increase enrollee engagement, responsiveness and satisfaction, to drive our CAHPS scores higher. Continuous quality improvement (CQI) has always been the backbone of Magellan’s services, but as this SMI program launched and matured, it is even more critical. The goal of our quality program, including those program elements related to satisfaction, is to ensure the provision of consistently excellent healthcare, health information, and service to Magellan enrollees. The values of patient-centered, community-focused, and evidence-based services are core to the Quality Program. CQI touches every functional area of the plan, including healthcare service delivery; service operations with members and providers; case management, disease management, and population health; core utilization management processes; network composition; compliance and risk management; and information management.

Magellan Complete Care staff obtain input from a broad spectrum of stakeholders, using a Plan Do Study Act (PDSA) framework. This applies to all areas of our operations that touch our enrollees. We monitor quality with metrics derived from multiple data sources to ensure the timely identification of barriers and interventions that lead to improvement. We use this model in all QI activities to resolve complex or multifaceted issues in a logical and systemic manner, as well as to engage stakeholders in planning efforts. The program has sponsorship from the CEO, COO and top leadership of the organization including the Chief Medical Officer (CMO), who shares joint accountability with the Magellan Complete Care Director of Quality Management (QI Director) for quality outcomes. Quality is everyone’s job at Magellan Complete Care, and in fact, as evidence of our commitment, all Magellan Complete Care staff have at least one goal tied to quality in their annual performance assessments. Our experience has shown that supporting CQI and plan-wide
quality ownership yields optimal service delivery and member outcomes, leads to systems improvement, and instills a pervasive culture of quality.

Magellan Complete Care understands the importance of quality and outcomes improvement for AHCA, including CAHPS, and we fully-embrace and support the same goals. Our recent acquisition of Senior Whole Health, a healthcare company focused on serving complex, high-risk populations, providing Medicare and Medicaid dual-eligible benefits to more than 22,000 enrollees in Massachusetts and New York testifies to that commitment. Senior Whole Health has an outstanding reputation, strong track record and extensive experience facilitating high-quality, cost-effective health care to its members which is demonstrated by being a 4.5 Star Medicare Plan and also being in the highest quality tier in the State of New York. Senior Whole Health, which has been serving these populations since 2004, adds its deep experience and expertise, and its quality programs and results to the in-depth experience Magellan Complete Care has gained as Florida’s first SMI Specialty Plan. During its more than 13 years of operations, it has developed and refined its quality programs to address the unique needs of complex, high-risk populations. We look forward to integrating their programs and approaches to further enhance our programs for Magellan Complete Care.

In our drive to improve quality and produce outstanding outcomes for this population, we have looked beyond our internal resources and acquisitions. Magellan’s goal has been to establish meaningful partnerships with best in class organizations in other areas as well, so we may continue to learn, grow, and innovate in development of quality improvement initiatives and continued refinements of our overall system of care and care management.

As part of those ongoing efforts, we are partnering with, and have engaged Shared Health, a wholly-owned subsidiary of Blue Cross Blue Shield of Tennessee to support continued enhancements to our quality management, population health, and disease management (DM) programs. Through this partnership, we leverage Shared Health’s 24 years of experience covering 1.3 million members to enhance our models for stratification of enrollees; targeting of quality, DM, and population health interventions; and, engagement and outreach campaigns.

Magellan’s relationship with Shared Health began in 2016, as we partnered with their organization to successfully bid for the managed Medicaid Long Term Services and Supports (LTSS) contract in the Commonwealth of Virginia. Magellan Complete Care of Virginia was awarded that contract, and has collaboratively been working with Shared Health for the past year to leverage their Medicaid expertise to build the systems, frameworks, and strategies to successfully launch their plan as of August 1.

In addition to their collaboration with Magellan Complete Care of Virginia, Shared Health has also joined the Magellan Complete Care team as a consultative partner in developing our population health management framework, and as an expert advisor for HEDIS quality improvement. HEDIS 2017 rates for Blue Cross Blue Shield of Tennessee East Region exceeded the 2016 Quality Compass 50th percentile for 10 of 12 measures included in this SRC.

Areas of expertise for Shared Health that align with Magellan Complete Care’s strategic vision include greater focus on sub-populations through data-driven analyses and well-developed community-based outreach strategy. Their algorithm using psychographics to better tailor interventions around demographic and cultural differences that may drive health disparities, includes use of self-reported data from enrollment files and through various health plan
assessments, and census tract information. Additionally, Blue Cross Blue Shield of Tennessee has a rich history of working within the communities they serve, and conducts more than 500 community events a year to reach their Medicaid population across the state. An important area of focus for Magellan Complete Care in continuing to achieve population health improvements is to leverage similar data-driven strategies to create tailored programs and to increase our existing community presence to reach an even greater percentage of our members.

Magellan Complete Care believes that the addition of Shared Health as an important partner in these efforts, when combined with the deep understanding we have gained about our population and the key mechanisms that drive successful interventions, will yield continued significant improvements in quality and outcomes results for our enrollees.

We provide our completed Exhibit A-4-a-4, Consumer Assessment of Healthcare Providers and Systems for 2017 for our Florida MMA plan. Our review of the SRC instructions and the responses to the Questions and Answers, notably in the use of “respondent” for purposes of the scores that can be submitted, were unclear. In an abundance of caution, we felt it necessary to provide you two separate spreadsheets to ensure that we answered in the way you intended. The first only includes scores for Magellan Complete Care of Florida, while the second spreadsheet includes scores for Magellan Complete Care of Florida and our other two largest contracts for similar target populations for the SMI Specialty Plan. Both are based in Massachusetts. One CAHPS survey was fielded for both Massachusetts products, and includes dual eligible enrollees. We recognize that Medicare CAHPS results are reported differently than Medicaid results. We have reported these CAHPS rating and composite results as calculated by Medicare.

Evaluation Criteria:

1. The extent to which the respondent exceeded the national Medicaid mean for each CAHPS survey item/component reported.

Score: This section is worth a maximum of 20 raw points as described below.

Exhibit A-4-a-4. Standard CAHPS Measurement Tool, provides for thirty (30) opportunities for a respondent to report prior experience in providing desirable experiences with health care (five (5) measures, three (3) states each, adult population for each, and child population for each). For each of the five (5) measures, a total of six (6) points are available.

The respondent will be awarded 1 point if their reported plan rate exceeded the national Medicaid mean, for each available state, for adults and for children, respectively. An aggregate score will be calculated and respondents will receive a final score of 0 through 20 corresponding to the number and percentage of points received out of the total available points. For example, if a respondent receives 100% of the available 30 points, the final score will be 20 points (100%). If a respondent receives 27 (90%) of the available 30 points, the final score will be 18 points (90%). If a respondent receives 3 (10%) of the available 30 points, the final score will be 2 points (10%).
D. PROVIDER EXPERIENCE

SRC# 15 – Provider Engagement Model (Statewide):

The respondent shall describe in detail its provider engagement model. The respondent shall include the following elements in its description, at a minimum:

a. The respondent’s staff that play a role in provider engagement;

b. The presence of local provider field representatives and their role;

c. The mechanism to track interactions with providers (electronic, physical and telephonic);

d. How the respondent collects and analyzes utilization data and provider feedback, including complaints received, to identify specific training needs;

e. The metrics used to measure the overall satisfaction of network providers with the respondent; and

f. The approach and frequency of provider training on respondent and Agency requirements.

Response:

OVERVIEW

Magellan Complete Care’s goal is to work with providers to ensure every enrollee receives the very best care. We deeply value our provider partnerships and have developed meaningful relationships to support them in the care of our enrollees. Magellan Complete Care firmly commits to our continued efforts to improve the provider experience through a high-touch provider engagement model that is designed to streamline provider management processes. We maintain the executive commitment and an effective staffing model to support this commitment to our network providers. Our integrated provider engagement model offers a hybrid of onsite, personalized support within each Florida region, as well as virtual, self-service and technology-based support capabilities. We believe that provider engagement model fosters healthcare innovation, integration, community inclusion, and collaboration with all providers and caregivers across the enrollee’s entire care continuum. Most importantly it is built on the belief that recovery and wellness is possible for all enrollees.

Magellan Complete Care has extensive experience working with and supporting individuals who are living with serious mental illness (SMI). We know and understand that individuals who are living with SMI experience extremely difficult life circumstances and typically have to work through a complex array of access challenges to obtain effective treatment for their illness. Magellan Health has been supporting SMI enrollees in Florida since the late 1990’s. As a result, Magellan Complete Care has developed a robust statewide provider network to support the unique needs of our enrollees who are living with SMI.

Over this same period, we have developed successful approaches to engaging and supporting providers and over 4,000 community-based organizations across the state. In many instances we have become advisors to providers and community organizations on how to organize and integrate their practice into our model of care as a way to effectively support enrollees living with SMI. To support Magellan Complete Care’s commitment to our unique provider engagement model and its effectiveness to deliver, we point to the below provider testimonial as evidence of the value Magellan Complete Care brings to the provider community and our specialized knowledge of the SMI enrollees needs in Florida.
"To Whom It May Concern;

I am writing this email to gratefully acknowledge and document Magellan Complete Care's (Magellan Complete Care) total commitment to engagement and community relationships in North Florida’s AHCA Area 2.

"I am the Chief Executive Officer of Apalachee Center, Inc., the largest community mental health center between Pensacola and Gainesville, which provides inpatient, residential, outpatient behavioral health and primary care to about six thousand unduplicated clients annually in the 5500 square mile, eight-county region of Florida’s Big Bend. Apalachee has been in contract with Magellan Complete Care since the beginning of their new, SMI focused business model, and it has turned out to be, without exception, an unusually supportive and responsive relationship. At a community level, Magellan Complete Care has been unique in maintaining a consistent local presence and visibility among advocacy groups such as NAMI Tallahassee. Magellan Complete Care has partnered with local advocates and Apalachee Center in sponsoring events, facilitating town hall dialogues, and being readily available to severely mentally ill clients who, too frequently, experience themselves as unheard by health plans.

"Magellan Complete Care has created a robust voice for peers by employing some of the most respected peer advocates in this community, supporting their efforts to advance awareness and treatment for severely mentally ill enrollees, and championing and supporting increased training for peer certifications. Moreover, Magellan has accomplished this by letting peers do their job – there is never a sense that Magellan employed peers are “selling” Magellan. Instead, they are supporting and expanding all community efforts to increase the scope and excellence of treatment for severe mental illness.

"At an operational level, Apalachee Center senior, mid-level and line staff are uniform in their praise of Magellan’s rapid response to bureaucratic roadblocks, miscommunication, and payment issues, which can happen with any MCO. In fact, since the advent of Medicaid managed care in Florida, I have never heard Apalachee’s billing and finance staff as positive about any MCO as they are about Magellan Complete Care.

"At an executive level, I can personally attest that Magellan is not only willing to pick up the phone or return the text immediately when issues arise, but that senior Magellan staff (notably Magellan’s Senior Director for Systems of Care) will personally shepherd any issue through the system until it is resolved. I can say without exaggeration that every technical and bureaucratic issue that has emerged between Apalachee and Magellan has been resolved rapidly, positively, and usually within 24 hours.

"In summary, I wholeheartedly applaud Magellan Complete Care’s benchmark excellence in community engagement, and look forward to a long and positive relationship between our organizations."

CRITERIA 1: THE EXTENT TO WHICH PLAN LEADERSHIP ARE INVOLVED IN...
Our overarching provider engagement goal is to ensure timely access to quality health care services and an improved provider experience for all enrollees. Magellan Complete Care’s Chief Executive Officer (CEO), Chief Medical Officer (CMO), Chief Operating Officer (COO) and
provider network leadership set priorities and actively supports our provider network engagement efforts. Our CEO regularly reports updates on our provider engagement activities to the Board of Directors. Our leadership has assigned our provider network one of our highest organizational priorities and has engaged staff, cross-functionally, to establish an annual plan, which includes strategic goals and activities for system transformation, provider engagement, and commitments to improve the provider experience. Our annual plan is informed by input from the provider community gathered through various forums, such as:

> CEO Direct Reports Meetings: Provider Engagement is a standing agenda item on our CEO’s direct report management team meetings. This forum provides an opportunity for senior leadership to continue to inform and shape our evolving strategy and tactics.

> Face-to-Face Meetings: Since we initiated our current contract with AHCA in 2013, our Executive team and Network leadership regularly meet with local and regional health systems, hospitals, rehabilitation hospitals, community-based providers, community mental health centers (CMHCs) and federally qualified health centers (FQHCs) to better understand the patterns of care of our population and better meet the needs of our providers. We recognize the level of importance in effectively engaging with our provider community, because our model of care requires the integration of multiple provider types to support the complex and comorbid conditions related to our enrollees’ SMI conditions.

> Physician Advisory Committee: Magellan Complete Care operates Florida Physician Advisory Board (PAB), chaired by our CMO and attended by our CEO, COO and network leadership. Physicians play an active role in our program oversight, strategic planning, and program initiatives. The PAB has had a positive impact and have made a difference for providers, enrollees and the community. The PAB meets quarterly to review and provide feedback on new programs and QI initiatives. The PAB members provide insight into local population health concerns, review program evaluation and Performance Improvement Project results and provide guidance on how we can help improve the provider experience. The PAB also represents the provider network by providing ideas and feedback on innovative strategies to help us transform the health delivery system, such as our value-based payment programs. The PAB has had such great success that we recently launched Hospital Advisory Committees in FL.

> Joint Operating Committee (JOC): Magellan Complete Care conducts monthly and quarterly Joint Operating Committee (JOC) meetings with our network hospital systems, delegated subcontractors, vendors and multi-specialty provider groups as well as clinics, facilities and high-volume practitioners that include members of our senior leadership team. These joint operating meetings are cross-functional, by design, and incorporate representation from Magellan Complete Care’s medical directors, care coordination, utilization management, network development, provider relations, claims, quality improvement, compliance, and legal departments. The agenda for each JOC meeting includes discussions with the provider community, issues, concerns, and functional considerations as providers administer the Magellan Complete Care program in order to increase communication, provide transparency and accountability to providers, and to establish rapport in future partnership initiatives.

> Provider Organizations: The critical nature and work of the Florida Medicaid provider community requires communication and collaboration on a shared advocacy strategy between the health plans, providers, and community associations. Magellan Complete Care supports this strategy by collaborating with the Florida Council for Mental Health, Florida Behavioral Health Association,
Managing Entities, DCF, Florida Hospital Association, Florida Association of Community Health Centers, and other organizations. By fostering these relationships, we are able to advance care delivery strategies that have improved care and increased enrollee access to care. Our partnerships have taught us about the specific challenges providers face in the development of new programs and when policies are changed. By learning from our partners, sharing our collective experiences and resources, we are able to obtain provider consensus that results in improved care and access for our enrollees.

~~Executive Team Commitment Example~~
Through a commitment to provider partnership and system transformation, our executive team played a “hands on” role, collaborating with providers, in the development and implementation of our Integrated Behavioral Health Program. Based on an internal data analysis and external environmental scan, senior leadership identified targeted provider partners to engage and develop a meaningful program to creatively and effectively meet the needs of the most complex enrollees in Miami-Dade County—a process known as an “Innovation Hub.” Over a period of six months, Magellan Complete Care’s CEO, COO, CFO, CMO, VP of Health Services and other members of the executive team participated in a series of onsite meetings at the provider organizations—Jackson Hospital and Citrus Health Network. Most importantly the Magellan Complete Care executive team focused on understanding first hand, from the provider’s perspective, what actions would enable providers to make a meaningful impact in the lives of the enrollees and improve the health of the community.

In May 2017, Magellan Health Service’s VP of Analytics and the CMO of Jackson Behavioral Health Hospital presented the Integrated Behavioral Health Program (IBHP) at the Most Powerful Women in Healthcare IT conference. The Magellan Complete Care and Jackson teams co-presented IBHP, which continued to demonstrate our partnership and commitment to enrollees and the model to further progress and innovation in the healthcare sector. This presentation focused on how we leveraged technology and analytics associated with machine learning to develop and model the program.

**CRITERIA 2: THE EXTENT TO WHICH LOCAL PROVIDER FIELD REPRESENTATIVES...**
We have developed and implemented a provider engagement model that reflects and is consistent with our person-centered, community-focused, and evidence-driven Specialty Plan model of care. This model is supported by a dedicated team of Provider Relations Managers (PRM) and Provider Support Specialists (PSS), who function as our provider field representatives in each region to ensure real-time, personalized support. Our ratio of local provider-facing field representatives to providers is 1:75 providers.

The foundation of our regional approach to provider engagement and support in Florida is our Integrated Health Neighborhood™ (IHN). Improved overall health and wellness can only be achieved where enrollees live—in Florida’s neighborhoods and communities. We facilitate our Florida MMA model of care by deploying teams dedicated to all regions of the State with first-hand knowledge of community strengths, resources, and service gaps. The beauty of this neighborhood-based model is that it naturally bridges language and cultural barriers no matter which region we are serving—from Miami to Tallahassee. The model works in rural underserved areas as well as in urban communities. Our Integrated Health Neighborhood approach enables us to “think locally” as we work with providers in each region to meet enrollees where they are. Participating providers play an integral role within our IHN and the overall delivery of high quality care.
services to our enrollees. We proactively seek opportunities to customize our provider support approach by region, and/or as market trends dictate to ensure optimal care collaboration and partnerships with providers.

We believe our hands on, local approach to provider engagement has been critical to our broader success and we are committed to extending our collaborative approach with individual, community- and facility-based providers.

~~Testimonial from Katie Reeley, the CEO of Behavioral Support Services~~

“Magellan has been the most outstanding provider partnership out of all our contracted relationships. The utilization management department has always ensured collaborative and cohesive care for our patients. Our provider partnerships in the field are thoughtful, collaborative and have significantly impacted and improved our counties and patients. The use of training, open dialogue, case management and multiple tools is a dynamic approach not used by any other Managed Care entity with which we are contracted. The way that Magellan embraces mental health and holistic health is forward thinking, dynamic and promotes positive quality of care. Magellan has had a significant positive impact to improving care in the Central Florida community. We are proud to call them our partners.”

By design, we have retooled traditional health plan roles and created new ones. By forming IHN teams, we have broken apart the silos normally seen between functional areas at a health plan. We have assigned these teams’ accountability and responsibility for a group of enrollees and providers, which enables them to be nimble and flexible as they work collaboratively to facilitate the best possible service options for enrollees and ease the administrative burden for providers. And where gaps exist, our multidisciplinary team members leverage their backgrounds and experience to develop and implement creative solutions. Our interdisciplinary team consists of: Integrated Care Case Managers, Health Guides, Peer and Family Support Specialists, Community Outreach Specialists, Provider Support Specialists, and Provider Relations Managers, as well as housing and employment support [General SRC #15, Attachment 1: Magellan Complete Care Field Staff].

We support our IHN model and provider engagement strategy with a team of highly skilled and experienced PRMs. Our PRMs are located statewide and focus on making sure our service delivery system aligns with enrollee needs. Each PRM serves as the primary contact to providers and manages the overall support needs of their assigned region. This team leverages our advance analytics, group and individual training models, and cross-functional collaboration to ensure early engagement between providers and enrollees, quick resolution of clinical and administrative issues, and the identification of opportunities for expanding our impact across Florida.

Our PRM team follows a rigorous engagement protocol, which is clearly described in our PRM administrative policies and procedures, and includes guidance on issues such as:

> Data analyses: these activities include a prospective review of claim denials (including denial reasons), authorization denials, known credentialing applications in process, clinical trends, and related training opportunities

> Internal collaboration: these efforts focus on resolving provider challenges and related administrative issues, gathering input/feedback from internal stakeholders to best understand
policy, system and other changes that will directly impact providers, and developing training and communication strategies to support these changes.

> Structured provider interaction: this activity is designed to focus our PSS provider support efforts and maximize the time we spend with providers regarding our administrative and clinical resources, systems, and related capabilities.

> Outcomes: our commitment to providers includes a focus on action, documentation, and reliability. Our PRMs support this commitment by making sure all provider interactions and follow-up efforts are documented and addressed.

Magellan Complete Care’s goal continues to be the transformation of the system of care and, with our continued support, we are shifting care coordination and quality improvement resources to the point of care through the integrated care, provider-based models. Our Provider Support Specialist team is proof of our commitment to our network providers and to provider-led system change in Florida. A participant of the regional Integrated Health Neighborhood team, the Magellan Complete Care PSS team facilitates and supports our partnerships with our providers to develop and improve integrated care models.

The PSS team consists of licensed behavioral health clinicians or RNs with significant behavioral health experience. These highly trained and qualified clinicians, who are expert at working with enrollees who are living with SMI, enable us to be more effective with providers and their office staff. Our PSS team identifies opportunities for practice transformation activities that will have a lasting impact on the system of care throughout Florida and the way our enrollees interface with the healthcare system.

The PSS team is tasked with focusing on the clinical needs of the provider network. We believe that actively engaging the network through education, training, and knowledge provides a level of commitment and partnership that will yield improved health and wellness and an improved enrollee experience. Magellan Complete Care views this integrated care model as an investment that adds considerable value to the provider network by creating access to local subject matter experts who help improve our collective capability and capacity to serve special populations in a meaningful way.

~~Testimonial from Sally Leonard, RN, Community Health Centers of Pinellas, FQHC in St. Petersburg, FL~~

“The Provider Support Specialist’s role has helped us understand the Magellan “way” so to speak. She has educated us on the process that case management works through Magellan- giving us the various levels and what they mean….Responds timely to provider/ network/client/internal issues….I believe our partnership created a better system of care and improved the overall experience with Magellan. The role truly makes for a better working relationship with the health plan than a plan without it.”

The PSS team consists of locally-based behavioral health experts with years of experience working directly with enrollees to provide clinical care, history working within behavioral health access points and have a thorough understanding of quality protocols, best practices and person centered care to ensure our enrollees needs are addressed at the right time, the right level and grounded in principles of recovery. Our unique and comprehensive approach is built upon:
An ongoing and evolving understanding of our enrolled populations and sub-populations
Hiring provider support specialists who live and work in our communities
A focus on provider partnerships to drive innovation and improve enrollee outcomes
Practice transformation and improvement activities
Educating providers on the importance and impact of Social Determinants of Health
Brokering provider relationships across specialties to support integration of care
Sharing knowledge to increase awareness, support parity, and reduce stigma
A comprehensive array of covered services and supports
Effective provider and community stakeholder collaboration
Appropriate provider credentialing and contracting
A robust and accessible provider network
High quality network management and monitoring practices
Ongoing provider support and technical assistance
Connecting providers with their quality performance related to the patients they serve, and helping to foster the enrollee and provider relationship
Providing monthly on-site education, support, and training on HEDIS and enrollee engagement

2.1 Local, Hands On Approach Example
Since 2015, our PSS team has conducted more than 3,500 face-to-face visits with approximately 1,000 unique network providers throughout Florida. The foci of those onsite meetings vary according the provider’s needs and goals, and have addressed issues such as: quality programming, technical support, clinical training and plan introduction and orientation sessions with our care coordination team. All of these meetings are designed to help providers build or expand their practice capacity in order to provide the highest quality of care to our enrollees, who are living with SMI.

~~Testimonial from Elaine Churton, Northside Mental Health, CMHC in Tampa~~
"Northside’s working relationship continues to be a positive one. From a provider’s prospective, Magellan Complete Care’s strongest asset is communication. Representatives display a genuine interest in providers as well as members. Northside has been afforded with training proactively as well as upon request. We feel informed well in advance of any changes to Magellan Complete Care procedures, inclusive of on-site conferencing if needed and individualized solutions to any concerns."

~~Integrated Health Neighborhood Team Approach Example~~
Working as a dedicated team we facilitated critically needed care for an enrollee with schizophrenia in a safe and monitored environment. Due to the Provider Support Specialist’s (PSS) clinical knowledge and background and a strong, established relationship with the Boley Center’s FACT team, our PSS and Integrated Care Case Manager (ICCM) were able to connect our enrollee, with the support of his family, to a PCP and help with his care coordination needs. Ultimately, these efforts had a positive impact and made a significant difference in in our enrollee’s life.

One of our Magellan Complete Care PSS staff established a strong relationship with the Boley Center FACT Team through regular trainings, meetings and touch points. This PSS has a master’s degree in nursing and over the past 30 years has worked in a multitude of settings including inpatient behavioral health. Additionally, she has extensive experience successfully working with providers during her career in pharmaceutical clinical support.
In September 2015, the FACT team RN called our PSS with concerns regarding a Magellan Complete Care enrollee she had worked with for 13 years to address multiple complex conditions including Schizophrenia, Diabetes, COPD, Hypertension, and Obesity. This enrollee was deteriorating physically, losing mobility, and urinating frequently with occasional incontinence. This enrollee refused to leave the house to see a PCP, consistent with his symptoms, associated with schizophrenia. The enrollee’s assigned PCP refused to make a home health referral because he had never seen our enrollee.

The PSS connected the Boley Center’s FACT team to our Magellan Complete Care health services team to assist with coordination of services for the enrollee. The ICCM and the PSS met with a local PCP with whom the PSS had established good rapport. The PCP agreed to take on the patient and ordered a home health skilled nursing visit. After an initial visit, the enrollee was hospitalized with a urinary tract infection and sepsis. Our ICCM assisted with the discharge planning and transition to a skilled nursing facility before returning home. Our ICCM continued regular follow-up, until the enrollee was approved for LTC services which prevented further hospitalizations. Ultimately, the enrollee transitioned to LTC community-based services, as he had been stable for 90 days.

CRITERIA 3: THE EXTENT TO WHICH THE METHOD THE RESPONDENT USES TO...
Magellan Complete Care’s robust processes and systems track interactions with providers. Our integrated systems produce meaningful data and reports that are regularly reviewed by management, staff and various committees including the Quality Improvement Committee and the Network Strategy and Oversight Committee to address both clinical and administrative problem areas. We track provider interactions and issues from multiple touch points to ensure we have a strong pulse on the needs of our providers. The Customer Service Team uses Total Member Record (TMR) to track and document all interactions with providers who e-mail or call the Provider Services line. Our Quality department uses a software application, Resolve, to assist us in managing complaints and issues related to quality of care. The Provider Support Specialists and Provider Relations Managers use Salesforce, described below. As part of the Magellan Complete Care provider engagement model, we integrate reports, data and information across these systems to share knowledge and improve the provider experience. Additionally, our integrated systems assist us to ensure cross functional communication to best manage the network.

We have developed a rigorous, proactive, systematic approach to the identification of issues and trends in both clinical and administrative problem areas and subsequent process improvement, staff training, and/or system enhancements. Depending on the issue, trends are reviewed in Magellan Complete Care’s Quality Improvement Committee or Network Strategy and Oversight Committee. Additionally the Magellan Complete Care compliance, quality, network, and provider support teams hold bi-weekly Provider Monitoring Meetings which focus on reviewing data and information collected from the above stated sources as well as from the teams in local regions to address network needs, issues, and ensure oversight of a comprehensive resolution. As part of this process, we perform trend analysis, document resulting actions, assign actions to an accountable owner, and establish resolution timelines for all activities.

All provider e-mails and calls to Provider Services are documented in TMR. The Provider Relations Managers receive monthly reports from TMR to identify the highest call volume providers, the reason for their calls, and providers with emerging claims dispute issues. If an issue
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

is not resolved on the first call, it is documented and tracked in Magellan Complete Care’s Resolve
system. Resolve is used to track, document, proactively resolve and report on provider
complaints, including provider claim disputes. This system-based work flow solution ensures
complete data collection, calculation of required turnaround times, and dashboards that help staff
prioritize their work loads. All information on a case, including archived letters, is maintained in
Resolve.

Magellan Complete Care Provider Support Specialists and Provider Relations Managers use
Salesforce to ensure consistency and continuity in our outreach efforts and to identify potential
training needs for our field-based team. Salesforce is a cloud-based customer relationship
management (CRM) software application we use to track daily field representative tasks including
preparation, planning, research, outreach, and follow-up. Salesforce contains information on all
of our network provider groups, along with their contact information, practice profile information,
meeting agendas and minutes, meeting dates, etc. The PRM and PSS teams track all electronic,
face-to-face and telephonic interactions with providers using this tool. Salesforce produces
meaningful reports that our PSS teams use to guide their daily work.

Based on the reports produced from TMR and Resolve, when clinical or administrative problem
areas are identified, the local PRM or PSS proactively outreaches to provide follow-up on issue
resolution or onsite support if needed. The PRM guides the provider to the portal and other self-
service tools to support their needs in real time. These outreach efforts are recorded into
Salesforce to develop end to end documentation to identify, track, and address the networks
needs. Once outreach is included into Salesforce, the PRM manager can provide reports
demonstrating the education and support efforts to internal departments and compare them when
or if issues are identified in the future.

Our PSS teams use Salesforce to track practice facilitation activities and technical assistance
including provider education and training sessions, practice assessments, development and
monitoring of projects, quality and process improvement plans, HEDIS outreach and education,
practice management, and integration work plans. For example, our PSS team leverages
Salesforce for the “Clinical Support Process” resulting from deficiencies we identify during our
medical chart audit process. Our PSS team documents the identified challenges and clinical
improvement plan in Salesforce, along with our monthly on-site meetings and trainings needed to
successfully address the identified issue(s). This documentation is critical to reflect back to the
provider and to share with our Quality Improvement Committee and eventually with the Regional
Network Credentialing Committee (RNCC). As a result of the tracking and documentation
protocols, the Salesforce platform provides, the PSS team is able to accurately demonstrate the
diligence and commitment to improve the quality of services the enrollees receive.

Our management staff access reports and dashboards to determine staff productivity, consistency
in contact and time spent with providers, and associated provider activities. In addition, these
reports and dashboards help track both clinical and administrative issues, resolutions and trends.
An example of a proactive resolution of an administrative issue using Salesforce helped the PSS
team resolve a statewide administrative challenge for a critical behavioral health provider in
Region 10. The provider reported issues with outstanding prior authorizations for TCM services.
The manager reviewed the PSS’s documentation in Salesforce and called this to the attention of
other regional PSSs to explore if this was a larger issue that had not yet been reported in other
areas of the state. After further investigation, it was found that this was in fact a larger issue. The
root cause was identified and the problem was successfully resolved. As part of Magellan
Complete Care’s commitment to our high touch provider engagement strategy, the PSS co-facilitated a face to face meeting between the providers and Magellan Complete Care’s Utilization Management leadership and a single point of contact was assigned in UM. The provider reports “they are happy … and the issues have long been resolved and grateful for the opportunity to meet with Magellan Complete Care leadership face to face to rectify important issues that have a direct impact on member care.”

CRITERIA 4: THE EXTENT TO WHICH THE METHOD THE RESPONDENT USES...
We have built out robust tracking mechanisms within our integrated IT tracking platforms as well as meeting structures to support our localized approach to provider engagement and assist with managing the PRM and PSS teams training needs. If PRM or PSS training needs are identified in customer service or through the complaint process. For example. If a PRM provides wrong information or there is a miscommunication with a provider, the issue is forwarded to the provider field representative manager. Trended summaries are shared in the Quality Improvement Committee (QIC) and Network Strategy and Oversight Committee to quickly identify potential training needs and where to focus improvement efforts. In keeping with Magellan Complete Care’s use of rapid cycle quality improvement methodologies like Plan-Do-Study-Act (PDSA) or Plan-Do-Check-Act (PDCA), the teams monitor and modify interventions as necessary to ensure improved performance and continued incorporation of the changes into our daily operations.

Our Magellan Complete Care Provider Support Specialists and Provider Relations Managers use Salesforce to ensure consistency and continuity in outreach and to identify potential training needs for our field-based team. By reviewing the weekly outreach activity, the Magellan Complete Care management team is able to identify educational opportunities for our team to ensure they are equipped with the knowledge and skills to address the providers’ clinical and administrative needs. For example, as the PSS team launched the Provider Partnership Program, training and re-training needs were identified based on their Salesforce input information that was reviewed by the team’s manager. As a result, additional team training around Practice Facilitation was provided, bi-weekly PPP meetings with the team were instituted, and the PSS team was assigned several integrated care trainings through the Relias training platform.

Our management staff can also access reports to determine staff productivity, consistency in contact, time spent with providers, and associated provider activities.

Our CRM tool, Salesforce, enables us to document and maintain accurate provider contact and role information to support more streamlined access to the right person within the provider organization. This capability helps us to establish more effective and efficient communication with provider offices and results in higher provider satisfaction.

Utilization of Salesforce enables us to share critical programmatic and policy documentation during provider meetings, and includes items such as: agendas, “take-aways”, provider and PSS next steps, and identified provider needs that are highlighted in our provider profiles.

Reports such as Practice Integration Assessments are built into the platform providing an additional dimension to the ability and readiness of practices for integration of physical and behavioral healthcare. This report assists the PSS in identifying those organizations interested and ready for additional support and education around practice facilitation and integration.
Salesforce offers a mobile application allowing the PSS to enter provider updates via their cell phone or tablet. This feature enables the PSS to perform real-time updates while working in the field.

Salesforce includes the capability for building additional tracking measures into the platform to generate data on provider-based new educational information, outreach activities, launched projects, specific types of interactions as needed, etc.

We also use Salesforce and corresponding reports to inform and update our training curriculum and related training resources.

**CRITERIA 5: THE EXTENT TO WHICH THE METRICS USED PRODUCE ACTIONABLE DATA...**

The results from the below-referenced activities and tools are discussed in our Physician Advisory Board meetings and our Network Quality and Oversight Committee meetings, which report the results to our Quality Improvement Committee. Our PRM and PSS teams monitor and modify interventions as necessary to ensure improved performance and continued incorporation of the changes into our daily operations.

5.1 Measuring Provider Satisfaction
Magellan Complete Care uses a multi-pronged approach to identify areas of improvement related to provider-focused written materials and communications including the Provider Satisfaction Survey [General SRC #15, Attachment 2: Provider Satisfaction Survey], training evaluations, real-time Monitoring Partnership Alliance tool, Provider Advisory Board, and documentation in Salesforce. Feedback from these various sources defines communication needs and tactics e.g. dissemination of best practices in our provider newsletter, need for a specific training module, and the development of Joint Operations Committees with larger practices.

5.1.a Provider Satisfaction Survey
Magellan Complete Care surveys its participating network practitioners annually to obtain their perceptions of the service received in collaboration with Magellan Complete Care. Feedback is collected using the Magellan Complete Care Provider Satisfaction Survey questionnaire designed and administered by Magellan Health's QI, Surveys, Evaluation and ASD, Survey Operations teams. All participating practitioners/providers who received at least one authorization or submitted a claim for service between the designated dates are selected to receive a questionnaire. The questionnaires are distributed by email, fax, and postal mail with an option to return them by email or fax to encourage optimal participation.

Our Quality Improvement department administers and analyzes this annual survey. The “Provider Relations and Communications” section of the survey includes the following questions:

How satisfied are you with:
1. The credentialing/contracting process
2. Opportunities to give input to Magellan Complete Care
3. Magellan Complete Care’s publications (provider handbook, provider newsletter)
4. Magellan Complete Care’s language assistance services (i.e. interpretation, translation services)
5. If you have called or written to file a formal complaint, what was your satisfaction with the ease and timeliness of Magellan Complete Care’s complaint resolution process?
6. Representatives on the provider services 1-800 line(s) ability to resolve your problem or answer your questions in a timely manner?
7. Overall satisfaction with the Magellan Complete Care’s provider services 1-800line(s)
8. Do you have a need for additional office training from our network relations team?

For 2016, the overall satisfaction result of 85.1% is 5.1 percentage points above the established performance threshold goal of 80%. After review and discussion of the survey elements, the Magellan Complete Care Florida Satisfaction Survey Workgroup determined to evaluate all elements not meeting a threshold goal of 80% for improvement opportunities. As part of our ongoing commitment to quality improvement and provider satisfaction and engagement, we have established a quality improvement plan to address areas of opportunity so we could respond to provider feedback in a meaningful, collaborative manner. Once we addressed this feedback, we conveyed the changes and improvements we made by leveraging the strength of our field-based IHN structure so that providers were aware of the changes we implemented.

Magellan Complete Care has also developed a real-time mechanism to track provider satisfaction and maintain our organizational commitment to the provider engagement model. “Monitoring Partnership Alliance” is our way of ensuring providers have an ongoing platform to share feedback, improve the way we engage their practice, and build a foundation of communication and support. [General SRC #15, Attachment 3: Monitoring Partnership Alliance] This simple survey tool enables providers to quickly share feedback to their PSS after each and every touch point, giving us the opportunity to evaluate our approach on a continual basis. This tool also sends a clear message to providers that their opinions are valuable and will help to shape our provider engagement strategy and collaboration efforts. Our Provider Support management team reviews these survey results as a way of maintaining a close pulse on how our model is being received in the market and to inform modifications as needed.

5.2 Increasing Provider Performance
The Magellan Complete Care Quality Improvement department continuously monitors quality, including provider performance, using metrics derived from multiple data sources. This ensures the timely identification of barriers and interventions that lead to improvement, such as provider training and education, when issues with provider performance are identified.

The PSS team maintains provider clinical profiles in Salesforce. The profiles are based on practice assessments, site visits, medical record reviews, and performance data. PSSs work with practices to utilize Magellan Complete Care provider portal self-service tools including the Impact Pro® Connect Portal to support performance improvement efforts. The Connect Portal assists and informs providers in improved care management, identification of enrollee gaps in care and performance comparisons to quality benchmarks. In the future these provider profiles will incorporate the ranking results from the Magellan Preferred Provider Quality Rating (MPPQR) - our methodology for establishing preferred provider status based on quality and cost. Salesforce helps inform the PSS outreach efforts associated with provider performance. All major clinical initiatives are specifically documented and tracked in Salesforce so our PRM/PSS management team can easily quantify our outreach efforts and measure the impact. Using a data-informed strategy enables us to be effective and efficient in our provider outreach, training and technical assistance. A specific example is HEDIS performance improvement outreach.

~~Provider Engagement and Support - an Example of Increasing Provider Performance~~
PSS staff provide enrollee registries to PCPs. The registries include patients that have not received recommended preventive care (HEDIS Gap reports) along with their level of risk and risk factors. The PSS Team provides education to help link providers to our self-service online portal
for easy access to this information. They conduct monthly or bi-weekly on-site follow up meetings to address questions, provide training or troubleshoot barriers the providers are experiencing to improve the success of their outreach efforts. During the fourth quarter of 2016, our PSS team conducted over 900 onsite HEDIS outreach visits. The team leverages our robust analytics platform, Provider Quality Management System, to target providers and provide detailed information identifying gaps in care and through predictive modeling and risk stratification, the risk level of enrollees. The data-informed PSS team strategy to focus their outreach on providers with the highest volume of gaps in care and the largest volume providers based on assigned membership. Our PSS collaborative efforts with providers have been instrumental in improving provider performance and closing gaps in care resulting in year-over-year improvement in HEDIS scores.

The Magellan Complete Care PSS team has also developed a quality-driven provider survey that uses Salesforce. The Provider Assessment Readiness questions give us qualitative information so that we are able understand each practice’s individual strengths and opportunities for improvement. This assessment includes specific questions that enable the Magellan Complete Care PSS team to better apply meaningful resources, tools and supports to meet each practices individualized needs. The Provider Assessment Readiness includes questions such as:

>What is the provider organization’s attitude towards working with the SMI population?
>How interested is the practice in partnering with Magellan Complete Care?
>How much quality improvement does the practice engage in on a regular basis? >What is their commitment level to QI?
>How open is the practice organization to learning new processes that affect the quality of care for Magellan Complete Care enrollees?
>How operationally functional or healthy is the practice?
>Does the practice conduct PDSA or similar evaluations to assess the effectiveness of change efforts?
>Is there an identified leader or owner of QI efforts?
>Does their organization use an EHR? If yes, include the system
>Does the practice complete health risk assessments?
>Does the practice complete substance abuse assessments?
>Is the practice an accredited PCMH?
>Does the practice have a working knowledge of caring for individuals living with SMI?
>Does the practice support an integrated model of care?

The questions are formatted in reportable fields within Salesforce and an average score is produced so that the results can be measured, compared, and tracked. The PSS team uses these results to appropriately target opportunities to improve provider performance through quality focused practice transformation activities. These activities leverage their clinical skills and expertise, resulting in a positive provider experience and better enrollee outcomes.

5.3 Improving Provider Engagement Model
The Magellan Complete Care provider engagement model is rooted in hands on support to the provider network. We use Salesforce to produce actionable data to measure provider satisfaction, increase provider performance, improve the provider engagement model, and identify areas of improvement for provider-related communications and written materials. On a weekly basis, Salesforce provides PSS and PRM management with dashboards that illustrate each team’s activity. This capability supports a high level of transparency, tracking, and management to ensure
we are delivering on our provider engagement model. Each PSS and PRM is given a general dashboard that encompasses all of their weekly activity including time spent on administrative activities.

Through the robust reporting and tracking capabilities that Salesforce provides, we manage each PSS team’s time to ensure we are effective and efficient in our provider engagement approach. Each PSS and PRM is expected to dedicate 60% of their work week to on-site, face-to-face provider engagement activities. We support this requirement through the weekly provider activity dashboard to demonstrate our community-based outreach and engagement model.

Salesforce includes a feature to flag provider activity using a “red, yellow, green” system for easy use and quick recognition. The teams and management use this system to ensure all providers have touch points and engagement with our field based team per the timelines that have been developed. Any providers whose activity shows as yellow or red self-select for discussion during supervision as well as to alert the assigned PSS that outreach is needed. These mechanisms help us to address provider needs in an expeditious manner demonstrating seamless provider service.

Results from provider satisfaction surveys, training evaluations, complaints, and other trend reports are reviewed by management and the teams on a monthly basis to help inform improvements in our provider outreach and engagement strategies. In addition, our Provider Advisory Board provides input and recommendations for improvement.

5.4 Identifying Areas of Improvement for Provider Written Materials and Communications:
5.4.a Training Evaluations
Following Magellan Complete Care personal and online trainings such as annual orientations, providers can share their feedback via written or online surveys. Magellan Complete Care encourages all participants to complete the survey as part of our ongoing process improvement and to promote partnership, transparency, and communication between the providers and the health plan. The provider relations team includes the survey in packets as a standard part of their provider training protocol. The management team regularly reviews the training evaluations to identify opportunities for future improvement.

5.4.b Provider Advisory Board
Our Physician Advisory Board is a platform for the collection of provider insight, feedback, and information to inform needed changes throughout the health plan. Started in 2015, the Magellan Complete Care Physician Advisory Board meets quarterly with 13 doctors statewide. The Magellan Complete Care executive team and other senior level attendees from throughout the organization participate to share updates, vet new changes, and engage the providers in meaningful, honest conversations about how to improve Magellan Complete Care, operations, clinical supports, trainings, quality, and much more. Including the providers as part of the material development process is essential to creating provider-centric information and materials. During our HEDIS strategy development process in 2016, we shared the HEDIS provider education documents with the PAB and requested feedback. Their opinions and needs helped to shape our end product, which was more practice-friendly and a better all around tool.

To address the specialized needs of our memberships, Magellan Complete Care developed and launched a homeless housing strategy in 2014 to connect our enrollees to housing services. During a PAB, Magellan Complete Care provided education around the importance of housing,
and its impact on healthcare outcomes. The Magellan Complete Care team also shared the Magellan Complete Care resources and supports available to meet the housing needs of the enrollees, to build awareness and drive action within their organizations to address this critical need.

The PRM/PSS in Salesforce documents provider feedback, questions, and areas of need for every visit and interaction they perform with providers. As a result, we can leverage the information to identify emerging educational and training opportunities, topics of interest, and innovative best practices to remain on the cutting edge of provider engagement. The PSS Management team, Magellan Complete Care marketing department, and our network team leverage the provider feedback gathered from Salesforce to create materials such as: “The importance and purpose of Alcohol Use Disorders” to educate enrollees on the meaning and value of coordinated care and “Substance Abuse Toolkit” which is posted on our website and provides comprehensive information to ensure providers have the knowledge, resources and awareness of how to best screen and address substance use with our enrollees.

Additionally, Magellan Complete Care has developed specific written educational materials as part of the development of a youth- and family-specific toolkit to increase community knowledge around health and wellness for this population. Examples of these materials include: “Healthy Habits for Kids,” “Stress in Children and Teens,” “Depression in Children and Teens,” and “Helping Your Children Build Inner Strength.” The need for materials like these is driven by feedback from providers and community organizations in discussions with the Magellan Complete Care Community Outreach and Provider Support staff.

CRITERIA 6: THE EXTENT TO WHICH THE TRAINING INCLUDES SERVICE COVERAGE...

As part of our provider engagement process, we have implemented a multi-faceted training and education program. We training and education through various approaches and media, specifically designed to ease the administrative burden for our providers and provide holistic care for our enrollees. Enrollees, who are living with SMI, carry a disproportionate illness burden and pose significant challenges in management. They require deep clinical expertise and patience combined with new models of care, including close care coordination to ensure the best chance at recovery and living a productive life.

Magellan Complete Care’s comprehensive provider training program, as reviewed and approved by AHCA, orients and trains providers on an initial and ongoing basis on the administration of our programs and the established procedural methodology to ensure success. Our Magellan Complete Care provider orientation and training program addresses, among other issues, our policies and procedures as described in our provider handbook, covered benefits, service authorizations, claims processing, payment and billing procedures, and our dispute resolution process as summarized below.

>Service coverage guidelines – we review mandated and related benefits associated with the Specialty Plan, and address covered procedures, diagnosis categories, and related services.

>Service authorization requirements – we describe the processes that providers and enrollees need to follow to obtain an authorization for services. This training area addresses when and how and when to contact Magellan Complete Care. We provide scenarios and useful tips to help providers navigate our authorization process quickly and efficiently.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Billing procedures – we focus on helping providers with the collection and documentation of encounter-related information that will be needed for billing purposes. We review key fields such as procedure codes, diagnosis information and other data, including the importance of maintaining accurate and current provider demographic details.

Claims processing – we describe CAPS and the process for submitting paper and electronic claims.

Payment timeframes – We explain the process and timeframes for provider payment. We cover the importance of submitting a “clean” or complete claim as well as our internal processes for reconciling claims and generating provider payments.

Dispute resolution process and timeframes – we describe the policies and procedures along with the dispute resolution process and timeframe. This training includes examples of common mistakes providers make when submitting claims and techniques that will help providers submit accurate and complete claims.

Our Magellan Complete Care Training complies with AHCA standards and has been reviewed and approved by AHCA for our current provider training program.

Beyond the required training standards, Magellan Complete Care recognizes the ongoing need to support the network’s practice transformation needs and uses Relias as a web based platform to do just that. Magellan Complete Care funds the Relias training platform for the entire provider network. This valuable tool supports clinical growth, practice integration, and staff education. Providers earn CEU’s in Relias to meet their licensing requirements, realizing cost savings and convenience because the trainings are available on-demand through the Magellan Complete Care provider portal. The Magellan Complete Care PSS team teaches providers to access the Relias site through the Magellan Complete Care provider portal. Each PSS team suggests individualized, specific trainings for providers based on their unique interests, organizational goals, and/or quality improvements. Examples of trainings include: “Addressing Overweight and Obesity in Individuals with Mental Illness,” “Assessing Integration Readiness,” “Overview of Cardiovascular Disease for Behavioral Health Professionals,” “Integrated Care Treatment Planning,” and many more.

As part of our ongoing educational efforts, Magellan has created the Magellan Learning Alliance, which is the central hub for all training related activities—a training ecosystem. Magellan Complete Care is implementing the Learning Alliance Ecosystem to support the next phase of our provider engagement strategy. This multi-modal training hub creates a single point for all training and is customized to ensure all federal and state requirements are met. Training modules include provider orientation, model of care, claims processing, quality improvement, care coordination, stakeholder engagement, care management, and member services. Trainings also include living well, outcomes, community health, and recovery. Training can be delivered in a variety of formats including instructor led training, online courses, customized technical assistance, coaching and modeling, community-based education, printed resources, and self-study alternatives. The Magellan Learning Alliance offers a full range of SMI, physical, and behavioral health trainings with the integration of those services to our provider network. Please refer to [General SRC #15, Attachment 4: Magellan Complete Care Learning Alliance – Training Ecosystem] for more information about network provider education and training.
Our provider education plan has been thoughtfully developed to support our providers in the care of our enrollees including:

> Improving the overall health, longevity and well-being of the enrollees
> Improving provider performance
> Reducing or eliminating administrative issues
> Improving the coordination of care between and satisfaction of providers caring for these enrollees
> Lowering the cost of care by providing better access and care coordination for this vulnerable population
> Decreasing overutilization of institutional and facility-based care and increasing community tenure for these enrollees
> Creating system transparency and accountability through data sharing and outcome tracking.

Our provider training includes medical and behavioral health topics, managed Medicaid concepts, and focuses on our philosophy of meeting all individual needs across a comprehensive continuum of care, whether medical, behavioral, or social. Themes of independent living, recovery and resiliency, person-centered planning, cultural competency, accessibility and accommodations, wellness and prevention principles, and trauma services are embedded throughout the training models.

Magellan Complete Care conducts an orientation session for each newly contracted provider. Our goal is to ensure that all providers are knowledgeable about Magellan Complete Care processes and AHCA contract requirements. The multi-disciplinary training includes PRM/PSSs, clinical staff, and often community outreach staff. Our provider orientations include information on all aspects of the operations of Magellan Complete Care including, but not limited to, the following topics:

> Service Coverage Guidelines
> Scope of Service Requirements
> Service Authorization Requirements
> Network Support Resources
> Customer Service Center
> Enrollee Eligibility and Enrollment Assignment
> Enrollee Benefits
> Outreach and Marketing (Dos and Don’ts)
> Claims Processing and Billing Procedures
> Payment Timeframes
> Clinical Team and Programs
> Complaints, Grievances, and Appeals
> Dispute Resolution Process and Timeframes
> Fraud, Waste, and Abuse
> Direct training for providers focused on the medical/psychiatric aspects of caring for victims and perpetrators of physical/mental abuse, neglect, exploitation, and domestic violence

6.1 Ongoing Training:
All providers are invited to participate in quarterly training programs. These programs focus on specific areas of concern for the provider community or on clinical care and also serve as refreshers on key items. Training is delivered in-person or facilitated through written or electronic
communication, such as our provider newsletter. Depending on the content, invitations may only be extended to relevant sub-group(s) within the provider network.

A summary of these training sessions is posted to our provider portal and our Provider Network team is always available to review the content with providers who are unable to attend. Participation in these training sessions is not mandatory. Topics for training include:

> Quality improvement and Clinical Training
> Technical Assistance
> Magellan Complete Care Peer Connections
> Claims and Encounters
> Provider Portal Tutorial and Refresher

All providers are requested to attend an annual refresher course to review updates to the Provider Handbook and any other key issues. Some annual training sessions are initiated via written or electronic means. Our Provider Network team works to schedule ad hoc time with providers who are unable to attend. Additional training topics include:

> Provider Recognition Initiatives
> Incident Management Training
> Cultural Competency Training
> Compliance and Fraud, Waste, and Abuse Training
> Disaster Recovery

We optimize provider learning using Provider Support Specialists (PSS) to educate medical and behavioral health providers on our plan operations, policies, and health topics. We also coordinate community-based events around health promotion. Similarly, we invite medical and behavioral health subject matter experts to present learning opportunities to primary care providers, placing special emphasis on cultivating our steadfast commitment to the recovery philosophy.

We recognize that learning can also be presented in less formal environments. For example, we emphasize that our Field Network team respond to provider inquiries as they arise in their assigned regions. This dedicated approach provides a familiar face to the provider office and allows Magellan Complete Care to develop lasting, collaborative relationships with providers.

To create a transparent and collaborative whole-health system of care, our learning program is designed around interdisciplinary learning and community collaboration. Magellan Complete Care staff enrollees, network providers, primary care network providers, enrollees, family members, system partners, and a multitude of valued stakeholders have the opportunity to participate in cross-disciplinary learning through ongoing training events. As a result, participants also learn from each other and training content becomes more culturally relevant for all stakeholders. Some of these training techniques include:

> Enrollees provide input into curriculum development, as well as facilitating classes as subject matter experts
> Learning specialists co-facilitate topics with family members
> Medical, behavioral, and primary care providers come together to educate each other about chronic health conditions and the implications for enrollees with complex and chronic health care conditions
Field-based Complaint Resolution: an Example of Provider Training

Magellan Complete Care leverages our local teams to resolve complaints in real time with an emphasis on timeliness, training, and support.

Magellan Complete Care received multiple enrollee complaints about an in-network Methadone Treatment provider who had a sign posted in the office stating they were no longer accepting Magellan Complete Care and refused to meet with our PSS stating, “It’s not worth it” and “we do not want to waste more of our time”. After assembling a multi-departmental team to research the sources of provider frustration and to outline a plan to resolve any issues, the PSS reached out to the provider’s leadership through email and letter outlining a plan for issue resolution, transparency, and partnership. The PSS was invited to launch the action plan which included: on site provider education at all five locations and meetings with management to define and resolve the root cause of identified issues. The Executive Director participated in a meeting with the PSS in person and after reviewing resolutions reopened all five locations for our enrollees, stating: “I have got to hand it to you…you are persistent.”
Evaluation Criteria:

1. The extent to which plan leadership are involved in provider engagement.

2. The extent to which local provider field representatives are incorporated into the model, including the ratio of local provider representatives to providers.

3. The extent to which the method the respondent uses to track interactions with providers is capable of producing meaningful data the respondent will use to address both clinical and administrative problem areas.

4. The extent to which the method the respondent uses to track interactions with providers addresses potential provider field representative training needs.

5. The extent to which the metrics used produce actionable data for measuring provider satisfaction, increasing provider performance, improving the provider engagement model, and identifying areas of improvement for provider related communications or written materials.

6. The extent to which the training includes service coverage guidelines, service authorization requirements, billing procedures, claims processing, payment timeframes, and respondent's dispute resolution process and timeframes, including corresponding requirements in scope of services.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.
SRC# 16 – Dispute Resolution (Statewide):

The respondent shall describe in detail its provider dispute resolution process.

**Note:** Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

**Response:**

**OVERVIEW**

Magellan Complete Care maintains structured provider complaint/dispute resolution processes and timeframes, supported by our automated system, Resolve, for managing, monitoring and reporting. These processes and the Resolve system allow the organization to track and manage receipt, processing and resolution of ALL provider disputes, regardless of source, including claims/billing disputes and service authorization authorizations. These same processes are applied for tracking and resolution of complaints through ACHA’s claims dispute resolution program.

Receipt of complaints and all key activities and proposed actions are monitored and managed against AHCA timeframes, our policies, and procedures. Our resolution process includes participation in ACHA’s claims dispute resolution program authorized in Section 408.7057, Florida Statutes. Magellan Complete Care’s programs and processes for dispute resolution also include root-cause analysis, continuous quality improvement, and retroactive application of required changes to providers and claims.

**CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT’S PROCESS IDENTIFIES CLAIMS…**

Magellan Complete Care places a high-value on strong and positive relationships with our provider partners and resolving disputes in a manner that supports enrollee continuity of care and clinical outcomes. As noted in the recent University of Southern Florida study commissioned by ACHA, “The SMI specialty plan has a more comprehensive approach to communicating with and engaging new enrollees through the implementation of various outreach strategies. The interviewees also indicated that providers have a favorable opinion of the provider relations staff employed by the SMI Specialty plan, which contributes to their view that the SMI Specialty Plan has more useful communication strategies than many of the Standard plans.”

Our strategy for achieving these positive results for our provider partners is the use of a responsive, continuously adaptive approach to meet provider and AHCA needs and requirements. Our dispute resolution process includes the following key elements:

> Dedicated staff including Resolution Specialists and provider field staff, Provider Relations Managers and Provider Support Specialists.

> Clear and efficient mechanisms for provider submission of disputes including telephone, e-mail, regular mail or in person, although all formal disputes must be submitted in writing.

> Efficient desktop procedures for dispute processing and resolution using applicable statutory, regulatory, contractual and provider timeframes and agreements.
>Dispute trend monitoring and management for issue identification.

>Continuous quality improvement process, which includes root-cause analysis, and identification and implementation of process improvement and/or system enhancements.

>Closed loop processes that support retrospective correction of issues for all affected providers, when a systemic issue is identified.

>Executive-level management and Quality Improvement Committee oversight.

>Provider training and support for claims submission, dispute resolution, and changes to required processes or policies.

>Controls to limit risks of fraud, waste and abuse.

1.1 Identification of Claims Related Dispute Trends
In accordance with 641.3155 F.S. the Resolve reporting dashboard provides a summary of dispute trends, which we use to identify process improvement activities and system enhancements. Provider calls to customer services are tracked and reported using our Total Member Record (TMR).

We may also receive complaints from AHCA, which have been at a rate of approximately one to two claim-related complaints per week, over the course of our current contract. The nature of these claim-related complaints varies, but we commonly see complaints regarding a dual eligible enrollee’s ambulance claims for mileage and emergency transports. We quickly address and resolve these issues. If additional information is required to resolve a claim dispute, the Resolution Specialist will work directly with the billing office to gather the needed information.

Reports on call trends and outcomes are regularly reviewed with the Resolution Specialist team. The team is heavily focused on root cause analysis and resolution of disputes through provider education and/or by system configuration or refinement of internal operations. When we receive a complaint about a claim and identify that we processed the claim incorrectly, we initiate a business process to systematically examine all related claims we have processed, re-process and pay the claim according to the plan parameter and notify the provider of this re-processing activity.

The Network Strategy and Oversight Committee receives the monthly reports on performance and trends and makes recommendations for oversight of this process and using root cause analysis and trended data to initiate improvement projects. Tracking and monitoring of provider complaints is managed by our Director of Quality who oversees Quality Improvement. The Magellan Complete Care Quality Improvement Committee reviews the provider complaints report quarterly including an analysis of types, trends and systemic improvement interventions implemented as a result of the analysis. We present a summary report of all quality initiatives and committee work, including challenges and barriers, to our Board of Directors for follow-up and action where appropriate.

We also submit monthly reports of both provider complaints and claims disputes to AHCA that includes the date the claim dispute was received, the resolution date and a description of the complaint disposition.
1.2 Process Improvement Activities and System Enhancement
Accurate claims processing is critical to collecting the necessary data for our quality improvement and clinical programs leading to superior care for our Magellan Complete Care enrollees and provider satisfaction. Magellan Complete Care places a high-value on provider satisfaction, particularly given the importance of these relationships for managing the complex and challenging needs of our SMI enrollees. For that reason, we have developed a rigorous, proactive, systematic approach to the identification of claims related trends and subsequent process improvements, staff/provider training, provider communications, and/or system enhancements. As a result of the focused attention we have provided to this issue, including the use of standing meetings with executive leadership, and application of proven process improvement methods and tools, we have effectively improved the accuracy and timeliness of our claims processing and decreased provider claims disputes. We describe some of the key elements of those efforts in the sections that follow.

1.2.a Joint Claims Operations Meeting
The Magellan Complete Care Joint Claims Operations meeting, led by the Chief Operating Officer (COO), includes medical directors, health services, utilization management, network development, service operations, call center and claims staff members. While issues are solved outside of this meeting, we have found that providing an opportunity to proactively work through identified trends or issues with all of the cross-functional areas “in the same room”, allows us to proactively make decisions that lead to rapid process improvements or issue resolution. This includes review, evaluation and resolution of trends in claims disputes to help identify systemic issues, patterns with specific providers or types of claims or services and improvement opportunities, allowing us to quickly address issues, and agree to solutions that can be implemented in a timely fashion.

As part of this process, key trends and results of trend analysis and actions taken are documented. Required actions are assigned to an accountable owner and timelines for resolution are documented. Action items and resolution of those items are tracked to closure during the weekly meetings. A key component of the Magellan Complete Care process improvement method is the Plan-Do-Study-Act (PDSA) rapid cycle improvement process. We have effectively deployed this method throughout our organization. PDSA is an iterative, four-stage problem-solving model used for improving a process or carrying out change quickly. This model, which is widely used for continuous improvement throughout the healthcare industry drives our organization-wide quality improvement processes.

1.2.b Provider-Based Joint Operations Committee (JOC)
Magellan Complete Care convenes a Joint Operating Committee (JOC) meeting on a quarterly or monthly basis (depending on provider type) with hospital systems, delegated subcontractors, vendors and multi-specialty provider groups as well as clinics, facilities and high-volume practitioners. The joint operating meetings are cross-functional by design to incorporate representation from Magellan Complete Care medical directors, care coordination, utilization management, network development, provider relations, claims, customer service, quality, compliance and legal. Each monthly JOC meeting jointly addresses, with the provider community, issues, concerns and functional considerations for providers administering the Magellan Complete Care program. Following are specific areas of emphasis that Magellan Complete Care representatives address with providers:
Health plan updates
Contracting/Credentialing
Magellan policies and procedures
Network adequacy and contract compliance
Appeals/Grievances
Claims
Underpayments and overpayments,
Claims submission and correct coding directives
Fraud, waste and abuse
Provider education and training
Patient access to healthcare services
Care coordination

We have found this forum to be extremely effective in understanding and resolving issues and building trust with our provider partners.

In addition, Magellan Complete Care has found that our Physician Advisory Board is an important partner for providing collective guidance on how certain issues should be handled. When needed, we will bring claims and dispute resolution information forward to that group to develop recommended solutions. That collaborative approach also extends to AHCA, which sometimes works with Magellan Complete Care to determine the appropriate course of action and specific improvements.

1.2.c Provider Education and Technical Assistance
Magellan Complete Care provides regular and timely communication with providers about changes to billing or claims processing requirements. This includes direct communication related to specific claims disputes or reprocessing of claims resulting from claims disputes. In addition, information that is applicable to the broader provider community, or a group of providers or type of claim, would be posted on our website, including in updated provider handbook materials, or included in our provider newsletter. We would also include this updated information in our regular provider training conducted throughout the year.

In addition, our dedicated provider support teams, including Provider Relations Managers (PRM) and Provider Support Specialists (PSS-clinicians), provide more direct, one-on-one training with individual providers and their staff. These Magellan Complete Care staff members are in the provider offices and facilities working side-by-side to offer training, technical assistance and process improvement strategies. We proactively review denial reasons with the provider and work with them to solve billing issues, increase their understanding of requirements, and identify opportunities for improvement for both the provider and Magellan Complete Care. When trends or common issues are identified within a practice, the PRMs work on a one-on-one basis with the practice to resolve issues. If the issue is more generalized within the provider network, we inform providers through e-alert, fax blasts, newsletters, webinars and updates to our Provider Manual and website.

CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT’S PROCESS INCLUDES...
Magellan Complete Care has consistently resolved claims disputes within AHCA-defined timeframes. All claims are resolved within 60 days of receipt. Magellan Complete Care provides written notice of the resolution within three business days of the resolution.
We maintain a number of systems and business processes to systematically support our organization in achieving those outcomes, allowing us to review and process all claims according to plan requirements. We maintain a dedicated team of Resolution Specialists, as well as our “boots on the ground” Provider Relations Manager (PRM) teams who work directly with providers on issue resolution. For larger providers and hospitals, our established JOCs address disputes as a standing agenda item. Our Magellan Complete Care customer service representatives are well versed in first level claims research and resolution. All calls are documented in Total Member Record (TMR). Calls and call reasons are tracked and trended to help inform the volume and patterns of issues that arise.

Magellan Complete Care Resolution Specialists use our Resolve system to track, document, proactively resolve, and report on complaints, including provider claims disputes, in accordance with applicable statutory, regulatory and contractual and provider agreements. This system-based work flow solution ensures complete data collection, calculation of required turnaround times, and dashboards that help staff prioritize their work loads. All information on a case, including archived letters, is maintained in Resolve. This includes complaints submitted through contracted vendors. In addition, Magellan Complete Care currently reports all complaint activities to AHCA in the required format. {General SRC #16, Attachment 1: Complaints and Grievances Desktop Procedure} provides detail on the features of the Resolve system and its uses.

Staff responsible for handling disputes receive rigorous training in the specific policies and procedures related to dispute resolution. They also receive training in the use of the Resolve System, how to use the monitoring and timeline compliance reports, and the use of the System for data analysis. Additionally, all Magellan Complete Care staff receive training on the concepts of complaints, grievances, and appeals, and their importance to contract compliance and enrollee and provider satisfaction. Staff are also trained in how to receive a dispute and the steps to follow as outlined in Magellan Complete Care desktop procedures.

Magellan Complete Care subcontractors also receive information about the dispute processing system and are required to participate in training to identify, report, and to follow all requirements implemented by Magellan Complete Care in order to expeditiously address provider disputes.

Providers are trained on claims, disputes, and appeals submission and processing. Our Provider Relations Managers (PRM) provide one-on-one support and education to providers with questions, or consistent patterns of issues. Our claims dispute procedures call for outreach and provider education when a provider has 10 or more claims denials. Providers can also ask questions or submit a complaint by calling the Magellan Complete Care provider services line or their PRM representative, via e-mail, regular mail, or in person. Our goal is to support the timely and accurate processing of claims and resolution of disputes. The PRM is our hands-on liaison between the provider and internal health plan departments to ensure a positive customer service experience and timely responses.

As noted earlier, our COO provides executive oversight to ensure timely appropriate determinations, timely payments and resolution of claims disputes. The dedicated Magellan Complete Care Resolution Specialists document claims disputes in Resolve to ensure complete data collection, calculation of required turnaround times, and dashboards that help them prioritize their work loads. The COO or operations managers review dashboards daily to evaluate whetherappropriate resolution and timelines are met in accordance with Magellan Complete Care policies and procedures in accordance with 641.311 F.S. [General SRC #16, Attachment 2:
GENERAL SUBMISSION REQUIREMENTS
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We offer the following two quotes from several of our provider partners as evidence of the strength of our provider relationships and our commitment to timely and appropriate resolution of issues as they arise:

~~ From Jennifer Grow, Outpatient Billing Specialist, Apalachee Center, Inc. ~~
“I am working to collect payment on all our claims that are being denied from all Medicaid HMOs and Magellan is the most helpful when I have a question about our claims. Thanks to Corey, Malerie and to your team for prompt attention to this issue. Hope for your continuous support and assistance, we really appreciated."

~~ From Ken Chisholm, Life Management Center of Panama City ~~
“Magellan Complete Care is a true community partner not only with contracted behavioral health providers but other community organizations as well....For me personally, I really appreciate the effort their staff makes to be immediately available if I need to reach out to them. Initially when I would reach out by phone or e-mail and would receive an immediate response I assumed that it was just an anomaly that would soon extinguish as they grew but happily I was very wrong. The opposite has occurred. Not only do I continue to enjoy the fantastic responsiveness when I reach out but in addition they reach out to check if I need them for anything and to just check on how things are going. We, as a provider, can’t ask for anything more. They are a pleasure to have as a true community partner to join with to meet the needs of a special population of people who would be forgotten otherwise."

Magellan Complete Care executive leadership, the COO, is accountable for oversight of our systematic approach to dispute resolution, which demonstrates our commitment to effective management of these areas. Our dedicated Florida Resolution Specialists are guided by policies and procedures based on our AHCA contract and Florida Statute.

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT’S PROCESS INCORPORATES...
All AHCA claims-related complaints are sent directly to our dedicated Magellan Complete Care Senior Director, Account Manager who is accountable for reporting back the resolution of the issue and expediting the issue based on the scope of the services. The Account Manager works with the dedicated Magellan Complete Care Resolution Specialists who enter the dispute into the Resolve system and work to resolve the issue. The claims Resolution Specialist follows up with the provider to communicate the resolution outcome. The provider’s response to the outcome is included in the response back to AHCA.

As mentioned, Resolve systematically ensures complete data collection, calculation of required turnaround times, and dashboards that help staff prioritize their work loads. The Magellan Complete Care Account Manager provides timely feedback to AHCA on the resolution. In addition, our Quality Improvement (QI) department runs monthly reports to submit to AHCA per its Report Guide specifications with the date the dispute was received and the date of the resolution as well as the description of the complaint disposition.
Our quality team has successfully compiled and submitted responses to every AHCA request related to complaint resolution issues during the term of this contract, based on the requirements as noted below.

The provider is required to submit the claims dispute within 90 days from the date of the final determination of the claim. Consistent with requirements for timely resolution, the following processes and timelines are tracked in Resolve:

>Magellan Complete Care will notify the provider in writing or verbally that the complaint has been received within three business days of receipt.
>Magellan Complete Care will research the complaint. Within 15 days of the receipt of the dispute, and every 15 days thereafter (if an extensions is granted by ACHA), we send a written notice of the status to ACHA and the provider.
>If more information is needed, Magellan Complete Care will provide a written request to ACHA within three business days of receipt of the dispute, including an explanation for the need of the extension and the expected timeframe needed to resolve the issue.

CRITERIA 4: THE EXTENT TO WHICH THE RESPONDENT INTEGRATES ALL COMPLAINTS...
Magellan Complete Care staff enter and monitor ALL complaints regardless of referral source through our Resolve system, which, as described previously, tracks and reports on progress against required timeframes and actions toward resolution. This integrated tracking system provides a comprehensive view of complaints, timeframes, processing steps, and complaint reasons and trends. Any complaints received by other parties are logged into the Resolve system daily for resolution by our internal staff. Processing of these items is handled in the same manner as items received directly through Magellan staff.

All complaints concerning claims payment issues must be filed in writing. Providers may also contact Magellan Complete Care Provider Services Staff who are available to answer questions or assist with filing a provider complaint and resolving any issues.

Upon receipt of a complaint by fax or mail, the documentation is scanned into a common pending folder and logged by date received by our customer service staff. Customer service staff then enter all information regarding the complaint into our Resolve system. Customer service staff are then assigned cases daily based on required processing timelines in our Resolve system.

Before working any dispute, timely filing (90 days in-network, 365 days out-of-network) is verified. Complaints filed after that time will be denied for untimely filing. There is no second level consideration for cases denied for untimely filing. If the providers feels they have filed their case within the appropriate timeframe, they may submit proof.

As part of the dispute resolution team’s daily process, in the morning and at the end of day, a fully detailed report is pulled and used to manage new items, as well as those items already in process. This allows us to account for all items and ensure that no notice or letter is missed and that each is sent out in accordance with contractual timeframes.

As part of this daily process, the team meets for a quick status check to discuss the details and timeframes for their assigned issues. To ensure that the contractual timeframes (90 days for in-
network providers, and 365 days for out-of-network providers) for dispute resolution are met, the
team operates with internal timeframes that are within contractual timeframes and maintains
contingency plans if an unforeseen situation occurs that renders any team member or reviewer
unable to complete their activities.

All provider complaints, regardless of the original source for the complaint, are thoroughly
investigated using the applicable statutory, regulatory and contractual provisions, collecting all
pertinent facts from all parties and applying Magellan Complete Care written policies and
procedures. Magellan Complete Care ensures that the appropriate decision makers with the
authority to implement corrective action are involved in the provider complaint process.

The Magellan Complete Care Quality Improvement Program places great emphasis on reviewing
dispute, complaint, grievance and appeals data from ALL sources, to identify both individual
provider or vendor issues and potential systemic concerns. The Senior Quality Coordinator
prepares a regular report with trended data for review. The report will display disputes, grievances
and appeals by type (standard or expedited); the established category (e.g., access, clinical
care, claims); subject of the item (e.g., provider, agency, or Magellan Complete Care);
percentage that met the resolution timeliness standard; and percentage found to be satisfactory.
Complaint, grievance and dispute data are aggregated for reporting and trending purposes. These
reports are analyzed for patterns and trends, such as a disproportionate number of an individual
type of issue or a high or increasing number of issues related to a particular provider or a particular
set of circumstances. When an aberrant pattern or trend is identified, the appropriate committee
will conduct a root cause analysis and recommend interventions to be implemented. Magellan
Complete Care currently reports all complaint activities to AHCA in the required format.

This information allows the Quality Improvement Committee (QIC), to quickly identify where to
focus improvement efforts. Should we identify a negative trend that may affect access to services,
we will quickly mobilize interventions to look at causes, implement system changes, and improve
access. We review this information continuously so improvements to the system can be made on
an ongoing basis. The dispute, grievance and appeal coordinators log concerns, which are
assigned by category to the appropriate departmental leadership for investigation, review and
resolution.

As with other issues, we will monitor and look for patterns of disputes which may point to a need
for changes in processes, systems, training, or potentially even changes in covered services. We
conduct the same root cause analysis and develop recommendations and plans for required
additional actions where necessary. Results will be reported to the appropriate QIC for further
action and follow-up.

In all cases, action plans will include a specific timeline for implementation of interventions,
completion and follow-up.

Evidence of access or quality of care issues found by the QIC can result in the immediate
restriction or exclusion of the provider from participation in the network and may result in the
reporting of any concerns to the applicable State licensing board and national data bank. Magellan
Complete Care’s policies and procedures describe the processes by which quality of care
concerns are addressed, up to and including a provider’s appeal of a network termination
decision.
CRITERIA 5: THE EXTENT TO WHICH THE RESPONDENT’S RESOLUTION PROCESS…
Magellan Complete Care participates in the ACHA’s Claims Dispute Resolution Program authorized in Section 408.7057, Florida Statutes. This includes claims disputes submitted by either a provider or health plan, involving claims that were denied in full or in part, or which were presumed to have been underpaid, or overpaid. Magellan Complete Care’s claims resolution process described earlier in this SRC response, would be applicable to any dispute brought to our attention by ACHA’s claims dispute resolution program managed by Maximus. To date, Magellan Complete Care has not been contacted by Maximus on behalf of a provider regarding a claim dispute nor have we needed to bring to Maximus a claim dispute issue with a provider. Magellan Complete Care and the provider have been able to successfully resolve any and all claim disputes without the need for a third party intervention.

5.a Responding to Requests for Information from the State-contracted Independent Dispute Resolution Organization
Upon receipt of notification by ACHA’s state-contracted dispute resolution organization of a dispute Magellan Complete Care would follow the following process:

1. Magellan Complete Care’s Contract Manager is the primary point of contact for notification. This point of contact was submitted to AHCA when requested earlier in 2017 and will receive the notification.

2. The claim dispute will be reviewed in detail to learn of the circumstances around the dispute, including listening to the provider’s case and reviewing internal documentation related to the claim. This may include authorization requirements, network status of the provider, reason for denial and any other applicable details related to the dispute.

3. Magellan Complete Care will prepare and submit dispute summaries to the review organization in accordance with requested information and required timeframes.

4. Magellan Complete Care will meet all State and federal laws, regulations, and policies regarding the content for dispute summaries, and prepare dispute summaries accordingly.

5. If Magellan Complete Care does not prevail in ACHA’s order, we would pay a review cost to the review organization, as determined by agency.

5.b A Global Process for Analysis of Arbitrated Cases for Possible Identification of Process Improvement/System Enhancements
All claim disputes brought to the attention of the state’s contracted independent dispute resolution organization will be entered into Resolve for tracking purposes once it is received by Magellan Complete Care. The claims disputes entered into Resolve will follow the same process and tracking by Magellan Complete Care’s Quality Improvement department, as described earlier in this SRC.

In accordance with 641.3155 F.S., the Resolve reporting dashboard provides a summary of ALL dispute trends, including arbitrated cases, which we use to identify process improvement activities, system enhancements, changes to policies, staff or provider training/education, or communications. As with other disputes, arbitrated claims are included in trend data, and we complete root-cause analysis to determine whether there are systemic issues that need to be
addressed to prevent the same or similar issues in the future. We also initiate a review of all related/similar claims we have processed to determine the need for and complete re-processing and payment of claims, based on the results of the dispute resolution process.

As with all other types of disputes processed and resolved through other channels, the Network Strategy and Oversight Committee receives monthly reports on performance and trends and makes recommendations for oversight of this process and using root cause analysis and trended data to initiate improvement projects. Tracking and monitoring of provider complaints is managed by our Director of Quality who oversees Quality Improvement. The Magellan Complete Care QIC reviews the provider complaints report on a regular basis. We analyze provider dispute resolution (PDR) by complaint type, provider type, resolution and trends in each of these categories. We have developed a rigorous, proactive, systematic approach for analysis of these trends and subsequent process improvements, staff/provider training and/or system enhancements. Additional key elements of this process include:

1. Joint Claims Operations Meeting: The Magellan Complete Care JCO Meeting, led by the COO, includes medical directors, health services, utilization management, network development, service operations, call center and claims staff members. As part of these meetings the team focuses on review, evaluation and resolution of trends in claims disputes to help identify systemic issues, improvement opportunities, quickly address issues, and agree to solutions that can be implemented in a timely fashion. As part of this process, trend analysis and resulting actions are documented, actions are assigned to an accountable owner and timelines for resolution are attached. Action items and resolution of those items are tracked to closure during the weekly meetings.

2. Plan-Do-Study-Act (PDSA): Magellan Complete Care uses the Plan-Do-Study-Act (PDSA) rapid cycle improvement process with claims and dispute resolution improvement activities. PDSA, which is used throughout our organization, is an iterative, four-stage problem-solving model used for improving a process or carrying out change quickly. This model allows us to design the required improvement, implement, test, and refine to ensure it is addressing any root-cause issues and ensuring the issue does not arise in the future.

3. Provider-Based Joint Operations Committee (JOC): Magellan Complete Care convenes a JOC meeting on a quarterly/monthly basis with hospital systems, delegated subcontractors, vendors and multi-specialty provider groups, as well as clinics, facilities and high-volume practitioners. Each monthly JOC meeting addresses issues, concerns and functional considerations for providers participating in the Magellan Complete Care program. The JOC addresses claims processing, dispute resolution and related issues and proposed changes. We have found this forum to be extremely effective in understanding and resolving issues and building trust with our provider partners.

4. Provider Education and Technical Assistance: When trends or common issues are identified across practices within the provider network, we inform providers through e-alert, fax blasts, newsletters, webinars, training programs, and updates to our Provider Manual and website. If we identify a pattern of issues within a practice, our Provider Relations Managers (PRMs) and Provider Support Specialists (PSS-clinicians) work on a one-on-one basis with the practice to resolve issues. These staff are in the provider offices and facilities, working side-by-side to offer training, technical assistance and process improvement strategies. We proactively review denial reasons with the provider and work with them to solve billing issues, increase their understanding
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of requirements, and identify opportunities for improvement for both the provider and Magellan
Complete Care.

5.c Prompt Payment of Final Orders Issued by the Agency Related to Claims Arbitration Case
Determinations
Should the State’s contracted independent dispute resolution organization rule against Magellan
Complete Care and order payment of the claim, we will follow any instructions from the arbitrator
and adhere to timelines for prompt payment to the provider or other instructions the arbitrator has
provided. In the absence of specific instructions, we will process the claim as quickly as possible
and meet the timelines laid out in policy, as defined earlier in this response.

If, as a result of the determination, and/or as part of our review processes, we identify a system-
wide issue that is the source of the dispute, we implement a system-wide correction process. This
includes identifying providers and/or claims that may have been affected by the same issue,
selecting those claims, and re-processing them if needed. If necessary, we may implement
system changes, systems re-configuration, process changes, etc., to address the cause of the
related issues. We may also develop additional provider training and provider communications to
explain changes that have been made.

Evaluation Criteria:

1. The extent to which the respondent’s process identifies claims related dispute trends and
initiates process improvement activities/system enhancements.

2. The extent to which the respondent’s process includes oversight to ensure appropriate
plan dispute determinations are made, timely payments are made, and claims disputes
resolved within required timeframes.

3. The extent to which the respondent’s process incorporates timely response to Agency
requests related to complaint resolution in accordance with the scope of services.

4. The extent to which the respondent integrates all complaints, regardless of the complaint
referral source (e.g., Agency, third party).

5. The extent to which the respondent’s resolution process includes the respondent’s
participation in the Agency’s claims dispute resolution program authorized in Section
408.7057, Florida Statues, as well as includes the following:

(a) Responding to requests for information from the State contracted independent
dispute resolution organization;

(b) A global process for analysis of arbitrated cases for possible identification of
process improvement/system enhancements; and

(c) Prompt payment of final orders issued by the Agency related to claims arbitration
case determinations.
Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.
SRC# 17 – Claims Processing and Payment Process (Statewide):

In a manner suitable for the provider community, the respondent shall submit key components of its claims processing and payment process, addressing both paper and electronic claims submissions for both participating and non-participating providers.

The response shall include detailed information on the metrics to be employed by the vendor to track timeliness and accuracy of claims adjudication and payment for claims submitted by participating providers and how these metrics will be used by line level and management staff to improve processes and provide for rapid cycle improvement.

The response shall also include a detailed description of how the respondent will make data and metrics regarding claims and payment available to the Agency and will ensure that network providers have access to real-time and trend data regarding claims processing and payment by the respondent and all applicable proposed subcontractors.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

Response:

OVERVIEW
Magellan Complete Care’s business practices focus on putting enrollees first, by delivering quality professional physical and behavioral health services and by easing the administrative burden on providers. Accurate claims processing is critical to collecting the necessary data for our quality improvement and clinical programs, which leads to superior enrollee care. Over the past three years, we have successfully demonstrated our claims processing capabilities for our Specialty Plan as well as meeting the requirements outlined in 42 CFR 447.45 and 447.46 and Chapter 641, F.S. (whichever is more stringent). As a result of our 22 years processing public sector claims in multiple states, combined with our Florida experience, we have been able to demonstrate our commitment and ability to continually improve and refine our processes and tools to ensure accurate and timely claims processing and payment. We count on our strong partnership with AHCA and our provider network to help inform areas for improvement. Magellan Complete Care understands the importance of effective and efficient claims and payment processing, as is highlighted by the feedback below.

“I am working to collect payment on all of our claims that are being denied by all Medicaid HMOs. And, Magellan is the most helpful when I have a question about our claims. Thanks to Corey, Malerie and to your team for your prompt attention to this issue. Hope for your continuous support and assistance. We really appreciate it.” - Outpatient Billing Specialists, Apalachee Center, Inc.

Magellan Complete Care’s Chief Operating Officer (COO) is the executive accountable for our accurate and timely claims processing and payment performance. To better serve our enrollees and support our providers, Magellan Complete Care maintains dedicated Florida claims operations and provider support teams. Our claims operations team, including managers, claims processors, resolution specialists, and provider data management specialists, has a deep understanding of Medicaid claims payment and is very well versed in Florida-specific claims administration and payment rules. The work of this dedicated team is guided by policies and
procedures, Florida-specific desktop procedures and other reference documents. The careful attention of this team to our documented business practices, combined with our highly automated claims processing platform results in consistent timely and accurate claims processing and payment.

Evaluation Criteria:

CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT HAS DESCRIBED KEY COMPONENTS...

Timely and accurate claims processing and payment starts with the submission of a clean claim, whether the claim is submitted on paper or electronically, through our electronic data interface (EDI) tool. Our dedicated provider support teams, including our Provider Relations Managers and Provider Support Specialists, spend significant time in provider offices and facilities working side-by-side to offer training, technical assistance and process improvement strategies.

Magellan Complete Care employs a high-speed claims system with robust financial and fraud prevention controls. We offer providers a variety of convenient options to submit claims and receive timely payment both via paper and electronic submission.

Magellan Complete Care supports and consistently complies with the following AHCA standards for claims turnaround and timeliness:

EDl Claims
Claims Turnaround: 15 calendar days
Timeliness: 98%

Paper Claims
Claims Turnaround: 20 calendar days
Timeliness: 95%

EDI Claims for Nursing Facility and Hospice
Claims Turnaround: 10 business days
Timeliness: 98%

Magellan Complete Care’s claims processing environments are highly scalable, ensuring excess capacity is continuously available to support regular processing and potential spikes in processing loads. In 2016 alone, Magellan’s corporate claims system processed more than 13.5 million medical claims, of which 1.9 million (14 percent of the total volume) medical claims were processed for Magellan Complete Care (see Table 1: Magellan Complete Care Claims Core Quality Indicators; Table 2: Magellan Complete Care 7-Day Claims Processing Timelines, and Table 3: Magellan Complete Care 10-Day Claims Processing Timeliness (by quarter and year overall), included in [General SRC #17, Attachment 1: Tables and Figures]).

Our fully integrated system and our processes to configure and support this system are designed to maximize timely and accurate claims processing and payment for both participating and non-participating providers. Our ability to receive and enter claims through various means allows providers to enter claims into our systems efficiently and accurately. This process is depicted in Figure 1: Claims Adjudication and Payment System (CAPS) Workflow, as part of [General SRC #17, Attachment 1: Tables and Figures].

Magellan Complete Care uses an integrated suite of information systems that support claims processing and adjudication, informatics, data analytics, care coordination, and utilization
management functions. The key components of our claims receipt and adjudication processes include:

> Claims Receipt and Entry Process
  >> >> Electronic claim submission
  >> >> Paper-based claim submission

> Claims Adjudication Process
  >> >> Claims Adjudication and Payment System (CAPS)
  >> >> Provider Data and Reimbursement
  >> >> Enrollee Eligibility and Benefits
  >> >> System Edits
  >> >> Coordination of Benefits

> Pre-pay Review
  >> >> Provider Payment and Communication
  >> >> Remittance Advice/Electronic Remittance Advice (ERA)
  >> >> Checks/Electronic Funds Transfer (EFT)

1.1 Claims Receipt and Entry Process
The following narrative details our approach to processing paper and EDI claims to demonstrate the edits and controls we have in place to ensure accurate claims processing and payment. Magellan Complete Care offers flexible options for the submission of claims that enable providers of varying capabilities to get their claims into Magellan Complete Care’s claims processing system efficiently and accurately. Magellan Complete Care supports the auto-adjudication of clean professional and institutional claims that are received in electronic format via three methods: (1) clearinghouse, (2) direct submit, and (3) direct data entry of claims through our web entry tool called Claims Courier. Providers may find it necessary to submit claims in paper format whereby Magellan Complete Care has a precise workflow to adjudicate, monitor and track payment and performance metrics. Magellan Complete Care proactively conducts outreach to providers who are utilizing paper claims submission to ensure they are aware of the multiple options available to the provider community. The success of this outreach is evidenced by the current 92 percent EDI rate which is 11 percent higher than it was at the end of 2016.

1.2 Electronic Claim Submission
We offer providers multiple options to submit claims to us electronically. All electronic submission options are HIPAA-compliant and are at no cost to providers. We also provide a number of technical and help desk resources to providers who may need assistance submitting electronic claims. Magellan Complete Care requires industry standard forms for claims submission.

>Clearinghouse: Magellan Complete Care maintains relationships with seven clearinghouses in order to allow providers to use that avenue for electronic claims submissions. External EDI clearinghouses act as a middleman between the provider and Magellan Complete Care, and can transform non-HIPAA-compliant formats to compliant 837P or 837I. Magellan Complete Care accepts 837 transactions from seven clearinghouses; the clearinghouse contacts are available on Magellan Complete Care’s provider website. Claims submitted electronically through a clearinghouse hit front end edits to verify real-time for HIPAA compliant formats, syntax and completeness. If a claim does not pass these edits it is rejected and returned to the provider for resolution of the issue(s). If it passes the edits, it is loaded into CAPS.
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>Direct Submission: Magellan Complete Care offers high-claim volume providers the use of our EDI Direct Submit application, an electronic claims tool available on our provider web site. This application enables the submission of HIPAA claims format transaction files directly to Magellan Complete Care, allowing providers to receive response files without the use of a clearinghouse. The HIPAA transaction files we currently support include the X12 837 Professional (837P) and X12 837 Institutional (837I) claims submission files. Files sent to Magellan Complete Care are validated, and if certification is granted, the provider is then permitted to submit claims files and receive responses. Of the EDI claims received by Magellan Complete Care, 47 percent are from direct submitters.

>Interactive Claims Courier: For providers who are not able to submit claims via EDI or choose not to, Magellan Complete Care offers an option to submit claims electronically on our web site through the interactive, web-based submissions tool, Claims Courier. This tool provides immediate notification of the potential errors in claims submission—allowing providers to resolve the errors quickly and resubmit their claims in a timely manner. Claims Courier uses Transport Layer Security (TLS) for secure claims data transfer. Additionally, claims submitted through Claims Courier are processed in real-time, allowing providers to find out immediately whether their claims were approved for payment. The average response time for real-time adjudication is approximately five seconds. We average about 4,500 claims submitted each month by Florida providers via Claims Courier.

Magellan Complete Care provides acknowledgement of receipt to the electronic source submitting the claims within 24 hours after the beginning of the next business day after receipt of the claim. Once the claim is loaded into the claims system, providers can access claims status information directly through our secure provider portal or interactive voice response (IVR) system.

1.3 Paper-based Claim Submission
Magellan offers providers the option of submitting their claims on paper. We image all paper claims in-house through our Health Axis imaging system, which enables us to route the claim electronically within the department, eliminating paper handling. This feature improves our efficiency for processing claims and enhances our claim storage and retrieval process. Upon receipt, a paper claim is sorted so claims that can be read by optical character recognition (OCR) are routed to our OCR transformation process. Claims that are successfully read by OCR are electronically transferred to the claims system. Claims that cannot be read by OCR or do not pass the OCR transformation process are routed to the appropriate data entry workflow queue. Magellan Complete Care’s batch entry claim unit utilizes a desktop application (Image Worker) to view the image of the claim within the data entry workflow queue and enter the claim into the claims system.

After the paper claim is scanned by OCR, the claim image is available for viewing immediately. In addition to electronic images of these paper claims, an image facsimile of all electronically submitted claims is created so an image of all claims we receive is available for viewing.

Magellan Complete Care provides acknowledgment of receipt of electronic claims within 24 hours, paper claims within 15 days, and status of the claim as soon as it is loaded into CAPS through our secure provider portal or IVR system.
1.4 Claims Adjudication Process
Regardless of the method of receipt and entry of the claim, all claims go through a robust claims processing and payment process. Below we describe the core system used to process and pay claims for Magellan Complete Care. Key components of claims adjudication include the following:

- **Claims Adjudication and Payment System (CAPS)**
- **Provider Data and Reimbursement**
- **Enrollee Eligibility and Benefits**
- **System Edits**
- **Coordination of Benefits**
- **Pre-pPay Review**

1.5 Claims Adjudication and Payment System (CAPS)
The cornerstone of our claims processing platform is our Claims Adjudication and Payment System (CAPS). CAPS is a robust claims adjudication and administration application that receives authorizations from TruCare, our clinical/care management and customer service application, and is fully integrated with our provider and eligibility data systems. This integration between applications supports secure and seamless transactions of information between applications through single database instance and tightly controlled interfaces.

CAPS supports all of our eligibility, benefit, and claim functions to ensure proper clinical care is delivered and reimbursed while minimizing instances of fraud, waste, and abuse. Magellan Complete Care supports the CAPS system internally and owns the source code. This approach gives us maximum flexibility to modify and configure the system that currently meets Florida-specific and internal Magellan Complete Care claims payment and processing needs.

We gather benefit plan information from several sources ensuring there are accurate documentation and approval processes in place for configuration. We require AHCA documentation for any benefit plan updates, including the use of project tracking tools to monitor our timeliness of new benefit installations and/or large benefit maintenance changes. We review the correlation between benefit information, account reporting requirements, and proper administration of the covered services in order to document all covered services. This information is used to develop and configure all necessary systems, including user acceptance testing, before the implementation of any new or updated benefit plan. CAPS’ ease of configurability enables our Benefit Configuration Group to be nimble in adapting to AHCA’s needs. Even if notifications of benefit plan changes are received after the plan’s effective date, the goal of our Benefit Configuration Group is to enter the changes as soon as possible, based on the size and extent of the changes, in an effort to limit the impact on provider payments.

1.6 Provider Data and Reimbursement
During claims adjudication, CAPS uses claim-specific data to find the correct provider in CAPS and then CAPS selects the appropriate network and reimbursement methodology. Once this selection is made, CAPS now knows and has all the information we need to continue the processing of the claims. For example, CAPS will determine whether the provider participating or not in the plan. This information is used to determine what happens during adjudication of benefits. If the claim ends up as a payable claim, the provider’s reimbursement methodology will enable CAPS to calculate reimbursement to the provider. All provider data is entered into CAPS by the Network Operations team. Provider data is received via multiple methods including the following:
Contracts and applications received by Network Operations for participating providers
Provider rosters received from provider groups and healthcare systems
Non-participating providers who are authorized for services
Non-participating providers who submit a claim for services provided to one of our enrollees

CAPS provides us the flexibility to organize providers based on multiple business relationships. Providers can be associated with multiple groups. Providers can also have multiple office locations. Healthcare systems can provide multiple types of services based on their contract with Magellan Complete Care. Payment can be made at the individual provider level, a group level, or a higher corporate level. Because of the configurability of CAPS and our ability to modify CAPS as needed, we are able to keep up with the evolving business arrangements to ensure that we load providers correctly and are able to pay accurately and to the right entity.

All providers, both participating and non-participating are subject to validation prior to entry and through ongoing processes. Provider demographic data, including location(s), NPI, reimbursement rates, and payment arrangements, are bumped up against AHCA provider data to ensure participation in the program, down to the authorized services they are allowed to perform. All providers are subject to validation against State and Federal databases to ensure they are not excluded or sanctioned. Each month, we check for Medicare/Medicaid sanctions and exclusions by monitoring data sources that include:

- Department of Health and Human Services Office of Inspector General List of Excluded Individuals and Entities (OIG-LEIE)
- The General Service Administration’s List of Parties Excluded from Federal Programs (SAM.Gov)
- AHCA exclusion lists

Magellan Complete Care receives updates on provider participation in the program from AHCA and updates provider data immediately upon receipt. CAPS claims processing will validate against the provider file during claims processing to ensure that a provider who should not be receiving payment, will not receive payment.

1.7 Participating Providers
All participating providers, which are documented in CAPS, are associated with Magellan Complete Care networks and has the provider’s reimbursement methodology configured to pay against their contracted arrangement.

We establish provider rate schedules based on a variety of factors, including the type of provider, type of business, number of covered enrollees, utilization data, Medicare reimbursement guidelines, Medicaid rates, industry data of usual and customary charges, and geographic hospital cost reporting. After the changes to the reimbursement schedules and contract amendments are approved and interface/entry within TruCare and Integrated Product Database (IPD), our Network Rates Administration Department and Contract Administration Department review and release contracts, amendments, and updated rate schedules for distribution to providers. Providers with non-standard rates must sign and return their contracts unless the changes reflect increases or state-mandated modifications.

We configure against industry standard payment methodologies, which enables us to automatically calculate payment during claims processing. CAPS maintains fee schedules and
other tables of data, which are required to calculate payment. Magellan Complete Care Network Operations staff monitor sources of fee schedules, like AHCA, to ensure accurate and current data is identified and timely updates are made to the system. Standard contracts, which include any contract that is used more than once, only has to be configured once in CAPS. Once the contract is configured, the file can be connected to any subsequent provider that has the same contracted arrangement.

1.8 Non-participating Providers
Claims for out-of-network or non-participating providers pend to a queue unless both a single case agreement (SCA) and authorization are in place. The use of an SCA enables us to auto-adjudicate the claims we receive from non-participating providers. Prior to payment of a claim to an out-of-network provider, Magellan Complete Care screens the provider to validate: licensure, participation in Florida Medicaid, NPI, and for sanctions/exclusions. We pay 100 percent of Medicaid rates unless otherwise negotiated in a SCA. Our Network Quality and Compliance (CQI) Department conducts monthly audits on all provider and organizational demographic information for accuracy.

1.9 Enrollee Eligibility and Benefits
CAPS maintains relevant enrollee profile data, including enrollment per eligibility date spans, benefit plans (i.e., types of coverage), historical data (i.e., enrollment audit trail), and demographic data (i.e., enrollee ID number, social security number, date of birth, gender).

Upon confirming receipt of the State’s 834 enrollment file, we apply validation and processing rules for an automated process utilizing the Eligibility Feed Application (EFA), and complete remediation of any issues in a timely manner. The resulting “clean” file is then uploaded into the CAPS eligibility system. Once loaded, enrollee eligibility information is pushed to other integrated systems including TruCare, our clinical/authorization system. Conversely, CAPS receives authorization files from TruCare. When an authorization is required, electronic and paper claims that we receive are processed and each line is checked against the authorizations received from our clinical system.

Once loaded, enrollee eligibility information is used by our clinical/authorization system, TruCare, for establishing benefit plans and approving services, and by CAPS during claims processing. Changes in eligibility can be loaded on a daily, weekly, monthly, or other AHCA-defined requirements.

Magellan Complete Care monitors requirements from AHCA and determines if updates to benefits configuration is required. Because CAPS is a highly configurable claims processing system, the Benefits Configuration team is able to respond to change benefits quickly. All benefit changes are configured in a test environment first and fully tested prior to moving it to production.

1.10 System Edits
Magellan Complete Care uses leading technology and high-touch processes to evaluate claims, determine billing and coding accuracy by cross-referencing our claims history and claims data. We produce fast and accurate results that are fully aligned with industry-recognized guidelines, ever-changing compliance requirements, and AHCA’s needs. Much of this work is done before we make any payments, which is part of our program integrity efforts. We assure proper claims payment and combat fraud, waste, and abuse by prioritizing the following objectives in our claims edits approach:
Adherence to industry-recognized and regulatory-required edits and guidelines to ensure compliance with Magellan Complete Care and AHCA payment policies

Ability to configure and customize edits based on our payment policies, to detect most overbilling occurrences and ensure claim accuracy

Support AHCA’s program integrity initiatives

Magellan Complete Care’s systems are programmed with AHCA-specific system edits and algorithms to ensure the proper adjudication and payment of claims. These edits will stop a claim from completing auto-adjudication should manual intervention by a resolution specialist be required. For example, we have edits in place that will discover prior-authorization issues, so if a matching prior authorization is not available in the system as required by plan benefits, the claim will be pended for manual review.

Our systems are configured to help detect instances of claims and utilization fraud and abuse. Claims edits resident in CAPS cover a wide range of tasks, such as confirming eligibility, reconciling age and gender to appropriateness of services, timely filing, third party liability and other possible incidents of fraud.

We have included National Correct Coding Initiative (NCCI) rules into our standard claims edits to help us control improper coding leading to inappropriate payment. Our clinical system provides authorizations to CAPS to ensure appropriate authorizations are in place and help reduce fraudulent claims.

Table 4: System Edits, which is part of [General SRC #17, Attachment 1: Tables and Figures], includes a detailed summary of our system edits. Below, we list a sample of our standard edit categories:

> Prior Authorization Review: Compare claim data to benefits configuration to determine prior authorization requirements and if applicable, search for a matching authorization in the system.

> Duplicate Claims: Review claims data such as enrollee, provider, date of service, and services rendered whereby all elements match to a previously submitted/paid claim. Claim will be pended for manual review if necessary.

> Enrollee Eligibility: Review for enrollee’s eligibility for specific plan and services based on the date of service submitted.

> Covered Services/Benefits Eligibility: Review for benefits and services to align with enrollee and plan specifics.

> Provider Eligibility: Review of servicing provider regarding eligibility/certification for reimbursement purposes.

> Rate Review: Review for specific provider rates based on procedure code submitted.

> Missing or Incomplete Information: Review of “clean claim” mandates based on the Provider Handbook, Federal and State guidelines, which allows for a speedy return to the claimant for correction.
Timely Filing Provisions: Review of the date of service and receipt date to allow for specific ACHA timelines to have claims submitted.

Coding Validation: Review of the built-in, Integrated ICD-10, CPT, NDC and NCCI edits to ensure appropriate claims processing. Code sets in CAPS are reviewed as updates are published by the governing agency. Updates to the systems code sets and configuration are made in CAPS.

Appropriateness of Services: Review for appropriateness of services/procedures based on consumer's age. Additional edits are applied, e.g. consumer's gender, as required by ACHA.

Magellan Complete Care promotes correct coding through prepayment edits including Florida specific edits and ClaimCheck® edits as a “final filter” before professional and outpatient facility claims are paid while maintaining prompt payment to providers. ClaimCheck includes NCCI edits and automatically detects coding errors related to unbundling, modifier appropriateness, diagnoses, and duplicate claims. The edits improve the accuracy of claims payment in accordance with the required editing protocols for the Florida Managed Medical Assistance (MMA) program. Claims will either pay or will deny providing a HIPPA compliant remittance advice remark code for provider follow-up.

1.11 Coordination of Benefits
Coordination of benefits is a key component to accurate payment to providers based on other third party coverage and AHCA’s liability based that other coverage. Individuals with dual coverage play an especially critical part in this process as Magellan Complete Care’s dual population comprises almost 30 percent of our membership. During claims processing, CAPS validates the enrollee on the claim against known third party coverage for that enrollee. This activity includes validating for crossover claims. Based on identified third party coverage, including Medicare, CAPS includes tables that determine the service provided is not covered by the third party insurance. Based on this finding, we increase our auto adjudication capabilities by processing those claims regardless of third party coverage. If the service billed is covered by Magellan Complete Care, the claim will pend in CAPS for a review of the submitted Remittance Advice from the third party insurer. CAPS has the ability to receive third party insurance information, via EDI claim record, which facilitates faster and more accurate coordination of benefits.

We have systems and processes in place to successfully coordinate benefits that is invisible to the enrollee and their families and enables coordination of comprehensive care and services, regardless of payer. Our cost containment department is dedicated to coordination of benefits and detecting third party liability (TPL). Our highly configurable systems and processes minimize AHCA expenditures by maximizing other coverage parameters available in the claims system. Our claims processing system includes checks and balances to adjudicate claims with other insurance coverage to ensure that Medicaid is the payer of last resort. To minimize involvement of the enrollee, we work directly with the other payers and our providers to coordinate other coverage and resolve any issue.

Magellan Complete Care has mechanisms in place to identify enrollees who have other coverage including:

AHCA enrollment files: The process begins with the receipt of the 834 enrollment file. Coordination of Benefits (COB) information from AHCA is systematically loaded into Facets and
we verify the other coverage if any discrepancies are found. Information from the verified eligibility file feeds to downstream systems, such as TruCare, TMR, and other integrated systems. COB is included in our eligibility file to select vendors that pay claims.

Subcontractor: Magellan Complete Care employs the services of a Coordination of Benefits subcontractor, Health Management Systems, Inc. (HMS) to augment the capabilities of our internal Cost Containment Department. We share membership files with HMS, and perform data matches for other insurance carriers. If other insurance is found on the contractors’ databases, a file is created and loaded into our databases for future coordination and savings efforts.

We validate TPL data we receive from HMS by systematically matching the enrollee’s information in the TPL files received from HMS with the corresponding identifiers on the enrollee’s record in CAPS, our eligibility and claims adjudication system. Once validated, we notify AHCA in the monthly reporting process via the secure data transfer already in place.

Data mining: Magellan Complete Care identifies other coverage by data mining through our claims system. An Enrollment Specialist validates TPL when the information is received on a claim with either the third party and/or the enrollee to ensure we are coordinating benefits appropriately. We also data mine using diagnosis and trauma edits to identify potential subrogation cases. Once coverage is verified, the enrollee’s record is updated in the system to cost avoid claims payments going forward.

Our system automatically adjudicates the claim for enrollees with other coverage if the primary payer remittance advice (RA) is attached to the claim. If the RA is not attached, the claim pends or denies based on the information contained within the enrollee’s eligibility record. A dedicated, experienced team within our claims operations department processes the claim according to establish COB processing guidelines.

Providers: We routinely request other insurance information when interacting with providers.

Enrollee: Other coverage is also identified through new enrollee Welcome Calls or from Magellan Complete Care team members, such as care coordinators or customer service associates. When this occurs, the information is sent to an Enrollment Specialist to verify coverage.

CMS Coordination of Benefits Agreement (COBA) files: Daily COBA files identify Medicare primary payments.

CAPS is programmed using “Order of Benefit Determination” logic, assuming Medicaid is the payer of last resort. The system carries effective and termination dates for coverage so that there is a historical record for claims payment purposes.

CAPS generates monthly COB reports listing enrollees’ files that have been updated within the prior month and comparing them against any claims that may have been paid during that month where benefits were not coordinated. If overpayments are identified, an auditor in the COB department then reviews the enrollee’s claims history through CAPS and identifies all potentially overpaid claims and initiates the overpayment recovery process. Once other insurance information is validated, we notify AHCA in the monthly reporting process via the secure data transfer already in place.

1.12 Pre-Payment Review
Once a claim has passed through all of the validation, editing, and calculations described above, Magellan Complete Care has configured pre-payment edits to pend a claim for review if certain conditions exist, prior to payment. An example of this is high dollar claims. If the claim payment is above Magellan Complete Care’s high dollar threshold, it is reviewed by Claims Operations leadership before allowing it to go out the door.

1.13 Provider Payment and Communication
Once a claim has passed through all validation, editing, and calculations, including pre pay editing, the claim is now in a paid or denied status and is ready to be finalized. Magellan Complete Care runs a claims payable cycle every evening. This puts the claim in a final status and generates the remittance advice and check or electronic funds transfer (EFT).

Remittance Advice/Electronic Remittance Advice

Magellan Complete Care delivers remittance advice via multiple options including paper, electronic remittance advice (ERA) on the provider portal, or HIPAA compliant 835 data file. In order to receive an 835 electronic remittance advice, providers sign up with Magellan Complete Care through the provider portal. All providers are able to see their remittance advice data on the provider portal and are not required to sign up separately for that feature. If a provider does not sign up for ERA, we send a paper remittance advice to the provider based on the payment address that we maintain in CAPS.

1.14 Checks/Electronic Funds Transfer
Providers have the option to receive paper checks or payment via Electronic Funds Transfer (EFT). In order to receive payment via EFT, providers must first sign up with Magellan Complete Care via our provider portal. If a provider does not sign up for EFT, a paper check is printed and sent to the provider at the payment address maintained on CAPS.

CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT HAS INCLUDED DETAILED METRICS...
Magellan Complete Care uses a variety of processes and tools to produce data and metric-related reports to meet the operational needs of the plan, track plan progress and to deliver accurate and timely regulatory reporting. Our centralized integrated reporting process enables standardization of business rules and provides consistency and accuracy of the claims data across reports.

2.1 Reporting Tools
Tools include:

>Standardized reports and dashboards: generated through CAPS, HealthAxis, and the enterprise data warehouse (EDW). This reports, produced on a daily, weekly, monthly, and ad hoc basis provider claims processing leadership with the metrics used to manage inventories, system performance, and processor performance, as well as provider billing trends. This data, reviewed on a regular basis, enables us to adjust quickly to ensure we are processing claims on a timely basis and to develop strategies to ensure continued improvement in the timeliness and accuracy of our calims processing.

>Quality audit tools: results of quality audits are documented and reported on an individual and cumulative basis within the Magellan Audit Database application, a centralized audit database. This tool and the data it provides enables us to track the accuracy of our claims processing and
quickly identify root cause for any errors and develop solutions to improve the accuracy of our claims processing.

>BART: a centralized automated self-service, point and click, web-based Business Analytics and Reporting Tool (BART) using several sophisticated business intelligence software solutions such as Qlikview and Cognos to support the data management requirements of an SMI specialty plan. This system enables us to track our standard claims processing and payment trend metrics. Monitoring these trends help us to identify potential billing, processing, or system patterns that then allow us to develop strategies to improve the timeliness and accuracy of our claims processing.

2.1 Standardized reports and dashboards
To track timeliness and the overall process of our claims processing and payment process, Magellan Complete Care standardized reports and dashboards generated through CAPS, Health Axis and the enterprise data warehouse (EDW) that are real time, daily, weekly, monthly, and ad hoc. Claims leadership, including supervisors, managers, and directors are monitoring inventories and claims processing performance throughout the day to ensure appropriate workforce management is employed to allocate staff appropriately to handle inventories in every aspect of claims process. Below is a list of the detailed metrics to track timeliness and accuracy of the claims processing and payment process:

>Daily Claim Tracking
>>>>> Paper Receipts
>>>>> EDI Clearinghouse Receipts
>>>>> EDI Direct Submit Receipts
>>>>> EDI Web Entry (Claims Courier) Receipts
>>>>> Returns to Provider
>>>>> Claims Processed
>>>>> Claims Work on Hand
>>>>> EDI Rate
>>>>> Auto Adjudication Rate

>Pended Claims
>>>>> Overall Pend Reason Volume, Percent of Total, and Age
>>>>> Pend Queue Aging
>>>>> Pend Reason by Provider Volume, Percent of Total, and Age
>>>>> Pend Reason by Code Trend
>>>>> Pend Reason by Provider Trend

>Daily Finalized Claims and Dollars Paid
>>>>> Claim Count
>>>>> Paid Amount
>>>>> Interest Paid
>Denial Reasons
>>>>> Overall Denial Reason Volume and Percent of Total
>>>>> Denials Reason by Provider Volume and Percent of Total

>Claims Quality
>>>>> Financial Accuracy
2.2 Quality Audits Tool

Magellan Complete Care has a proven track record of meeting and exceeding claims payment accuracy and timeliness. Magellan Complete Care continually monitors claims processing performance and compliance. Daily, weekly, monthly, and ad hoc reports allow service operations and management to track and monitor performance, identify issues and review the quality and accuracy of claims processing and payment.

There are four key methods we pursue for accuracy:

1. Financial Accuracy: Claims total dollars paid less the total amount mispaid (absolute value of over plus under payments), divided by the total amount paid. Since we began our work with AHCA in 2014, our financial accuracy has exceeded 99.5 percent each year and is currently at 99.6 percent year-to-date.

2. Statistical Accuracy: Claims reviewed with correct statistics (non-financial errors). Since our 99.68 percent rate in 2014, we have exceeded 99.7 each year with a current year-to-date rate of 99.79.

3. Payment Accuracy: Claims reviewed less number of claims with disbursement errors, divided by the total number of claims. Our payment accuracy rate has improved each year and our current year to date rate is 99.82 percent.

4. Processing Accuracy: Claims reviewed less the number of claims with both payment and non-payment errors, divided by the total number of claims reviewed. Our processing accuracy has improved each year and our year to date rate is 99.61 percent.

Magellan Complete Care’s Quality Auditing team performs quality and adjudication accuracy audits against federal and Florida specific regulations and requirements. Magellan Complete Care ensures operational compliance with State and Federal requirements through multiple controls and audits. Through our robust claims monitoring program, we continuously monitor claims volume, claims turnaround time and electronic claims submission rates via BART. Below is a list of some of the audits performed by this team.

> Individual Claims Processor audits - A random audit of three percent of each claims processors' production (post disbursement) based on a daily, automated report of finalized claims.

> New Hire audits – We audit all claims processed by newly hired employees through an extensive new hire policy that ensures an associate meets certain thresholds before being released from the audit. This policy includes tiers so that a new employee is monitored with more scrutiny even after being released from the 100 percent audit. This activity enables us to provide immediate feedback to employees and is an enhancement to our employee orientation and training efforts.
High-dollar audits – 100 percent of our high-dollar claims are audited prior to approval for payment when:

>>> The payable amount on the claim is ten thousand dollars or more.
>>> >>The denied claims have a billed amount of fifteen thousand dollars or more.
>>> >>Any claim with a paid amount of seventy-five thousand dollars or more is sent to the Director and Vice President of Claims Operation for high dollar tier review.

Focused audits – Magellan Complete Care maintains targeted focused audits on specific claim types or processes related to potential fraud, waste and abuse, systemic claims issue resolution and to measure performance.

Implementation/post-implementation audits

The Magellan Complete Care audit team calculates statistical, dollar, payment, and processing accuracy ratings based on a Florida-specific audit tool that is hard-coded into our audit database. Audit criteria include a review of the claim against Magellan Complete Care’s standard practices, regulatory and AHCA-specific requirements. Our audit database produces specific audit reports with summary details which allows for management review of contractual performance standards and guarantees.

Table 5: Calculation Methods, which is part of the attachment for this SRC, summarizes the calculation method we apply to each measurement.

We document and report all quality audit results through a centralized audit database. A specific checklist developed by a user committee is hard-coded into the audit database enabling each auditor to audit the same data elements. The Audit Database is capable of producing specific audit reports by account, processor, and detail. Our supervisors can also run a standard audit report on individual processors, but are not required as their main focus at the individual level is their involvement in the error sign-off process. Cumulative audit findings generated by the standard audit report, and are reviewed on a continuing basis by immediate supervisors and at least monthly by senior management as part of the Service Operations Executive Report in monthly operations meetings. No sign-off of the cumulative audit report is required by the supervisor or senior management levels, and the report is reviewed and approved by our Chief Operating Officer. Our Quality Audit Department reviews Magellan Complete Care performance goals, particularly those goals that did not meet requisite standards. Quality performance of each processor is a key individual performance measurement. Processors, who do not maintain required standards, are entered into progressive disciplinary steps, which may result in termination for failure to achieve standards.

2.3 Second Level Audit

Magellan’s auditing program includes a second level audit to validate the integrity of audit methods and results. Magellan pulls a monthly sample of each auditor’s work and performs an additional audit of that claim to measure auditor accuracy and reliability. The goal of this process is to validate the proper decision was made, that all auditors would audit the claim the same way, and that any discrepancies should be surfaced for review and discussion. A secondary goal of the audit is to identify potential auditor training and performance improvement opportunities and address them in a timely fashion. Auditors are held accountable for errors identified through the
rebuttal process. Claims reviewed for the second level audit process focus on those with no errors in order to provide a full spectrum of auditor performance.

2.4 Business Analytics and Reporting Tool
We have built a centralized automated self-service, point and click, web-based Business Analytics and Reporting Tool (BART) using several sophisticated business intelligence software solutions such as Qlikview and Cognos to support the data management requirements of an SMI specialty plan. This system enables us to track our standard claims processing and payment trend metrics. BART also helps us to visualize/mining the data and gain new insights around enrollee/provider/facility behavior and utilization patterns. This flexible analytics system provides us with high-level trend information, and it enables us to help pinpoint root cause of the trends, shortens decision-making time-frames with self-service reporting, and strengthens the use of existing data by making it more readily available to stakeholders (see Figure 2: Medical Claims Trend Dashboard, which is included in [General SRC #17, Attachment 1: Tables and Figures]). The following BART dashboards represent a sample of the output our leadership regularly reviews.

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT HAS INCLUDED A DETAILED DESCRIPTION...
Accurate claims processing is critical to collecting the necessary data for our quality improvement and clinical programs, which leads to superior care for our enrollees and to improved provider satisfaction. For these reasons, we have developed a rigorous, proactive, systematic approach to process improvement across our claims processing and payment system. As a result of our focused quality improvement efforts, through standing meetings with executive leadership and proven methods and tools, we have effectively improved the accuracy and timeliness of our claims processing and payment month over month and year over year.

A key component of Magellan Complete Care’s Process Improvement Plan is the Plan-Do-Study-Act (PDSA) rapid cycle improvement process. Magellan Complete Care has effectively deployed this method throughout our organization. PDSA is an iterative, four-stage problem-solving model we use for improving claims processing and payment processes or carrying out change quickly.

3.1 Joint Claims Operations Meeting
The Magellan Complete Care Joint Claims Operations meeting led by the Chief Operating Officer (COO), includes medical directors, health services, utilization management, network development, service operations, pharmacy, call center and claims. While issues are resolved outside of this meeting, we have found that by providing an opportunity to proactively work though identified trends or issues with all of the cross-functional areas “in the room,” we are able to make decisions leading to rapid process improvements or issue resolution. The focus of these meetings is to review standardized management reports [Table 6: Management Reports, part of General SRC #17, Attachment 1: Tables and Figures]), BART and other reports and audit findings, including a review of weekly inventory reports, monthly, quarterly and annual trend reports for timeliness, claims accuracy and payment metrics (e.g. beginning and ending claims inventory numbers, days on hand, and aging). The meeting agenda includes escalated issues, trends in claims disputes to help identify systemic issues and improvement opportunities we can quickly address. The trend analysis and resulting actions are documented, actions are assigned to an accountable owner and resolution timelines are established. We track action items (e.g. system enhancements, provider or staff training and resolution) to closure during future meetings.
3.2 Claims Operations
To most effectively identify claims processing and payment process improvements and problem solve, Magellan Complete Care structures its analytic functions to provide daily enrollee-level claims information to the operational team, which span all types of service coverage (e.g., medical, pharmacy, behavioral health, transportation, vision, and dental services). For example, our claims supervisors monitor the volume and aging of pended claims on a daily basis through online system reports. The claims supervisor monitors the number and age of claims by each system-pend reason. Based upon this review, we allocate resources and initiate corrective actions to clear the pended claim and meet our performance standards.

Magellan Complete Care’s audit application generates standard reports for each audit, which is forwarded to the individual processor and supervisor for review and corrective action. These actions may include adjustment of a claim for under- or over-payment. We have established quality performance as a key individual performance measure for each of our processors. Processors, who do not meet these performance standards are referred to our progressive discipline program where we provide specific training and support to assist the processor. The processor’s immediate supervisor then generates and reviews additional audit reports for the processor on a weekly basis, and reports the results to senior management during the Joint Claims Operations meeting.

Magellan Complete Care’s auditing program includes a second-level audit to validate the integrity audit methods and results. We pull a monthly sample of each auditor’s work and perform an additional audit of that claim to measure the auditor’s accuracy and reliability. The goal of this process is to validate the appropriate decision was made in relation to how other auditors would process the claim, and to identify any processing discrepancies for review and discussion. A secondary goal of the audit is to identify potential auditor training and performance improvement opportunities and address them in a timely fashion.

The results of these reports and trended metrics are used to highlight staff training needs, process improvements, or staffing adjustments.

3.3 Provider Claim Submissions
Magellan Complete Care monitors provider adherence to timely submission of clean claims and EDI utilization. We track various metrics including EDI rejections, timely filing issues, and denial reasons by provider. Our dedicated provider support teams, including Provider Relations Managers (PRM) and Provider Support Specialists (PSS), who are in the provider offices and facilities working side-by-side to offer training, technical assistance and process improvement strategies. When we identify trends or common issues within a provider’s practice, our PRMs work one-on-one, with the practice, to resolve the issues. If the issue is more generalized across our provider network, we inform providers through e-alert, fax blasts, newsletters, webinars and updates to our Provider Manual and website.

3.4 Clinical and Quality Programs
Claims data is stored in our enterprise data warehouse (EDW). Daily extracts of claim information, vendor claims, provider information, enrollee eligibility and pharmacy claims are extracted into an input file which is fed into a clinical rules engine and predictive model. The model generates enrollee risk scores meant to predict the likelihood of an enrollee admission within 90 days. The models predict disease-specific admission risk (SAdhizophrenia & Psychosis, Mood Disorders),
potentially preventable admissions (ambulatory sensitive conditions), and all-cause admission risk. Clinical prioritization logic is employed to select the causal driver of an enrollee's "highest risk." The risk status is then joined to the rules engine results to extract the enrollee's clinical and pharmacy gaps in care, their HEDIS-like measure compliance status, their disease management segmentation, and clinical profile information. The information is converted to a daily file which is transmitted to the case management and utilization management application (TruCare), the provider Connect Portal, the HEDIS intervention application, and to reporting dashboards which are used by the clinical and health services team within Florida, and are reported to the Executive Teams within Florida as well as to the Corporate Executive team.

We have real-time access to our internal pharmacy benefit management enrollee utilization data, through our data warehouse, which enables us to use our data analytical tools to quickly identify and manage early risk indicators, such as those associated with medication over- and under-utilization (see Figure 3: Pharmacy Trend Dashboard, which is included in the attachment for this SRC).

Biweekly quality and analytics meetings, between our analytic teams and our clinical, quality and health services teams, serve to examine the accuracy and performance of our risk stratification and health segmentation models and enrollee gaps in care. These teams review current enrollment of enrollees who are in or in need of case management, identify areas of emerging risk for the enrollee population, and review analytic data related to drivers of inappropriate clinical utilization patterns. Enrollee outcomes, which are based upon clinical and operational metrics, are tracked via the Qlikview dashboard, reviewed bi-weekly with the clinical and operational teams and monthly at the Executive team meeting (see Figure 4: Magellan Complete Care Analytic Diagram, which is included in the attachment for this SRC).

A Magellan Complete Care priority is to provide actionable information to our providers in order to improve care for our enrollees. Our secure online Impact Pro® Connect Portal provides meaningful data to support our providers’ performance improvement efforts. The Connect Portal assists and informs providers about care management activities, the status of enrollee gaps in care and performance comparisons to quality benchmarks. Our PSS provide training and technical assistance on the use of the Connect Portal and assist practices establish outreach programs or support existing programs (e.g., to close gaps in recommended preventive care or decrease inappropriate emergency room visits).

CRITERIA 4: THE EXTENT TO WHICH THE RESPONDENT HAS INCLUDED A DETAILED DESCRIPTION OF ITS PROCESS...

As we do today, Magellan Complete Care is committed to ensuring that data and metrics regarding claims processing and payment are available to AHCA, including the monthly claims aging report and the Florida Office of Insurance Regulation (FLOIR) Monthly Financial Statement. This particular report contains claims statistical data and is filed with the FLOIR monthly. The Magellan Complete Care Encounters and Reporting team along with our Compliance Department maintains and manages to a schedule of all reporting and data that is due to AHCA, including reports that contain data and metrics regarding our claims processing and payment process. Magellan Complete Care developed a production schedule for all reports, so that we can generate reports within the required time parameters and to allow for internal review and approval before delivery to AHCA. Our Encounters and Reporting Team notify, via email, the accountable departments indicating that the report is available for their review. The Encounters and Reporting
team works with each accountable department to ensure the reports are complete and accurate. Upon report approval, this team delivers the reports to AHCA in the format and via the delivery method required.

To meet our ad hoc reporting needs, we use software solutions such as Qlikview and Cognos. These reports are delivered primarily through browser-based reporting tools that provide secure delivery of reports through a mid-tier application server on a prescheduled or on-demand basis.

In addition, Magellan Complete Care is committed to ensuring the collection and submission of claims and encounter data for all rendered services are in accordance with the established AHCA data quality standards. Magellan Complete Care stores every data element filed on a claim in our EDW. Since the beginning of our collaborative efforts with AHCA in 2014, we have developed a comprehensive set of processes and tools to produce encounter data and metric-related reports to meet the operational needs of the plan, track plan progress and to cater to the needs of AHCA via Compliance and regulatory reporting. Our centralized integrated reporting process enables standardization of business rules and provides consistency and accuracy of the claims data across reports.

Magellan Complete Care recognizes that AHCA may establish systems and processes to collect submitted claims data, including denied claims, directly from the providers. Magellan Complete Care is capable of sending and receiving all claims information directly to AHCA in standards and timeframes specified by AHCA within 60 days notice. Magellan Complete Care will work closely with AHCA during the transition period as network providers move to submitting claims through the State instead of directly to the Magellan Complete Care.

CRITERIA 5: THE EXTENT TO WHICH THE RESPONDENT HAS INCLUDED A DETAILED DESCRIPTION OF ITS PROCESS TO MAKE DATA AND METRICS AND TREND DATA...

Magellan Complete Care provides self-service opportunities for our network providers to access data, metrics and trend data regarding claims processing and payment on a real-time basis. The Magellan Complete Care provider portal contains many distinct transactions that allow network providers to effectively manage their business and streamline their communications with Magellan Complete Care.

Our provider portal is available to all contracted network providers. Providers are given their own privileged accounts which enable them to add their own staff logins. Staff, who are added to a provider site, have their access restricted to show only data affiliated with their contracted provider. This affiliation is identified at the account and contracted provider level for security and privacy reasons by the internal Magellan provider ID number. For security and privacy, the website is protected through end to end data encryption using SSL.

Accessed through the password protected provider-only password protected website, provider staff have access to the following online tools:

>Check Enrollee Eligibility – a simple to use display of an individual’s eligibility over time. The individual can be looked by either name and DOB or their Medicaid ID number. This view specifically helps providers as they process claims for enrollees to ensure that the enrollee had covered eligibility on the dates of service in question. This can be thought of as a real-time or
interactive HIPAA 270/271 transition and response which provides the enrollees coverage and benefit information to the provider on demand.

>Check Claim Status – a simple to use display of a single or group of claims submitted previously by the logged in provider.

>View Explanation of Benefits (EOB) – the network provider can pull an EOB at the claim detail level with all associated payment amounts or adjudication codes online at any time. These EOBs can be saved locally for future use by the network provider.

>Request Authorization – submit initial and subsequent outpatient authorization for services requiring authorization.

>Check Authorization Requests – review previously submitted authorization requests for status, and provides the ability to download the authorization report.

>View Authorization Letter – the network provider can view and print the authorization letters for specific services.

>View enrollee outcome reports.

>Provider Credentialing and Practice Information – the network provider can check on their own credentialing and contracting status and edit their specific practice information. If necessary, the provider can complete the necessary re-credentialing application.

>Enhance their own online provider portal (accessible to the community through our online provider search function) – including the practice hours, professional awards, if they're taking new patients, their photograph, etc.

>Free continuing education courses – the network provider can take free continuing education through the website after logging in.

>Registration for EFT – the contracted provider can register for electronic funds transfer for their payments.

These online transactions provide real-time access to core Magellan Complete Care databases. They show the current status of eligibility, claims, authorizations, etc., giving the provider the most up-to-date information and is available 24 hours a day.

Magellan Complete Care also provides IVR tools to enable providers using telephony the opportunity to check on enrollee eligibility and claims payment status. Magellan Complete Care strives to give providers multiple channels for information transmission, and by providing IVR we bring the opportunity to check claims status to an authenticated provider from virtually anywhere with a dial tone.

Magellan Complete Care also provides information to providers without sign-in. This information includes:

>Provider Focus online newsletter
>Information about joining our network
>Credentialing and contracting requirements
>National Provider Handbook and supplemental policy documents
>Clinical Practice Guidelines
>Magellan Care Guidelines
>Provider Trainings and demonstrations of our online tools
>Telehealth resources
>Clinical and administrative forms
>Claim submission tips and information on the HIPAA claim code sets
>Answers to frequently asked questions (FAQs)
>Relevant news headlines
>Links to other relevant health and community resource websites

As stated earlier, Magellan Complete Care offers providers multiple options to submit claims to us electronically. Electronically submitted claims offer our providers the best options for real-time claims processing and payment information. Our provider support teams provide technical assistance to facilitation adoption of electronic submission.

>Interactive Claims Courier: Claims are submitted electronically on our web site through the interactive, web-based submissions tool, Claims Courier. This tool provides immediate notification of the potential errors in claims submission—allowing providers to resolve the errors quickly and resubmit their claims in a timely manner. Additionally, claims submitted through Claims Courier are processed in real-time, allowing providers to find out immediately whether their claims were approved for payment, pended or denied and the reason. The average response time for real-time adjudication is approximately five seconds.

>Direct Submit: Magellan Complete Care offers high-claim volume providers our EDI Direct Submit application, an electronic claims tool available on our provider website. This application allows providers to receive response files and remittance advices via a HIPPA compliant 835 file.

>Clearinghouse: Magellan Complete Care maintains relationships with seven clearinghouses in order to allow providers to use that avenue to electronic claims submissions. This application allows providers to receive response files from the clearinghouse along with remittance advices via a HIPPA compliant 835 file.

Regardless of the mode of submission, electronic or paper, once the claim is loaded into CAPS, providers can access claims status information directly through our secure provider portal or IVR.

CRITERIA 6: THE EXTENT TO WHICH THE RESPONDENT HAS INCLUDED ITS APPLICABLE…
6.1 Pharmacy Benefit Management
Magellan Complete Care’s pharmacy benefit program provides a unique solution to administering pharmacy benefits for our enrollees, in that Magellan owns and operates a pharmacy benefit management (PBM) entity called Magellan Rx Management (MRx). The following narrative summarizes both the relationship Magellan Complete Care has with this entity as well as this entity’s claims processing and payment processes. This pharmacy benefit management service functions as an integrated component of our health plan and plays an integral part in our holistic approach to caring for our enrollees.
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Magellan Complete Care’s Pharmacy Director, with support from MRx, is responsible for coordinating pharmaceutical care for our enrollees and ensuring all pharmacy-related claims are processed timely and accurately. MRx provides access to all covered outpatient drugs required by AHCA and the MMA program. MRx does not pay for prescriptions, including refills, prescribed by providers that have had their prescribing rights suspended by the AHCA or by CMS.

MRx claims platform, FirstRx, is a highly configurable, rules-based, parameter and table-driven system designed to offer unparalleled flexibility. This system is both HIPAA and National Council for Prescription Drug Program (NCPDP) compliant, supporting the processing of all NCPDP pharmacy claims using interactive real-time processing in the NCPDP Telecommunication Standards vD.0 and Batch Standard v1.2. All Point-of-Sale (POS) claims routed by switch or direct lease line are captured and adjudicated using real-time (or batch submission) when received via a switch or clearinghouse.

Participating pharmacy providers are integrated with FirstRx via their chosen switch vendor. A switch vendor is a third-party that takes information from the pharmacy’s dispensing software and facilitates connectivity to our FirstRx. As pharmacy claims are submitted FirstRx processes the claim in real-time through full adjudication to paid or denied status. At all times, the pharmacy has the full inventory and disposition of their submitted claims at their fingertips, stored in their in-house system(s). MRx is currently integrated with all necessary switch vendors in place today that support the Florida program.

FirstRx can also process paper claims submitted by providers using industry-standard paper forms. This NCPDP compliant pharmacy solution meets all federal requirements as prescribed by CMS, as well as requirements outlined by the National Archives and Records Administration Code of Federal Regulations (CFR) parts 42 and 45.

To ensure accuracy and timeliness of claims processing Magellan Complete Care and MRx have jointly implemented a set of internal service level pharmacy program standards. These standards include encounter and claims processing metrics, such as claims processing times, claims accuracy and call center statistics (e.g., average speed to answer and average handling time). Magellan Complete Care executive leadership reviews these operational outcomes at Quarterly Improvement Committee (QIC) meetings and uses these outcomes as part of continuous process improvement initiatives.

In 2016, MRx processed over 3.5 million Magellan Complete Care pharmacy claims via FirstRx, with an average adjudication response time of 0.69 seconds and 98 percent of these claims in under 3.5 seconds. Currently, MRx pays 100 percent of claims within 14 days. This type of information, as well as all program metrics regarding the pharmacy modules’ claims accuracy and timeliness are monitored regularly and reviewed (in addition to the QIC) by Magellan Complete Care’s Pharmacy Director, QIC and executive leadership during monthly business reviews for trending purposes and for reporting purposes to AHCA.

MRx provides providers with Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) capabilities. This functionality satisfies the CAQH Committee Operating Rules for Information Exchange (CORE) mandate, which requires online capability for both Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA) enrollment. MRx Web Remittance Advice (WebRA) function allows pharmacy providers to use a web-based tool to view remittance advice information and to search for remittance advice reports and payment history.
To ensure claims processing accuracy, MRx thoroughly tests all changes prior to deployment and conducts continual quality assurance testing thereafter. The MRx quality assurance (QA) environment is a production-like environment, which is dedicated to testing all testable components, including detailed claims. This environment mirrors our production environment and is used to test changes prior to deployment. New builds and data loads are built into the environment throughout the implementation phase, upon our quality assurance department's approval. MRx places role-based security access control restrictions on the environment, as well as organized release management procedures.

MRx’s infrastructure support and application teams will continue to administer all PBM support systems under strict system development life cycle management support. As part of this system administration, the MRx QA Department audits a sample of paid and denied/rejected claims. These audited claims are randomly identified through a scheduled report process. The generated report identifies key data elements relating to each claim. Each claim is reviewed in the FirstRx POS system to validate the incoming data elements and post-adjudication disposition of the claim. The audit findings are shared with Magellan Complete Care’s Pharmacy Director during regularly scheduled business reviews or as needed. The following areas are validated for claims: paid claims — eligibility, payment amount, Third Party Liability (TPL) status, drug coverage, provider, prescriber; denied/rejected claims — validity of denial/rejection, correct NCPDP code returned, supplemental messages returned with appropriate code, and accumulations.

6.2 Magellan Complete Care Subcontractor Claims Processing and Payment

The following narrative describes our requirements associated with how our subcontractors align with our claims processing and payment systems. We have organized this section to correspond with each of the five evaluation criteria contained in this SRC. Magellan Complete Care contracts with six subcontractors that are delegated for claim processing:

>DentaQuest of Florida, Inc.
>Florida Eye Corporation, Inc.
>Premier Eye Care of Florida, LLC
>Provider Network Solutions Management, LLC (Podiatry, Dermatology and Orthopedic Services)
>DentaQuest of Florida, Inc.
>Florida Eye Corporation, Inc.
>Premier Eye Care of Florida, LLC
>Provider Network Solutions Management, LLC (Podiatry, Dermatology and Orthopedic Services)
>Sivantos d/b/a HearUSA
>Veyo, LLC

6.2 The extent to which the respondent has described key components of its claims processing and payment process in a format suitable for the public, including a description of the processes for claims submitted both on paper and electronically.

Magellan Complete Care selects subcontractors based on the capability to offer efficient approaches to claims processing for all claims types. Magellan Complete Care performs robust pre-delegation and ongoing audits to ensure compliance with all contract, AHCA and Federal requirements. In addition to verifying Medicaid eligibility and applicable active TPA licensures, all
subcontractors demonstrate the ability to adjudicate and pay provider health claims through real-time batch submission, authorized and credentialed web-portal systems, or industry standard paper formats. Contracts and addendums ensure that claims are processed according to AHCA requirements, Magellan Complete Care standards, as well as state and federal requirements set forth in 42 CFR 447.75, 447.76 and chapter 641, F.S., whichever is more stringent. All claims systems are verified to be fully HIPAA compliant and meet or exceed the quality-focused claims processing standards for paper claims and electronic claims files for both in and out of network providers.

Claims systems utilized for claims adjudication under the Magellan Complete Care plan include the ability to accept, verify and maintain accurate eligibility and enrollment information. Subcontractors are required to accept as enrolled all individuals appearing on the Magellan Complete Care enrollment file, and the provided eligibility files must be loaded within 24 hours of receipt. Policies and procedures must include terms for reconciling eligibility with a required monthly eligibility reconciliation process.

Integration with and support of the quality and medical management functions including prior authorization, medical necessity review, denials, continuity of care, care coordination, disease management, pharmacy management, emergency service management and quality improvement initiatives are verified to be included with claims systems support. Additional system integrated functions that are held as standard for subcontractors include:

> Capabilities to capture, collect, generate, transmit and maintain claims data and adjudication data elements per requirements.
> Service specific CPT, HCPC, or CPTII procedure coding ICD10 diagnosis coding data on a per enrollee basis.
> Detailed records of RAs, ERAs and EOBs to providers.
> Process to monitor and load Federal and State fee schedule updates on monthly basis.
> Built-in system edits, such as AMA CPT or NCCl, to ensure completeness and accuracy of claims payment.

6.3 Detailed metrics to be employed by the respondent to track timeliness and accuracy of the claims processing and payment process (Evaluation Criteria 1). To ensure quality, each claims delegate’s contract includes specific performance standards and data reporting requirements. Magellan Complete Care monitors subcontractor performance on a regular basis using metrics collected by required reports and by annual and semi-annual claims audits, in accordance with §626.8817. The resulting data is used by Magellan Complete Care to improve processes, resulting in overall higher than standard payment timeliness and accuracy. We measure claims payment timeliness according to AHCA guidelines and include the following measures:

> Pay or deny 50 percent of all clean claims submitted within 7 days
> Pay or deny 70 percent of all clean claims submitted with 10 days
> Pay or deny 90 percent of all clean claims submitted within 20 days

All subcontracts must achieve a score of 98 percent or better for claims processing accuracy and 99 percent or better for financial accuracy. The combined audit scores for all subcontractors is currently 98.89 percent for claims processing accuracy and 99 percent for payment timeliness.
6.3.a Claims Monitoring Process
The network data and reporting analyst submits all reports to the subject matter expert (SME) for compliance attestation. The SME attests Yes or No to the compliance report review. The network data and reporting analyst tracks the internal SME attestations for any trends or non-compliance reporting:

> Claims Aging Report
> Monthly Scorecard with Claim Universe Detail
> Provider Complaints, Provider Appeals if delegated
> FWA HIPAA Tracking Report

Claims Issue Monitoring – Our vendor management claims analysis runs an internal COGNOS claim report for all adjudicated encounters processed into the RCAPS claims system. The following pend or denied claim/encounter claims and related activities are reviewed and performed with the subcontractor weekly:

> Pend and Denied Claims
> Research and resolve the claim with the subcontractor making suggestions or modifications
> Analyze and identify track and trending root cause analysis
> Escalate issues as appropriate
> Provide reports as necessary
> Identify system/benefit errors by completing protocols and workflows to prevent future errors

Encounter Reconciliation Monitoring – We review and monitor the following functions and capabilities monthly:

> Reconciliation of all vendor claim/encounter submissions to Magellan Complete Care
> Collaboration between internal Magellan Complete Care staff, including EDI, encounter and vendor management for compliance of all subcontractor claim/encounter reconciliation
> Ensure operational efficiency; respond to requests, correspondence, accurate and timely inquiries

Claims Adjudication Audit – We audit the following subcontractor functions and capabilities semi-annually:

> Desktop audit is performed to evaluate compliance with the claims management process through an audit of random approval, denial and appeal adjudicated claim files
> Claim processing, accuracy, timeliness
> Financial and procedural

On-Site Claims Delegation Oversight Audit – We audit the following subcontractor functions and capabilities annually:

> Claim department staffing/structure membership, claim volume, training program – production and quality standards, confidential statements and HIPAA compliance, fraud and abuse training, audit program-production and quality standards, compliance level

> Claim processing: claim inventory and controls, sub-delegation/outsourcing, misdirected claims handling process, claims acknowledgement compliance, claim pay met policies and procedures and/or process workflow, payment methodology, coordination of
benefits/subrogation/TPL/overpayment/off-set process, medical review process/request, claim denial process and procedures, explanation of benefits and explanation of payments compliance, provider dispute resolution

>System capabilities: system security, reporting capabilities, claim history retention, disaster recovery

Detailed description of how metrics from the claims processing and payment process will be used throughout its organization to provide for rapid cycle improvement (Evaluation Criteria 3).

Magellan Complete Care retains responsibility for the quality of service delivered through our delegated subcontractors. Each delegate contract includes specific performance standards and requirements to ensure that the terms and conditions of contractual obligations are adhered to. Monitoring methods include: data review, joint partnership meetings, compliance assessments, and sanction and exclusion monitoring. Results of the reviewed data are evaluated by Magellan Complete Care’s Vendor Management Team and reported to the Vendor Oversight Committee and the Quality Committee.

Should performance issues arise, subcontractors are required to provide communications to Magellan Complete Care with any changes of processes or standards as a result of internal auditing and monitoring. Vendor Management then reports any issue to the Compliance Officer. Joint partnership meetings that include Vendor Management, relevant operational stakeholders and the subcontractor are conducted regularly with continued, on-going monitoring until the reported issue has been resolved.

When non-performance or non-compliance is identified, the subcontractor’s action plan for addressing the performance issue is addressed with the appropriate level of response which may include:

>Corrective Action Plan (CAP): A formal CAP is required if the performance issue is part of a trend or has no immediate or direct remedy. The CAP process is time limited and must be followed to completion.

>Monitoring: When the root cause of an issue is identified and corrected immediately, the Vendor Management team monitors through reporting to ensure that the implemented corrective action effectively resolves the issue. Monitoring may be more frequent with additional metrics added as needed to resolve the performance concern.

>Resolve: If the performance issue appears random and is corrected immediately, the Vendor Management team will consider the issue to be resolved. Ongoing monitoring through performance metrics will be included in routine reports, which allows the issue to be identified if repeated.

>Discretionary/For Cause Audit and Contract Evaluation: In the case of a performance issue or circumstance that could impact program integrity, the Vendor Management team works with legal, compliance, special investigations and quality teams to conduct a thorough evaluation of the subcontractor’s performance and compliance. Immediate corrective actions, including the consideration of contract termination or the implementation of payment penalties, will then be taken.
6.4 Detailed description of its process to make data and metrics regarding the claims processing and payment process available to AHCA and that the described process provides sufficient opportunity for AHCA to access this data (Evaluation Criteria 4).

Delegated subcontractors adjudicate claims using their claims processing systems. Magellan Complete Care collaborates with all subcontractors to extract the adjudicated claims data, submitted by EDI (through clearinghouses, Direct Submit or Magellan Complete Care Web Portal) or paper, into the ASC X12N 837 standard format. Encounter file formatting follows the standards in AHCA’s 5010 Companion Guides and include Managed Care Plan paid amounts for capitated and non-capitated providers. The formatted files are then ingested into the CAPS claims processing system where all claims, paper or EDI, are subjected to additional pre-processing edits, syntax and compliance checks to validate the quality of the data. Claims are then reviewed with standard system edits which include the verification of: enrollee eligibility, provider network status, authorization requirements, covered or non-covered services, accurate procedure coding and checking for potentially duplicated claims.

Magellan Complete Care uses an automated job scheduler to ensure the delivery of encounter files is in accordance with contractual obligations. Encounter file data is submitted for services rendered to all enrollees to AHCA’s fiscal agent no later than seven days following the date on which the claims were adjudicated. Adjustments, reversals or corrections will be submitted within 30 calendar days after the encounters fail edits. Magellan Complete Care receives, processes and stores all encounter data files from our subcontractors for a period of not less than six years.

6.6 The extent to which the respondent has included a detailed description of its process to make data and metrics and trend data regarding claims processing and payment process available to network providers on a real-time basis and that the described process provides sufficient opportunities for network providers to access this data (Evaluation Criteria 5).

Magellan Complete Care works collaboratively with all subcontractors delegated to adjudicate claims. Claims submitted electronically, using EDI or web-portals, or via paper are converted to the standard ASC X12N 837 format. As described in the response to question 4 above, the 837 encounter file is processed in the CAPS system. If during the process of loading the data into the claims system an error or rejection occurs, it is submitted back to the subcontractor to correct and resubmit. Magellan uses the following internal processes, procedures, and controls to maintain the quality and integrity of data received from subcontractors and data conveyed to the client:

1. Systems validate transactions at various control points through loads, audits, reconciliation processes, and cross-reference reports.
2. Operations staff monitors process outputs and reports to validate data integrity.
3. Procedural and automated controls operate at appropriate points throughout the cycle.
4. Magellan’s standard data exchanges include the building of quality and monitoring measures using header, trailer, file counts, record counts, totals, etc.
5. Header and trailer records are utilized to track the completeness of any feed. Record level edits track and report all data additions, deletions, and changes.
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Evaluation Criteria:

1. The extent to which the respondent has described key components of its claims processing and payment process in a format suitable for the public, including a description of the processes for claims submitted both on paper and electronically.

2. The extent to which the respondent has included detailed metrics to be employed by the respondent to track timeliness and accuracy of the claims processing and payment process.

3. The extent to which the respondent has included a detailed description of how metrics from the claims processing and payment process will be used throughout its organization to provide for rapid cycle improvement.

4. The extent to which the respondent has included a detailed description of its process to make data and metrics regarding the claims processing and payment process available to the Agency and that the described process provides sufficient opportunity for the Agency to access this data.

5. The extent to which the respondent has included a detailed description of its process to make data and metrics and trend data regarding claims processing and payment process available to network providers on a real-time basis and that the described process provides sufficient opportunities for network providers to access this data.

6. The extent to which the respondent has included its applicable proposed subcontractors in its response, with each component addressed for each applicable proposed subcontractor.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.
E. DELIVERY SYSTEM COORDINATION

SRC# 18 – Utilization Management (Statewide):

The respondent shall describe the following related to its utilization management (UM) approach:

a. A description of the process used to determine whether a service should be prior authorized and that the UM criteria for each service have been evaluated to determine their appropriateness for administering a Medicaid benefit.

b. A description of how the respondent will ensure consistent application of the review criteria for authorization decisions.

c. A description of how the respondent will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope.

d. A description of the approach used to determine whether a service will be needed short-term vs. long-term (i.e., maintenance therapy) for an enrollee, specifically highlighting any differences in the respondent’s service authorization approach (if any exists) based on the length of time that the service will be needed.

e. To the extent that a service is needed long-term, a description of the strategies that the respondent utilizes to ensure continuity of care and safeguards that are in place to reduce gaps in authorization.

f. A description and example of how the respondent will detect, monitor and evaluate under-utilization, over-utilization and inappropriate utilization as well as processes to identify and address opportunities for improvement.

Response:

OVERVIEW

Since January 2014, Magellan Complete Care has managed the AHCA Specialty Plan for Florida Medicaid recipients living with serious mental illness (SMI) or serious emotional disturbance (SED). The existing Magellan Complete Care UM Program Description has been evaluated and approved by AHCA since program inception. Our UM program, in combination with our benefit design, has been developed to be responsive to the unique requirements of our population, delivery system, and providers to support timely and appropriate access to the type of care that is needed for this fragile and complex population. Our utilization management programs are also focused on ensuring that we encourage appropriate utilization by our enrollees and our providers.

The UM program meets its objectives in part by conducting prospective, concurrent, and retrospective review of services rendered to enrollees. The Utilization department monitors quality, continuity, and coordination of care as well as over-utilization and under-utilization of services. High risk/high cost cases are followed closely by the Utilization staff to ensure that the most cost-effective services are identified, coordinated, implemented, and evaluated on a continual basis. The Utilization Program includes development, implementation and continuous...
monitoring of the Health Services (HS) and the Utilization Work Plan. In addition, the Utilization Program generates policy and procedures and provides general direction and guidance toward policy execution.

Magellan Complete Care also leverages the experience of Magellan Health, Inc., (Magellan) our parent company and its affiliates, which have successfully administered UM services for Medicaid-eligible populations for more than 40 years. Magellan performs over half a million UM reviews a year. Magellan’s extensive UM experience includes managing a broad array of service types for autism spectrum disorder, behavioral health, physical health, and pharmacy, for state and county public sector contracts across the nation serving both Medicaid-eligible and non-Medicaid populations. Our experience working with similar populations that have complex health conditions includes providing UM programs and applying clinical guidelines for the full range of Medicaid enrollees, including but not limited to: TANF; SCHIP, SSI, ABD, Enrollees with Special Health Care Needs (MSHCN), Children with Special Health Care Needs (CSHCN) and waiver eligible enrollees with complex health needs. In addition to our national UM experience, Magellan has extensive experience providing UM services in Florida and for AHCA. From 1997 to 2014, we provided fee-for-service Medicaid behavioral health UM as a QIO-like entity vendor.

Magellan Health’s Pharmacy UM experience has served different facets of Medicaid (primarily the fee-for-service program, but more recently Managed Medicaid) over the past four decades. Our core competency is as a full-service Medicaid Pharmacy Benefit Manager (PBM), providing all aspects of pharmaceutical benefit management. We provide expertise in Medicaid program management and administration, including Preferred Drug List (PDL) development, rebate services, clinical management, informatics, cost containment strategies, information systems, claims management, enrollment, formulary management, and customer service—all geared towards meeting the unique needs of people who receive their health benefits through Medicaid.

CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES THE PROCESS AND DATA SOURCES UTILIZED TO DETERMINE WHETHER A SERVICE...

Magellan Complete Care has and will continue to maintain the process and data sources utilized to determine whether a service should be prior authorized, including reviewing complaints or feedback from providers regarding burdensome or unnecessary prior authorization criteria. The evaluation of key indicators provided through provider satisfaction surveys are also analyzed and incorporated into the review process by measuring aberrant results concerning the UM review process. Our UM process ensures that we review service requests with minimal administrative barriers for providers. We provide an environment for consistent, collaborative, and optimal utilization of care that is responsive to our providers and enrollees. As part of our ongoing analysis of enrollee needs and outcomes we also regularly review our practices to determine whether the UM program should be modified to achieve desired improvements. We recognize that UM policies should not be a hindrance to achieving desired clinical results. As we determine the need for changes in clinical guidelines and/or medical policy to support those improvement goals, we will modify our UM practices and policies to reflect those changing needs.

The scope of UM activities covers clinical aspects of preventive care and diagnostic and treatment services in both the inpatient and outpatient settings, which includes physical and behavioral health and pharmacy management. Programs for care coordination, maternal health, child health checkup (EPSDT), disease management, and care management (including complex case management and care transitions) are the subject of other Magellan Complete Care program
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descriptions. Staff assigned to these programs collaborate with the UM team to ensure that seamless care and services are delivered to our enrollees at all times.

1.1 Determination Process for Prior Authorization of Services
Magellan Complete Care has a strong UM Program, including experienced staff and licensed clinical reviewers and is comprised of full-time nurses and Master level licensed professionals (LCSW, LMHC) who function as UM professionals and concurrent hospital reviewers using evidence-based medical necessity criteria and guidelines with expeditious and transparent processes.

Magellan Complete Care primarily uses the Florida Medicaid Handbooks and fee schedule as its data source to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. Additional information sources used to determine benefit coverage and medical necessity include, medical necessity guidelines and criteria, National Practice Guidelines/evidence-based guidelines, expert consultant advisors, enrollee-specific information gathered in the course of care coordination, including behavioral and physical health history, social needs, information from family enrollees, as well as specific treatment information from providers. Other data sources include provider request forms, provider notes (medical records), medical claims, encounter data, pharmacy claims, behavioral health claims, and referrals from hospital discharge planners, PCP and specialist provider referrals, and authorization.

The National Medical Policy Committee (NMPC) is responsible for the review and approval of Magellan medical policy. Medical policy consists of clinical utilization management criteria, clinical practice guidelines, new technology assessments and other medical management policies. The responsibilities of the NMPC include:

>Issue corporate medical policy as an outcome of investigation, discussion, and consensus. All policies are consistent with applicable laws and regulations, accreditation standards (e.g. NCQA), and when applicable, CMS
>Identify absence of existing medical policy and develop solutions to fill those gaps.
>Provide guidance to Magellan business segments to develop appropriate policies
>Review and approval of business segment specific policies
>Distribution of medical policy to all Magellan stakeholders impacted by the policy

The NMPC meets, at a minimum, quarterly. Membership includes standing members and guest medical and clinical specialists who are invited to attend when subject matter expert (SME) review is appropriate. These SMEs may be internal or external. Detailed minutes of each meeting are kept to ensure a record is maintained of all approved, revised and/or denied policies.

The NMPC is chaired by the Magellan Health Chief Medical Officer. The Senior Director of Clinical Network Quality is responsible for documenting the committee proceedings and distributing minutes and other materials to all enrollees. The NMPC may determine that the organization would benefit from the development of a new medical policy. Upon identification of such a need, the NMPC identifies a resource to develop the policy. Once a new policy is approved by the NMPC, it is distributed to the relevant business segments for review, customization and approval by their respective quality committees. Magellan business segments develop policy relevant to their clinical areas of scope. For example, the Behavioral Health business is supported by the Clinical Practice Guideline workgroup, New Technology Assessment Task Force, and the MNC
Taskforce. The Specialty business is supported by the NIA Clinical Guideline Committee. Magellan Complete Care is supported by the Magellan Complete Care Policy Committee. Output from each of these committees is reviewed by the NMPC and upon approval, is distributed to the organization.

The UM Department conducts ongoing analysis and evaluation of its process functions and timeliness metrics including monitoring for consistency in use of medical necessity criteria, potential over/under utilization, timeliness of decision-making for urgent and standard care requests, use of urgent care/ER services, non-urgent care pre-service, concurrent care, and post-service care. Ongoing review of the process used to authorize medical services is also overseen by the HS Committee (HSC). Data is reported on quarterly basis at minimum to the HSC for review and recommendations.

When coverage for a medical or behavioral health service is requested before service is delivered per the authorization provision of the benefit, a HS staff enrollee initiates the process by collecting information. A UM Licensed Health Professional (LHP) applies the clinical criteria against the clinical features of the individual enrollee. If the UM LHP cannot authorize the coverage based upon medical necessity, the request is forwarded to a Medical Director or Physician Advisor for a peer clinical review.

The Physician Advisor applies the clinical criteria using their knowledge and experience. Other clinical review decision support tools may also be referred to during the peer clinical review and the Physician Advisor also determines the necessity of a peer-to-peer conversation with the ordering/rendering provider. The peer clinical review results in a medical necessity decision for the basis of an approval or adverse coverage determination.

Magellan Complete Care notifies the provider and gives the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested in accordance with 42 CFR 438.210(c). Time-to-process and notification requirements for rendering and issuing a coverage determination to appropriate parties are dictated by Magellan policy and are in compliance with state requirements.

1.2 HS Workgroup
The purpose of the HS Workgroup is to support the responsibilities of the Health Service Committee (HSC), the HS Workgroup will monitor and analyze utilization and financial data and provide recommendation based on the analysis to the HSC. The data will be analyzed for the Medical, Behavioral Health and other utilization. The complete recommendation will be reported up through the Magellan committee structure.

Recommendations may include changes in the prior authorization requirements, provider specific interventions, and changes to configuration or contracting. Members of this workgroup will include representative of Analytics, Finance, Pharmacy, Behavioral Health, Utilization Review, Provider Network, including Community Outreach Specialists (COS) and Provider Support Specialists (PSS), Special Investigations, and Case Management. Representatives from other teams such as Vendor Management for Delegation oversight, Customer Service or Delegates will be included as needed.

At least yearly, data will be analyzed to determine prior authorization requirements. These recommendations will be presented to the Utilization Committee and the Quality Improvement
Committee. Grievance and appeal data along with enrollee/provider complaints will be presented in the HS workgroup at least quarterly to monitor for under and over utilization triggers. The HS workgroup will focus on, but not limited to:

Overutilization measures including but not limited to:
1. Inpatient stays per 1,000 enrollees by their PCPs
2. Utilization by provider compared to peer providers
3. Average Length of Stay
4. Readmission data.

Underutilization measures will include but not limited to:
1. Encounters/1,000 (DME, Office visits, selected Behavioral Health and Medical)
2. Inpatient utilization – behavioral and medical
3. HEDIS and other State performance metric results.

The HEDIS data can demonstrate trends in underutilization and is key information that is a national benchmark for identifying areas on which the HS workgroup should focus attention. HS workgroup enrollees who participate in other workgroups of committees will ensure that analysis and interventions are not duplicated and are fully vetted. Utilization data will be compared to the National Benchmarks such as Quality Compass to also assist in identifying over and underutilization.

A subgroup of the workgroup comprised of UM, Behavioral Health and other key directors, managers, and/or Team Leaders will review policy and procedures, workflows, and references tools to provide recommendations to the HS Committee.

1.2.a Frequency of Monitoring and Interventions: Meetings will be held at least quarterly but may occur monthly as critical issues are identified.

1.2.b Venue for Reporting, Monitoring, and Action Planning: HS Workgroup reporting to HS Committee

1.2.c Workgroup Leader: Senior Director of Utilization Management

1.3 Processing Prior Authorization Requests in a Timely Manner
The prior authorization timeliness data below demonstrates significant improvement on key indicators. All targeted metrics exceed the threshold goal of 95 percent. Magellan Complete Care continues to monitor multiple timeliness metrics to ensure compliance with State, federal, and NCQA requirements.

1.3.a Timeframes for Processing Requests for Authorization
Magellan Complete Care complies with the Magellan Complete Care AHCA following contractual standards, measured on a monthly basis, for processing prior authorization requests in a timely manner:

1. Magellan will process 95 percent of all standard authorizations within 14 calendar days.
2. Magellan’s average turnaround time for standard authorization requests will not exceed seven calendar days.
3. Magellan will process 95 percent of all expedited authorization requests within three business days.
4. Magellan’s average turnaround time for expedited authorization requests will not exceed two business days.

Magellan will make a determination and provide written notice of the determination as outlined by contractual and accreditation requirements, as provided in [General SRC #18, Attachment 1: Determination Timeframes by Urgency and Urgency Definitions].

1.3.b Process:
1.3.b.1. Turnaround Time Monitoring for Outpatient (pre-certification) Prior Authorization Requests for both Behavioral and Medical/Surgical subdivisions

a. Description: Utilize Key Performance Indicator (KPI) report to audit 100 percent of standard and expedited prior authorizations not processed within Turn Around Time (TAT) timeframes of 48 hours for expedited and seven days for standard to determine reasons for missed TAT. The HS Auditor (HSA) conducts audits to determine trends by staff or process and identifies needed interventions.

b. Frequency: HSA will review KPI report monthly. If KPI report shows pre-certification authorizations (standard and expedited) fall below 95 percent compliance of being processed within timeframe, then HSA will conduct audits to determine reasons and/or trends.

c. Reporting Frequency:
   >If audits are conducted, HSA will analyze, assess, and report audit results on a monthly and quarterly basis.
   >HSA will report quantitative and qualitative results to the UM Director and the Pre-certification Manager (and the pre-certification team if needed). Management collaborates with Magellan Complete Care trainers to schedule remedial trainings, if needed, and identify opportunities for process improvement.
   >HSA will provide audit results without delay to UM Director and Manager if outcomes of the audit present a risk or if audit results indicate delay that need to be addressed immediately.
   >HSA will provide team with authorization errors that can be corrected and follow up to ensure compliance with corrections.
   >HSA will provide audit results and analysis during quarterly HS Committee meeting.

1.3.b.2 Turnaround Time Monitoring for Inpatient Concurrent Authorization Requests for Behavioral Health Subdivision

a. Description: Use Key Performance Indicator (KPI) report to audit 100 percent of initial/concurrent and concurrent authorizations not processed within Turnaround Time timeframe to determine reasons for missed TAT. The HS Auditor (HSA) conducts an audit to determine trends by staff or process and identifies needed interventions.

b. Frequency: HSA will review the KPI report monthly. If the KPI report shows behavioral health inpatient authorization requests (concurrent) fall below 95 percent compliance of being processed within the 72 hour timeframe, HSA will conduct audits to determine reasons/trends.

c. Reporting Frequency:
   >If audits are conducted, HSA will analyze, assess, and report audit results monthly and quarterly.
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>HSA will report quantitative/qualitative results quarterly to UM Director and IP BH Manager (and
the IP team if needed). Managers will collaborate with Magellan Complete Care trainers to
schedule remedial trainings if needed and identify opportunities for process improvement.

>HSA will provide audit results without delay to UM Director and Manager if outcomes of the audit
present a risk or if audit results indicate trends that need to be addressed immediately

>HSA will provide the team with authorization errors that can be corrected and follow up to ensure
compliance with corrections.

>HSA will provide audit results and analysis during quarterly HS Committee meeting

1.3.b.3 Turnaround Time Monitoring for Inpatient Concurrent Authorization Requests for
Medical/Surgical Subdivision
a. Description: Utilize Key Performance Indicator (KPI) report to audit 100 percent of
initial/concurrent & concurrent authorizations not processed within Turnaround Time (TAT)
timeframe to determine reasons for missed TAT. HS Auditor (HSA) conducts audit to determine
trends by staff or process and identifies needed interventions.

b. Frequency: HSA will review KPI report monthly. If KPI report shows medical/surgical IP
authorizations requests (concurrent) fall below 95 percent compliance of being processed within
the 72 hour timeframe, HSA will conduct audits to determine reasons/trends.

c. Reporting Frequency:
> If audits are conducted, HSA will analyze, assess, and report audit results monthly and quarterly

>HSA will report quantitative/qualitative results quarterly to UM Director and IP PH Manager (and
the IP team if needed). Managers will collaborate with Magellan Complete Care trainers to
schedule remedial trainings if needed and identify opportunities for process improvement.

>HSA will provide audit results without delay to UM Director and Manager if outcomes of the audit
present a risk or if audit results indicate trends that need to be addressed immediately

>HSA will provide team with authorization errors that can be corrected and follow up to ensure
compliance with corrections.

>HSA will provide audit results and analysis during quarterly HS Committee meeting

1.3.b.4 Notice of Adverse Benefit Determination
a. Magellan shall notify the provider and give the enrollee written notice of any decision to deny a
service authorization request, or to authorize a service in an amount, duration or scope that is
less than requested.

b. For standard authorization decisions, Magellan shall provide notice as expeditiously as the
enrollee’s health condition requires and within no more than seven calendar days following receipt
of the request for service.
c. The timeframe for standard authorization decisions can be extended up to seven additional calendar days if the enrollee or the provider requests extension or Magellan justifies the need for additional information and how the extension is in the enrollee’s interest.

d. Expedited authorization is required when a provider indicates, or Magellan determines, that following the standard timeline could seriously jeopardize the enrollee’s life or health or ability to attain, maintain or regain maximum function. An expedited decision must be made no later than forty eight hours after receipt of the request for service.

e. Magellan may extend the timeframe for expedited authorization decisions by up to two additional business days if the enrollee or the provider requests an extension or if Magellan justifies the need for additional information and how the extension is in the enrollee’s interest.

1.3.b.5 Turnaround Time Monitoring for Notice of Adverse Benefit Determination

a. Description: Utilize Internal Denial reports to monitor/review 100 percent of all adverse benefit determinations daily, monthly and quarterly.

> Daily
>> Denial Letter Unit reviews daily denial report to identify all adverse determinations that missed timeframe, as specified in our internal Policies and Procedures.
>> Report is sent to UM Director and Managers, so they can identify percentage that missed the timeframe and identify the reason for missing turnaround time as well as trends.
>> UM Director and Managers follow up with staff to ensure compliance.

> Monthly
>> Denial Letter Unit Manager reviews daily and monthly Denial letter reports and submits a summary with findings to UM Director, Compliance department and Vice President of HS on a monthly basis. The report includes a summary of the total adverse benefit determinations and percent of compliance (total and by level of urgency).
>> The report includes areas that fall below 95% benchmark and reasons why turnaround time was missed.
>> Action Plan is developed by UM Director and Managers if any of the areas fall below benchmark and present a risk. Action Plan is in place to ensure compliance does not fall below benchmark and is modified as needed.

> Quarterly
>> A quarterly report with monthly compliance, analysis and action plan is presented during quarterly HS Committee.

1.3.c Monitoring of Turnaround Times
Magellan Complete Care demonstrates compliance with the following standards, measured monthly, for processing authorization requests in a timely manner:

Percent of Expedited Requests Processed within TAT (48 Hours): 96.12 percent
Percent of Expedited Requests Processed within TAT (72 Hours): 98.43 percent
Percent of Standard Requests Processed within TAT (7 Calendar Days): 98.81 percent
Percent of Standard Requests Processed within TAT (14 Calendar Days): 99.26 percent
Magellan Complete Care submits a monthly report of the authorization timeliness standards to the Agency as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

1.4 UM Clinical Decision Support Tools
In addition to compliance with the Florida Medicaid Handbooks, Magellan Complete Care uses developed or adopted clinical criteria that serve as the primary decision support tools for the UM program.

We have adopted Milliman Care Guidelines as a set of national standardized criteria for the management of physical health services. We also developed and maintain proprietary clinical criteria, Magellan Healthcare Guidelines for best practice, for the management of behavioral health services.

We also use proprietary diagnostic services criteria for imaging, sleep studies, and certain pain management procedures. These criteria sets are based on sound scientific evidence for recognized settings of care and used to decide the medical necessity and clinical appropriateness of services. If state law requires additional criteria, it is adopted into policy and used.

Criteria are utilized with consideration given to characteristics of the local delivery systems and services available for specific enrollees. We also consider enrollee-specific factors, such as enrollee’s age, co-morbidities, complications, progress in treatment, psychosocial situation, and home environment, while simultaneously ensuring consistent application of guidelines across all enrollees.

Medically necessary services – Magellan Complete Care will provide services to enrollees in accordance with medical necessity requirements set forth in 42C.F.R. 438.210, Coverage and Authorization of Services. Medicaid defines medically necessary services as services that are necessary for the diagnosis or treatment of disease, illness, or injury and without which the enrollee can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part or significant pain and discomfort. A determination of whether a covered benefit or service is medically necessary will be based on an individualized assessment of the enrollee’s medical needs. To be a medically necessary service, a covered benefit shall be:

> Reasonable and required to identify, diagnose, treat, correct, cure, palliate or prevent a disease, illness, injury, disability or other medical condition, including pregnancy

> Appropriate in terms of the service, amount, scope and duration based on generally accepted standards of good medical practice

> Provided for medical reasons rather than primarily for the convenience of the enrollee, the enrollee’s caregiver, the enrollee’s health care provider or cosmetic reasons

> Provided in the most appropriate location, with regard to generally accepted standards of good medical practice, where the service may be for practical purposes and be safely and effectively provided

> Needed, if used in reference to an emergency medical service using the prudent layperson standard
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> When applicable, provided in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT/CHCUP) requirements established by federal and state law

> Provided in an amount, duration, and scope to achieve its stated purpose

> Be the lowest cost alternative that effectively addresses and treats the problem

> Not arbitrarily denied or reduced in amount, duration, or scope, solely because of the enrollee’s diagnosis, type of illness or condition

Nationally accepted, evidence-based criteria, developed by specialty organizations, national policy committees (clinical practice guidelines) and/or industry recognized review organizations in addition to State or Federal criteria or regulations (as appropriate), medical policy or internally developed criteria, physician and clinical judgment are used to evaluate the necessity of medical and behavioral health services requested for both initial determinations and clinical appeals.

Magellan Complete Care utilizes Milliman medical determination/decision criteria to assist in the determination review of medical necessity. In accordance with 42 CFR §438.236 the Contractor shall use ASAM criteria for medical necessity determinations for all Addiction and Recovery Treatment Services (ARTS) to any Enrollee or contracting provider upon request.

The Magellan Complete Care medical necessity criteria are listed on our website and are available by hard copy upon request. The criteria used as the basis of an individual service determination is in the notice of action letters and is also available upon request. The Florida Medicaid Handbooks, Milliman Care Guidelines, and the Magellan Healthcare Guidelines are all embedded in our documentation TruCare care management system under “resources”. TruCare is our clinical documentation system.

If the need goes beyond the UM clinical decision support tools, we request a review from our Medical Directors.

1.5 Reviewing Complaints and Feedback from Providers
Magellan Complete Care reviews all complaints and feedback from providers regarding burdensome or unnecessary prior authorization criteria, and we endeavor to incorporate improvements as they are identified, as illustrated in the following four examples.

Example 1: We worked collaboratively with our providers to revise our Provider Authorization Form for ease of use. Provider feedback directed us to look at the length of the form. The Magellan Complete Care UM department revised the form and reduced the amount of information that we were requesting provider office staff to complete. As a result, we created the “Behavioral Health Outpatient Prior Authorization Request Form”, available on our website through the provider portal anticipated roll out will be conducted within the 4th quarter 2017.

Example 2: To assist providers, Magellan Complete Care UM Department developed two tools: 1) the “Quick Authorization Form for In-Network Providers” and 2) the “Prior Authorization Guide”. With these tools, providers have easy access to determine if a service(s) requires prior authorization, have a general idea of Magellan Complete Care covered services, and contracted and/or delegated services. These tools are available on the Magellan Complete Care website under the provider tab.
Example 3: We worked collaboratively with our providers to ease the prior authorization requirements for the OB ultrasound service authorization requirement. We received provider feedback stating that other plans did not require prior authorization for OB ultrasound. In order to make it less complicated for providers to obtain a service authorization for OB ultrasound, we reviewed utilization of this service.

After further discussion and revision, we decided to lift the OB services authorization requirement for both in-network and out-of-network providers. This includes OB ultrasound procedures, monitoring of OB ultrasounds, biophysical profiles, and the Vessel Doppler ultrasounds. This change took effect on February of 2016.

We also made this decision in an effort to assist our high risk enrollees seeking prenatal care. We continue to monitor the utilization of this service on a monthly basis during our monthly meeting with Magellan National Imaging Associates (NIA), our affiliate.

Example 4: Magellan Complete Care uses a multidisciplinary approach to expeditiously review the “Quick Provider Authorization Form” at least annually to mirror and align with the Medicaid fee schedule and ensure that all expired codes are deleted and new codes added. Enrollee and provider feedback regarding the ease of use of our form and process is also considered when updating this form. Magellan Complete Care continually monitors and evaluates under-utilization, over-utilization and inappropriate utilization of services on an ongoing basis and implements processes to address opportunities for improvement. UM Managers monitor the authorization process, especially to evaluate concurrent review authorization, which is an additional means to ensure consistent application of review criteria for authorization decisions, as well as to ensure minimal impact or disruption to care for providers or enrollees.

CRITERIA 2: THE ADEQUACY OF THE PROCESSES USED BY THE RESPONDENT TO DETERMINE...

The Magellan Board of Directors has the ultimate authority and responsibility for the quality of Magellan’s services and the delivery of medical and behavioral services to enrollees. The Board of Directors designates the Magellan Enterprise Quality Council (EQC) to have broad oversight of the Magellan Quality Improvement Program. The Integrated Health Committee (IHC) is a subcommittee of the EQC and is responsible for all Magellan integrated health programs. The Magellan Complete Care Quality Improvement Committee operates at the state level to fulfill its oversight role for the utilization management program and to enhance coordination of goals and objectives between departments.

2.1 Magellan Complete Care Committee Oversight
The role, functions and participants of the Magellan Complete Care Quality Improvement Committee (QIC) is fully described in the Magellan Complete Care Quality Improvement Program Description. The QIC is co-chaired by the Medical Director and the Quality Director.

The following outlines the Magellan Complete Care QIC functions associated with the Utilization Management (UM) program:

> Review, revise as needed, and approve the Magellan Complete Care UM Program, goals and related policies annually.
Review and approve a formal annual evaluation of the Magellan Complete Care UM Program contained within the Magellan Complete Care QI Program Evaluation.

Recommend actions as needed to address aggregate and trended utilization program outlier performance.

Oversee assigned work groups designated to: develop or adopt; review; and update or re-adopt, the UM clinical decision support tools, which include:

- Milliman Care Guidelines (MCG)
- Magellan Healthcare Guidelines
- Magellan Imaging Medical Necessity Criteria for diagnostic testing such as MRI, CT scans, and sleep studies.
- Magellan Pharmacy Criteria
- American Society of Addiction Medicine (ASAM -Florida modified version) criteria for substance abuse

Evidence-based clinical practice guidelines for preventive care and prevalent conditions are also reviewed and adopted by the Magellan Complete Care QI Committee. The Magellan Complete Care QIC includes standing UM items on its agenda to monitor the UM program for effectiveness and effect on its enrollee population within customer requirements and state regulations.

The following committee functions are performed at least annually:

- Review, customize as needed, approve and implement policies and procedures that are associated with the scope and activities of the UM program including a UM program description.
- Approve the Prior Authorization List, or as often as needed
- Review approved updates to medical necessity criteria
- Review findings, trends and interventions of QI Work Plan performance monitoring of the UM program
- Evaluate Magellan Complete Care’s UM program’s effectiveness and document within the Magellan Complete Care QI program evaluation
- Develop and periodically revise as needed Magellan Complete Care thresholds for the quantitative and qualitative evaluation of optimal medical and behavioral resource utilization (under or over utilization) in relation to experience, insured individual characteristics, medical and behavioral healthcare delivery network characteristics and customer requirements.
- Analyze input from providers and enrollees related to the UM program
- Review performance of any UM delegates
Review and evaluate patterns of care and patient safety practices, such as authorization turn-around time, and inpatient/outpatient care outcomes, drug utilization, complaints, quality of care concerns, adverse incidents and inter-rater reliability statistics.

Recommend strategies to increase compliance with clinical policies and procedures.

Ensure congruence with benefit coverage and enrollee communications.

Facilitate communication with network practitioners and providers regarding the UM Program, including updates to utilization management processes and progress in achieving QI Program goals, via provider newsletters, fax and web broadcasting, memorandums and periodic provider meetings.

Perform oversight monitoring of appeals for trends that may indicate the need for additional review of the UM review determinations.

The HS committee meets at least quarterly. Meeting frequency to fulfill all HS commiments is determined annually by Magellan Complete Care. Participation by the Magellan Complete Care Chief Medical Officer or Senior Medical Director, Vice President, HS, Senior Director of Utilization Management, QI lead, Compliance, Community Physician, Population Health, Pharmacy lead, and either the CEO or COO is required. The committee co-chairs or designee maintain approved meeting minutes.

The Magellan Complete Care HS committee has oversight of policy, procedures and metrics including but not limited to the following:

Procedures for handling suspected and/or confirmed fraud and abuse information identified through the utilization management program to the Agency’s MPI as described in Section VIII, Administration and Management, and referenced in 42 CFR 455.1(a)(1);

A procedure for enrollees to obtain a second medical opinion at no expense to the enrollee and for the Health Plan to authorize claims for such services in accordance with s. 641.51, F.S.

Service authorization protocols for prior authorization and denial of services; the process used to evaluate prior and concurrent authorization; mechanisms to ensure consistent application of review criteria for authorization decisions; consultation with the requesting provider when appropriate, hospital discharge planning, input of practitioners regarding the UM program’s implementation and criteria; and ensuring the consistent application of review criteria for authorization decisions and consulting with the requesting practitioner when appropriate.

Magellan policies provide comprehensive standards based upon regulations and accreditation requirements for UM program activities summarized in this document.

These policies are reviewed on an annual basis. In addition, procedures are reviewed annually and updated on an as needed basis. The policies and procedures provide documentation of the framework of authority in which the Utilization Management program operates.
Below is a snapshot of the clinical solutions we provide to assist in efforts to reduce costs, improve quality and the health and well-being for our enrollees. Our portfolio of successful cost containment strategies includes, but are not limited to the following:

> Formulary support, management, and compliance
> Utilization management (supported through system edits)
> Drug utilization review (DUR)
> Prior authorization (PA)
> Disease interventions and management programs
> Generic medications promotion
> Medication awareness programs (ex: Whole HealthRx, LARC initiative, etc.).

The UM Program and the Quality Improvement Committee (QIC) work together to ensure the health and well-being of individuals enrolled in Magellan Complete Care through the development and administration of health care benefits and health case coordination processes that facilitate availability and accessibility of services in accordance with corporate policies, Federal, State, and local regulations and accreditation standards. The UM Program’s purpose is to support optimal use of healthcare services for the evaluation, treatment, and integration of medical and behavioral health conditions and safeguard against unnecessary and inappropriate medical care delivered to Medicaid enrollees. Enrollee medical services and/or records are reviewed for medical necessity, quality of care, appropriateness of place of service, and length of stay (inpatient hospital).

Magellan Complete Care has a strong UM program, including experienced staff, evidence-based guidelines, and expeditious and transparent processes. Magellan Complete Care brings the following strengths to the SMI Specialty Plan for authorization of services:

> Our parent company’s behavioral health expertise
  >> Founded in 1969 as a pioneering managed behavioral health organization, Magellan has decades of experience managing enrollees with complex multi-system needs in programs across the U.S.
  >> Corporate support and UM experience with similar contracts and populations – enhances the experience for SMI Specialty Plan enrollees in Florida
> Our model of care is unique with collaboration between all departments
  >> Includes physical and behavioral health staff who work together for SMI Specialty Plan enrollees
  >> The UM team is a unique blend of staff with clinicians who have medical and behavioral health backgrounds e.g., Social Workers, LPN, RNs, doctorate level professionals, who all understand the SMI population
  >> Our integration/collaboration between the UM team and the hand off to the Clinical Coordination Team to manage our enrollees is also unique as both teams focus on quality of service together
  >> The intensive training that staff receives addresses medical and behavioral health services, UM service authorization protocols, community-based services, transitions of care, end of life issues, and palliative care
> Infrastructure to approve and support the creation and application of evidence-based guidelines and criteria for use in determining medical necessity
>>These criteria are created and applied based on the unique needs and conditions found in the Medicaid population in Florida
>>The UM Department is staffed by authorization representatives who process all requests for authorizations
>>Authorization determinations are made by licensed reviewers based on medical necessity and appropriateness and reflect the application of our approved review criteria and guidelines.
>>The Magellan Complete Care Medical Director oversees the clinical aspects of the program. The Senior Medical Director and BH Medical Director are responsible for both physical and behavioral health adverse determinations (respectively) and both participate in HS Committee meetings.

Magellan Complete Care’s UM Program and dedicated UM staff use our Florida experience as a strong foundation to develop models and approaches to UM that are based on standardized and compliant UM guidelines and review criteria. In addition, they reflect the provider community, and a detailed understanding of services, interventions, and outcome goals that best meet the needs of delivering medically necessary services and quality of care for this very complex population.

Magellan Complete Care has and will continue to determine whether the UM criteria selected are appropriate and consistent with policy requirements for a Medicaid benefit. Our written policies and procedures include detailed standards, clinical practice guidelines, review criteria, turnaround timeframes, and other requirements relevant to making medically necessity determinations related to, but not limited to: level of care, place of service, scope of service, and duration of service.

Magellan Complete Care adopts medical necessity guidelines that meet the following requirements (42 CFR 438.236(b)(1)):

>Are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field; (42 CFR 438.263(b)(1))
>Consider the needs of the enrollees; (42 CFR 438.236(b)(2))
>Are adopted in consultation with providers; (42 CFR 438.236(b)(3)) and
>Are reviewed and updated periodically, as appropriate (42 CFR 438.236(b)(4)).

As stated previously, in addition to compliance with Florida Medicaid policy (we always look at the Medicaid policy first), Magellan Complete Care uses covered benefits and developed or adopted clinical criteria that serve as the primary decision support tools for the UM program. We have adopted Milliman Care Guidelines for the management of physical health services, behavioral health acute services and other behavioral services as identified in our Magellan Complete Care Guidelines. Magellan Complete Care Behavioral Health has also developed proprietary clinical criteria for specialty behavioral outpatient and other services as well as Florida Medicaid service-specific policies.

The National Medical Policy Committee (NMPC) is responsible for the review and approval of Magellan medical policy. Medical policy consists of clinical utilization management criteria, clinical practice guidelines, new technology assessments and other medical management policies. The NMPC is chaired by the Magellan Health Chief Medical Officer. The NMPC may determine that the organization would benefit from the development of a new medical policy. Upon identification of such a need, the NMPC identifies a resource to develop the policy. Once a new policy is approved by the NMPC, it is distributed to the relevant business segments for review,
customization and approval by their respective quality committees. Magellan business segments develop policy relevant to their clinical areas of scope. Magellan Complete Care is supported by the Magellan Complete Care Policy Committee. Output from each of these committees is reviewed by the NMPC and upon approval, is distributed to the organization.

Magellan Complete Care disseminates any revised practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees (42 CFR 438.236(c)). We ensure consistency with regard to all decisions relating to UM, enrollee education, covered services, and other areas to which the practice guidelines apply (42 CFR 438.236(d)).

Prior authorizations are not required to access emergent or non-emergent eligibility screening, or crisis services. Inter-rater reliability reviews are also evaluated to ascertain that UM criteria are applied consistently by staff completing utilization review determinations.

2.2 Process to Confirm Appropriateness of UM Criteria
The Magellan Complete Care process used to determine whether UM criteria selected are appropriate and consistent with policy requirements for a Medicaid benefit includes the following 11 components:

2.2.a TruCare Care Coordination Documentation System: The Florida Medicaid Handbooks, Milliman Care Guidelines, and the Magellan Healthcare Guidelines are all embedded in TruCare under “Resources”:

>TruCare is our internal automated authorization system. Prior authorization requests are submitted electronically via Magellan Complete Care Provider Portal, as required in s. 409.967(2)(c)3., F.S. The authorization request is transferred to TruCare where it is reviewed for medical necessity.

>For ease of use, everything is within one system to access and exchange data, including fee schedules. For example, if staff look for durable medical equipment (DME), they would look at the Handbook for the limitations and coverage.

>Magellan Complete Care provides written notice of all denials, service limitations and reductions of authorization to providers and enrollees through the mailed Notice of Adverse Benefit Determination letter (42 CFR 438.210(c).) Participating providers are able to see status of “DENY/APPROVE/PARTIAL APPROVE” on the website, but we notify them via fax for real time notification and a mailed letter. In 1st quarter 2018 providers will be able to review a copy of any determination correspondence via the web portal.

>TruCare provides the authorization number and effective dates for authorization to providers and nonparticipating providers via the Notice of Adverse Benefit Determination letter. For participating providers, the portal also provides an authorization number and effective dates for authorization

2.2.b UM Department Oversight: Under the direction of the Director of UM, the UM Managers are responsible for the day-to-day management of the UM process including requests for behavioral and physical health services; discharge planning; second medical opinion; out of network services; all medical necessity appeals processes, and related work. The UM Managers assist the Director of UM and our Chief Medical Director, to monitor under- and over-and inappropriate utilization.
2.2.c Full-time Auditor: Reporting to a UM Manager, the HS Auditor conducts ongoing reviews to make sure that UM processes are carried out in compliance with state, federal and/or accreditation requirements. Monthly audits are completed for clinical reviewers to make sure criteria being used are consistent and to make sure clinical information reviewed supports criteria and determination. Auditing is performed through random selection. Results are shared with management and staff providing oversight on a monthly basis to identify issues and improve current processes. If a risk is identified, UM Managers and Director immediately implement strategies to improve performance and resolve non-compliance area. Trends of such findings are presented in the HS Committee.

2.2.d Quality Monitoring of the UM Activities: Magellan Complete Care assures and monitors continuous quality of utilization management activities performed by the UM Professionals and Medical Directors and the quality of utilization management activities performed by non-clinical utilization management support staff by performing quality assurance reviews and developing standards by which activities are measured. The standards of excellence quality assurance reviews are the mechanism by which Magellan Complete Care monitors UM activity for accuracy, consistency, completeness, completeness, and compliance by conducting documentation quality monitoring and inter-rater reliability.

2.2.e Inter-rater Reliability (IRR) Testing on a Quarterly Basis: To assure and ensure consistent application of review criteria, we perform IRR testing on a quarterly basis this allows for real time information and feedback to ensure consistent application of criteria and formulate additional training plans. We use this as an educational tool for the UM team. Training, coaching, and mentoring for UM staff with regard to their clinical decision-making and use of the medical necessity criteria (MNC) continues through daily rounding with the Medical Directors for behavioral and physical health. Training on MNC for both behavioral and physical health is delivered as part of our curriculum for all newly hired UM staff. The Clinical Training Manager and Medical Director for Behavioral Health provide training on updates to the Magellan Complete Care Medical Necessity criteria.

2.2.f Daily Documentation Monitoring:
> Daily census report – Monitor new admissions, concurrent admissions, and review associated determination timeframes

> Daily TAT report: Report allowing Magellan Complete Care management team to closely monitor TAT of individual UM department cases assigned

> Staff Productivity Report (daily, monthly weekly): Provide Magellan Complete Care management team the ability to monitor ongoing staff productivity, to assure UM criteria are appropriate and consistent.

> Daily Aging Report: Review on a daily basis, share with staff as cases are coming due, ensures compliance with state and accreditation TAT requirements.

2.2.g Daily Pre-rounding with Managers:
The UM Management team, which includes UM professionals (e.g., LPNs, RNs) complete daily rounds with managers or team leads. They review all inpatient cases to ensure that enrollees have the most appropriate level of care and to ensure the inpatient criteria was applied
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consistently. They also review to verify that the staff reviewed enrollee rationale, gaps, treatment
plan, and discharge planning; as well as any further services the enrollee needs at discharge.
Cases that need a higher review are referred to the medical staff and the physician to ensure
enrollees meet the level of care, discharge care, and assistance.

The reviewers share the case to confirm all needed information has been captured and
documented. This is presented to the Medical Director to ensure we address all care areas with
care collaboration between care coordination and discharge planning. Pre-rounds are also utilized
to guarantee that all areas of an individualized transition/discharge plan are addressed, to include
the BH/PH integration and care coordination involvement. This is also used as an educational
platform for the health services team enrollees to understand how to manage difficult cases,
prepare for discharge planning, care transitions and coordination with other enrollees of the health
services team.

2.2.h Daily and Ad Hoc Rounding with Medical Staff

> For cases where we need an external board certified physician specialist reviewer to provide
consultative services: Magellan Complete Care utilizes URAC accredited Independent Review
Organizations (IRO). The role of the IRO advisor is to make independent medical necessity and
appropriateness decisions and to provide independent medical consultation and
recommendations to Magellan Complete Care medical and care management staff. The role of
the IRO is to:
>> Provide independent peer review activity function, including review for medical necessity, level
of care, quality, and appropriateness of care.
>> Perform peer review by communicating directly with clinicians and/or by reviewing clinical
records.
>>> Interact with clinicians in a timely manner (usually the same day) and usually takes place
between peers. While peer to peer interactions are often preferred, psychiatrist physician advisors
may be called upon to review care and interact with all levels of therapists.
>> Perform second level of review for second opinions and appeals as requested.
>> Offer expert consultation and advice to formal committees as recommended by the Medical
Director

2.2.h Corporate Quality Monitoring and Auditing: Our Quality Monitoring and Auditing process is
a mandatory component of the program. As part of the annual risk assessment process, Internal
Audit selects certain aspects of our processes for review. Internal Audit also allocates time to
assist management throughout all parts of the organization with requested projects:

> As part of the annual planning process, Internal Audit selects certain aspects of our processes
for review, based on a risk assessment. Internal Audit also allocates time to assist management
throughout all parts of the organization with requested projects
> There is a local dedicated team assigned to the QM and Auditing process

> The Quality Monitoring and Auditing Program utilizes a comprehensive, systematic approach
through activities that include Evaluate, Prevent, Detect, and Improve Processes:
>> We have developed individualized quality auditing and monitoring tools specific to our clinical
programs to ensure that enrollees receive safe, high quality, and cost-effective care and services.
>> The monitoring approach is used with more intense scrutiny at the onset of new program launch
and transition until such time that the provider or delegate demonstrates that their performance
meets appropriate quality levels. We use a sampling method, frequency of review, and feedback process which has been modeled after NCQA standards and best practice.

>>Based on the findings of the QM auditing program UM will: (i) immediately remediate all individual findings identified through its monitoring process; (ii) track and trend such findings and remediation through the HS and Quality Improvement Committees to identify systemic issues of marginal performance and/or non-compliance - especially those potentially impacting enrollee satisfaction and health outcomes; (iii) implement strategies to improve provider performance and resolve areas of non-compliance or enrollee dissatisfaction; and (iv) measure the success of such strategies in addressing identified issues.

Results and any required performance improvement activities are tracked and maintained in the quality improvement work plan to demonstrate progress towards goals.

CRITERIA 3: THE ADEQUACY OF THE RESPONDENT'S APPROACH TO ENSURE THE CONSISTENT APPLICATION OF REVIEW CRITERIA FOR AUTHORIZATION DECISIONS…

Magellan Complete Care ensures the consistent application of review criteria through the adoption of Magellan Healthcare Guideline criteria. As noted above, all service authorization requests are run through the Magellan Healthcare Guideline criteria to determine if the request meets the evidence-based guidelines.

UM staff have been trained on the appropriate use of Magellan Healthcare Guideline criteria and a review of the application of Magellan Healthcare Guideline criteria is part of the quarterly evaluation of accuracy and consistency performed for all reviewers.

Further, the Senior Director of UM as well the UM managers perform ongoing monitoring of UM reviewer criteria/ guideline application through daily staff rounds to:

>Measure the reviewer’s comprehension of the review criteria and guideline application
>Ensure accurate and consistent application of the criteria among staff reviewers, and
>Ensure a peer review process for IRR.

Magellan Complete Care employs a multi-faceted approach to monitoring the accuracy and appropriateness for the consistent application of review criteria for authorization decisions. The approach includes the use of technology through the documentation system, TruCare, IRR studies, SMI Specialty Plan provider training, weekly clinical training, utilization call monitoring, documentation audits, full-time Auditor, inter-departmental communication, case audits, ongoing data analyses, physician peer review, Care Coordination / Case Management audits, and reporting.

The HS Committee has oversight of policy, procedures, and metrics to ensure the consistent application or review criteria for authorization decisions, including but not limited to the following:

>Procedures for handling suspected and/or confirmed fraud and abuse information identified through the UM program to the AHCA Medicaid Program Integrity (MPI) as described in Section VIII, Administration and Management, and referenced in 42 CFR 455.1(a)(1)

>A procedure for enrollees to obtain a second medical opinion at no expense to the enrollee and for the Health Plan to authorize claims for such services in accordance with s. 641.51, F.S.
Service authorization protocols for prior authorization and denial of services: The process used to evaluate prior and concurrent authorization; mechanisms to ensure consistent application of review criteria for authorization decisions; consultation with the requesting provider when appropriate, hospital discharge planning, input of practitioners regarding the UM Program's implementation and criteria; and ensuring the consistent application of review criteria for authorization decisions and consulting with the requesting practitioner when appropriate.

We provide more details on the following from our multi-faceted approach to monitoring the accuracy and appropriateness for the consistent application of review criteria for authorization decisions:

3.1 Consistent Application of Review Criteria through Technology: TruCare
As of July 2017, in-network providers are able to see the status of an authorization through the Magellan Complete Care provider portal, including status, authorization number, and date of service. Providers are able to request a prior authorization instead of submitting by fax.

In addition, providers can also visit the Magellan Complete Care website to obtain additional information regarding codes that do not require prior authorization; see [General SRC #16, Attachment 2: Provider Portal Screenshot].

3.2. Consistent Application of Review Criteria through Inter-rater Reliability Auditing and Testing for Staff
The degree to which clinical UM staff consistently apply the clinical criteria (inter-rater reliability) is evaluated at least quarterly using performance measurements approved by the HS committee. When measurement results are determined to be below performance expectations, a quality improvement activity is initiated to improve consistency in which the clinical criteria are applied, and/or recommendations are made for clarifying revisions to be made.

This process includes physicians and non-physicians making medical and behavioral health determinations. Cases are also reviewed at identified intervals as part of a group educational process; these include but are not limited to daily Case Rounds with the medical directors to highlight determinations and problem cases. When areas of improvement are identified, processes are developed or revised. Staff education may also be provided.

The goals of utilizing IRR testing as an educational tool, include, but are not limited to:

> Minimizing variation in the application of clinical guidelines
> Evaluating staff's ability to identify potentially avoidable utilization
> Evaluating staff's ability to identify quality of care issues
> Targeting staff needing additional training, and
> Avoiding complaints and enrollee inconvenience due to inconsistently applied criteria

The Senior Director of UM also conducts and/or oversees randomized audits of denials and the daily work of the UM staff. When there are issues or concerns, a process improvement plan is developed based on the findings. Areas of improvement which are identified as part of the audit are then discussed with individuals and/or at departmental staff meetings and appropriate changes are made in the department’s processes. If staff fails to meet these standards or improvement goals, we employ staff training, close monitoring for at least three months to ensure understanding of the IRR project.
In addition, Milliman staff offer refresher training to make sure staff follow, understand, and consistently apply review criteria. Milliman training is scheduled on a quarterly basis for staff. We also have three HS clinical trainers available for staff.

Any system issues that have been identified are addressed in global training opportunities.

3.3 Consistent Application of Review Criteria through Staff Training
All clinical staff receive extensive training on the appropriate application of the medical necessity criteria and the policies and processes to ensure enrollees receive medically necessary services. Training occurs at orientation and on an ongoing basis and when changes occur in the medical necessity criteria, or Magellan Complete Care UM processes and policies. At a minimum, it occurs annually.

In addition, we offer clinical training sessions on topics specific to the SMI population. For Magellan Complete Care to meet its goal to provide the right service at the right time for the right amount of time, the clinical staff receive ongoing education to ensure clinical best practices and process are followed.

The training sessions address topics that are critical to clinical staff’s performance with regard to the accuracy and appropriateness of authorization determinations, including:

> AHCA’s medical necessity definition, the Florida Medicaid Handbooks, review criteria including Magellan Care Guidelines, CMS Coverage Determinations Manual, NCD Manual, and other internally developed clinical policies and guidelines such as Magellan Care Guidelines for outpatient behavioral health criteria, and Guidelines for Physician Advisor Review and Peer to Peer requests

> Prior authorization requirements such as form completion, timelines, consultation opportunities, referral to the Medical Director/behavioral health peer reviewer, adverse determinations, medical necessity appeals, and appropriate documentation of decision making activities

> Concurrent review and discharge and transitional care planning

> CC/CM and Disease Management/Population Health including referral triggers and regional issues

> QI including quality of care concerns and current health plan initiatives

> Enrollee and provider complaints and grievances

> Performance standards, productivity goals, IRR testing, medical records audit, and quality

> Monitoring for under-, over-, and inappropriate-utilization

> HIPAA and confidentiality of medical records

> Detection and reporting of fraud, abuse, and waste

In addition to the above mentioned training sessions, we offer ongoing educational Lunch and Learn opportunities. All Lunch and Learn educational sessions include an agenda, evaluation,
and quiz. The June 2017 session was about identifying common chronic conditions and evaluating the acute manifestations that may require an observation or inpatient admission.

In 2016, we transitioned from InterQual to Milliman Care Guidelines Medical Necessity Criteria to be used for physical and behavioral determinations. Providers and AHCA were notified of the change and notification to providers was posted on our website. Ongoing staff trainings were scheduled three weeks prior to go live, as well daily lessons learned meeting were conducted after go live to ensure no gaps or issues with the use of Milliman Care Guidelines. Additional refresher sessions hosted by Milliman are planned at least quarterly throughout 2017.

Comprehensive, role-specific training was delivered to each of our UM teams dedicated to inpatient concurrent review for both physical and behavioral health, physical and behavioral health precertification, retro and denial requests.

The implementation included role specific training on the following licensed MCG products: Inpatient and Surgical Care, General Recovery Guidelines, Multiple Condition Management, Recovery Facility Care, Home Care, Common Complications and Conditions, and Behavioral Health Guidelines.

This training consisted of a content overview and hands-on practice for each group. Case Studies were provided and users were observed while working through each case. Cases were then discussed and reviewed among each group to ensure and verify consistent understanding and execution in each product.

During implementation of the new criteria, support was provided to observe individual users, assess skill level and provide additional instruction for consistent understanding and use across users. This was done with floor support and daily calls with individual users, training staff, UM Managers and subject matter experts from MCG and our technical support teams.

As part of our annual training plan we will be delivering a minimum of quarterly training for all staff along with a formal inter-rater reliability assessment.

Both the behavioral health and physical health assessments were made available to our clinical review staff in 2016 and assessments were assigned to staff based upon their area of focus with establishment of an individual passing score of 98 percent for behavioral health. These thresholds were set in accordance with standard guidelines for each criterion. The assessments were completed by identified staff and results were analyzed for areas of consistent difficulty across test takers.

The following illustrates the 2017 behavioral health Utilization Management Professionals (UMPs) and Managers IRR results. The IRR requirement is annual however, Magellan Complete Care made an internal decision to conduct IRR for clinical staff including Medical Directors, quarterly.

> Total Participants – BH UMPs and Managers: 29
> Number of IRR Cases Taken Overall: 78
> Number of Cases Passed: 76
> Percentage of Cases Passed: 97.4 percent
> Director and Manager’s Passing percent (10/10): 100 percent
> UMP Passing percent (66/68): 97 percent.
The following outlines the 2017 physical health UMPs and Managers IRR results:

>Total Participants - PH UMPs and Managers: 26
>Number of IRR Cases Taken Overall: 66
>Number of Cases Passed: 63
>Percentage of Cases Passed: 95.4 percent
>Director and Manager’s Passing percent (8/8): 100 percent
>UMP Passing percent (55/58): 94.9 percent.

The following summarizes the 2017 behavioral health physician IRR results:

>Total BH Physician Participants: 2
>Number of IRR Cases Taken Overall (4 BH, 2 PH): 6
>Number of Cases in Agreement: 6
>Percentage of Cases in Agreement: 100%

Finally, the following summarizes the 2017 physical health physician IRR results:

>Total PH Physician Participants: 3
>Number of IRR Cases Taken Overall (6 PH, 3 BH): 9
>Number of cases In Agreement: 7
>Percentage of Cases in Agreement: 77.7 percent

Medical Directors (MD) met after the final IRR results were published to go over the IRR cases and the results. After careful review of the cases, all MDs were in agreement on the final decisions. We will be adding following options (level of care) to the MD IRR: observation level, met criteria, not met criteria, and lack of clinical info.

3.3.a Action Plan for Staff Failing to Meet the Targeted Score
>1:1 training with the managers to improve their Retest scores
>MCG conducted multiple training sessions
>>06/20/2017 12pm – MCG Training for Precert BH
>>06/20/2017 10:30am – MCG Training for Precert PH
>>MCG Training 06/09/2017 10:30am – BH CCR
>>MCG Training 06/07/2017 10:30am – PH CCR
>>MCG Refresher 06/06/2017 10:30am – PH CCR

3.4 Consistent Application of Review Criteria through Provider Training
Magellan Complete Care views each service request as an opportunity to educate providers and to ensure that each enrollee receives the right care, at the right time, in the right setting and with the right outcome. Over time, these interactions reshape provider behaviors, promote integration of care, and guide treatment patterns towards the evidence-based practices that we advocate.

As part of our ongoing training series and during the mandatory provider orientation, Magellan Complete Care shares information about its authorization protocols, practice guidelines, medical necessity criteria and detailed review processes. Magellan Complete Care requires our providers to adopt, evidence-based UM guidelines and criteria to guide all review decisions.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Medical and behavioral health practice guidelines and information for training and education are available on the Magellan Complete Care website, under “Provider Tools”; Provider Handbook; and through the Provider Newsletter.

Our Provider Optimization Delivery System (PODS) team is at the core of our provider network management and relations activities in Florida. The PODS team assists providers with assessments of their practices for readiness to deliver integrated care, practice training, practice transformation, and support. The integrated PODS teams are organized throughout the State. Each of these teams are led by embedded Network Contract Manager, Provider Relations Specialist and a Network Contract Coordinators reporting to a Network Director and each of these teams report to the Vice President of Network Development.

Magellan Complete Care operates within this cutting edge network design because it provides the optimal structure for Magellan Complete Care to integrate our long standing behavioral health knowledge into physical health line of business and vice versa. The integration of behavioral and physical health maximizes the knowledge to construct specific resourcing within a POD structure and deploy the right network configuration in order for highly trained and accessible network providers to deliver more timely and effectively, health care services to our enrollees.

The same teams are responsible for the all physical and behavioral health practitioners, facilities, and ancillary providers within their assigned regions. Each regional team within the POD’s are specifically charged with network contracting, credentialing, provider maintenance, network monitoring and providing technical assistance, site visits evaluations, and providing education to providers in the network.

This model exhibits the Magellan Complete Care commitment to a high touch and prompt engagement with our physical, behavioral health providers, facilities and ancillary services. The following highlights the value of the PODS approach.

When we identify a need for additional training, we use our Provider Support Specialists (PSS) to educate our providers. We also discuss requirements for training with the Provider Advisory Board.

For further support on authorizations, we direct providers to our website, we direct providers to the “Authorizations” tab within the “Providers” tab, for supporting information about authorizations:

> Quick Authorizations Form for In-Network Providers
> Prior Authorization Guide
> Prior Authorization Form
> Pharmacy Prior Authorization
> Radiology Authorizations
> Instructions for Florida Prior Authorization Form

In addition, providers have access to bulletins, updates, newsletters, the Provider Handbook, and Provider Portal.

Through the credentialing and re-credentialing process, if necessary, we incorporate any quality issues related to review criteria into future training.
Magellan Complete Care’s approach to ensure the consistent application of review criteria for authorization decisions includes strong inter-departmental communication. As the existing SMI Specialty Plan, we have combined staff representing behavioral health and physical health working together “under one roof” where we can call together the appropriate individuals to discuss authorization decisions and communicate to a provider when we see a trend happening.

CRITERIA 4: THE ADEQUACY OF THE REVIEW PROCESSES...
Magellan Complete Care has and will continue to maintain review processes (data collection and analysis) to ensure services are not arbitrarily being denied or reduced deployed by the respondent to ensure services are not arbitrarily being denied or reduced.
Magellan Complete Care will ensure that all adverse decisions to deny a service authorization request, or limit a service in amount, duration or scope that is less than requested, must be:

> Made by a licensed physician, psychiatrist, or dentist, as appropriate, or other professional as approved by the Agency, who has the appropriate clinical expertise in treating the enrollee’s condition or disease (42 CFR 438.210(b)(3))

> Determined using the acceptable standards of care, State and federal laws, the Agency’s medical necessity definition, and clinical judgment of a licensed physician, psychiatrist, or dentist, as appropriate, or other professional as approved by the Agency

Magellan Complete Care will notify the provider and give the enrollee written notice of any adverse decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 CFR 438.210(c) and 42 CFR 438.404).

When the request determination results in an adverse decision, the utilization management staff will offer an alternate formulary, alternative/service/level of care for the enrollee, if appropriate.
Magellan Complete Care has established and maintained a UM system to monitor utilization of services, including an automated service authorization system for denials, service limitations, and reductions of authorization. We will not arbitrarily deny or reduce the amount, duration, or scope of a required service because of the enrollee’s diagnosis, type of illness, or condition (42 CFR 438.210(a)(3)(ii)).

As mentioned above, Magellan Complete Care uses nationally recognized, evidence-based review criteria to improve the consistency of decisions made by our UM personnel. These clinical criteria represent best practices and reflect national standards; created and applied based on the unique needs and conditions found in the Medicaid population in Florida. We also regularly analyze enrollee utilization and outcome trends to determine whether changes may be required to achieve goals for quality and outcomes for our enrollees. This is a continuous and ongoing process of improvement that supports all areas of our organization including utilization management processes and policies.

Magellan Complete Care has adopted the infrastructure required to approve and support the creation and application of evidence-based guidelines and criteria for use in determining medical necessity.

Our UM Department is responsible for compiling data, conducting and documenting reviews and inter-rater reliability (IRR) assessments, and reporting the results to our Chief Medical Officer.
The internal review of medical necessity decisions is made by the CMO in conjunction with the UM Director and staff.

The Medical Director and/or physician reviewer oversee UM decision-making based on clinical criteria and medical necessity. Our processes include utilizing a full-time Auditor to validate that staff are applying UM and medically necessary criteria and guidelines in accordance with established principles and processes along with IRR testing. UM staff performance is monitored at least quarterly including a review of whether decision-making related to the application of medical necessity criteria is completed in a timely manner. Results of these audits are included in each individual’s performance review.

In addition, we incorporate rounds with staff including the Medical Directors for complex cases that are not covered. For example, our inter-departmental communication and integration between care coordination/case management staff and UM staff includes review of complex cases. If a Case Manager identifies an enrollee who may require services beyond our benefit coverage, this request is sent to a UM Manager who expedites the process of review to include Medical Director approval.

The Magellan Complete Care HS Committee (HSC) and QIC meet on a quarterly basis. All of the results of the IRR and documentation quality monitoring are presented to the Senior Director of HS for review and recommendations. Interventions to enhance learning experience of the staff are determined after review of testing results. The HSC has oversight of policy, procedures, and metrics including service authorization protocols for prior authorization and denial of services.

**EVALUATION CRITERIA 5: THE ADEQUACY OF THE REVIEW PROCESSES…TO IDENTIFY ABERRANT UTILIZATION PATTERNS….**

Magellan Complete Care has and will continue to deploy review processes (data collection and analysis) to identify aberrant utilization patterns (under- and over-utilization). We monitor and evaluate under-utilization, over-utilization, and inappropriate utilization of services on an ongoing basis and implement processes to address opportunities for improvement.

Under- and over-utilization review processes have QI objectives and indicators that are dynamic and fully consider the enrollee’s clinical, safety, and cultural characteristics/needs as well as historic plan performance and specific customer requirements. Our UM Program develops thresholds both for qualitative and quantitative evaluation of behavioral and physical health resources to identify patterns of over- and under-utilization. Our processes include daily review, for example when staff identify a quality of care issue, they report it to a manager who reviews it and bring it to the Medical Director and the SIU if necessary.

Magellan Complete Care has a number of processes in place to monitor for under or over utilization on a continuing basis to facilitate the timely identification of any trends suggestive of under-utilization or over-utilization of medical or behavioral health services.

The Chief Medical Officer, the Behavioral Health Medical Officer, and health services staff review individual and aggregate utilization information weekly, based on current month and year-to-date data for all higher levels of care.
5.1 Data Analysis and Reports to Identify Over- and Under-utilization
Magellan Complete Care conducts ongoing data analysis and produces reports on daily, weekly, monthly utilization that identify under- and over-utilization for physical and behavioral health services, which are clinical, business, and quality oversight processes, including the following:

5.1.a Staff Review and Monitoring
> The Senior Medical Director, the Behavioral Health Medical Director, and HS staff (which includes all UM staff), review individual and aggregate utilization information, based on current month and year to date data on a weekly basis for all higher levels of care.

> Under the direction of the Senior Director of UM, the Managers of UM are responsible for the day-to-day management of the UM process including requests for behavioral and physical health services; discharge planning; second medical opinion; out of network services; all medical necessity appeals processes, and related work. The Managers of UM assist and Senior Medical Director and Chief Medical Officer (CMO) in monitoring under- and over-, and inappropriate-utilization.

5.1.b HS Committee (HSC) and QIC Review of Reports:
The HSC reviews aggregate utilization data for all levels of care, readmission rates, and adverse incidents related to the UM process, complaints related to the UM process, high cost services, access to care and enrollee and practitioner satisfaction survey data to determine if there are any indications of potential under-utilization or over-utilization and the need for additional analysis or intervention. This process may also serve as an opportunity to identify the need for changes in UM policies and practices to be responsive to enrollee and provider needs.

The HSC regularly reports its findings and any interventions to the Magellan Complete Care QIC. As part of its analysis, the HSC and QIC review other indicators such as the number and nature of complaints, grievances, and appeals related to the access and/or the authorization process to further substantiate suspected over-, and under-utilization findings. Magellan Complete Care monitors over-under-utilization, timeliness of urgent care/ER services, non-urgent care preservice, concurrent care, and post service care. This data is reported to the HSC. Utilization such as under- and over-utilization reports, inpatient authorization dashboard, business analytics and reporting tool (BART), allows us to capture top diagnoses, ER reports and utilization, top procedure codes, pharmacy top utilizers, and top prescribers, IP and OP.

Enrollee and provider satisfaction survey outcomes and access measures also serve a similar purpose. Utilization data is reviewed to monitor under-utilization of services for ER, inpatient, pharmacy, outpatient services and by particular racial/ethnic groups to allow for identification and implementation of strategies to address cultural disparities in access and utilization of services.

5.1.c Comprehensive Review of Data Elements
We conduct comprehensive review of the following data elements:

> Under- and over-utilization of service and cost data by service category and provider
> Avoidable hospital admissions, readmission rates, average length of stay for all inpatient facilities
> Follow up after discharge for all admissions
> Emergency department utilization and crisis services use
>Prior authorization/denial and notices of action through monthly tracking and review of expedited and standard authorizations and denials
>Pharmacy utilization and adherence
>Laboratory and diagnostic utilization
>Identification of gaps in care
>Call statistics by month and call volume
>HEDIS metrics

5.1.d TruCare CC/CM Platform for Reporting Dashboards
HEDIS gaps in care data are pushed to TruCare. Care coordination staff is able to identify open gaps in care directly from enrollee’s record in TruCare. The QI/HEDIS team works on closing gaps in care from the HEDIS application which is outside of TruCare; the Care Coordination team only works on closing gaps in care located in enrollee’s record in TruCare.

HEDIS gaps are addressed in every review via evaluation of all submitted clinical information. When gaps are identified reviewers communicate directly to facilities or to Hospitalist to address needed labs, medications, etc. Care coordination is also notified of identified gaps or of any HEDIS identified data that is completed or requires further intervention.

5.1.e Medical Action Plan (MAP) Team Review
This workgroup holds routine structured meetings to monitor use of services and identify under-utilization or over-utilization of services provided to our SMI Specialty population. A key purposes of the MAP team is to identify utilization patterns to evaluate provision of the right care at the right time for all enrollees. The MAP team analyzes monthly reports and indicators to identify trends and patterns among practitioners, organizational providers, and/or system-wide concerns. Indicators reviewed include but are not limited to:

>Top diagnosis for ER/Inpatient services
>Provider encounter submissions to monitor access to care
>Utilization data of delegated entities
>Inpatient services for enrollees diagnosed with diabetes, asthma, HIV/AIDS, CHF, hypertension, cancer for referral to the appropriate Magellan Complete Care DM program
>High specialty referrals including but not limited to transplant cases, cancer, ESRD and complex conditions to address enrollees with the greatest needs
>Readmission data to target regions with high readmissions and implement region specific interventions working collaboratively with facilities, providers and community resources
>Hospitalists usage including follow-up after hospitalization (FUH) and admission diversions
>Days/1000
>Admissions/1000
>Percentage of denials
>Decision timeliness

5.2 Review Process for Identifying Aberrant Utilization Patterns: Underutilization of Covered Services
Magellan Complete Care monitors and evaluates under-utilization of services on an ongoing basis and implements processes to address opportunities for improvement. We maintain a robust and multi-faceted program to monitor enrollee gaps-in-care through our Care Management and Quality Management organizations. This includes enrollee care plan gaps in care, HEDIS, and EPSDT/CHCUP gaps in care. We monitor and report this information throughout the year, with
additional outreach and enrollee/provider support efforts during the HEDIS and EPSDT/CHCUP reporting and monitoring periods. This information is made available to staff responsible for engaging enrollees and supporting the enrollee and their provider(s) in closing those gaps. A main goal of this process is to identify any enrollee or provider barriers to closing those gaps in care, addressing those barriers, and overcoming or eliminating them. As part of our continuous quality improvement efforts we evaluate whether changes to utilization management policies or practices may be needed to support more timely and appropriate utilization.

5.3 Review Process for Identifying Aberrant Utilization Patterns: Overutilization of Covered Services Magellan Complete Care monitors and evaluates over-utilization of services on an ongoing basis and implements processes to address opportunities for improvement.

We monitor various data sets to ensure enrollees receive adequate, timely, appropriate care. Our data analysis efforts in these areas are facilitated by the fact that Magellan Complete Care has established a uniform encounter management database CAPS system. All fee-for-service claims and encounters are deposited in this system to ensure we have the most up-to-date data from which staff can perform trend analysis.

We measure performance and assess health outcomes to evaluate the effectiveness of the care. Data is collected and analyzed by the analytical and financial teams working in collaboration with the Care Coordination team. Results are analyzed and evaluated to determine where opportunities for improvement relating to medical management (including UM policies and practices) exist.

Results and recommendations for change or improvement in the enrollee’s care are provided to the QIC. Discussion is documented in committee meeting minutes and opportunities for improvement, e.g. key gaps, are also incorporated in the annual HS and Quality Improvement plans.

To evaluate the performance and effectiveness of medical management, we use multiple approaches in collecting, evaluating, and making improvements, includes but is not limited to the following:

> Care transitions and transition planning
> Skilled Nursing Facility care
> Regular review of medication adherence, filling of prescriptions, and problems with Drug Utilization Review (DUR)
> Quality of care issues
> Regular review of key indicators (inpatient (IP)/outpatient (OP)/ emergency room (ER)/skilled nursing facility (SNF)/HEDIS/CHCUP)
> Timely completion of HRA
> Enrollee and providers concerns and complaints
>Transportation timeliness

>Preventative screening measures and immunizations

>Key indicators for chronic conditions including congestive heart failure, hypertension, diabetes, asthma, and cancer management

>HEDIS measures

>Quality of care satisfaction issues

>Complaints and grievances

>Appeals

>Sentinel events

>Provider issues (depth and breadth of network, access/availability)

>Satisfaction surveys

>Cost of care trended over time including total costs, hospital, ER, outpatient, and community services

5.4 Review Process for Identifying Aberrant Utilization Patterns; Annual QI Program Evaluation
The evaluation includes a description of completed and ongoing UM, DM and QI activities that address quality and safety of clinical care and quality of service; trending of measures to assess performance in the quality and safety of clinical care and quality of service; analysis of the results of the QI initiatives, including barrier analysis; and an evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide safe clinical practices.

We perform analysis of aggregate data using multiple data sets to validate under- or overutilization and establish mean performance, including claims and encounter data. Plan level utilization data is compared to industry accepted benchmarks such as NCQA Quality Compass and Florida Medicaid benchmarks.

Valid indicators are selected for baseline and follow-up measurement. Measures of clinical outcomes are evaluated in addition to process measures. Indicators are objective, clearly defined, and based on current clinical knowledge or health services research. Summary findings are presented during staff meetings. Individual training is conducted as needed, in addition to process-related training as global training issues are identified.

Data are also analyzed by practice and provider site for performance outside of performance thresholds. Behavioral health data are separately reported from medical/surgical data to address the specific needs of enrollees receiving behavioral health services. Any measures outside of thresholds are examined for causes and consequences.

Trends identified by UM, Network Management, or Pharmacy staff are addressed through system-wide interventions or referred to the individual provider or provider group. We require
documentation of actions taken to improve performance as a result of clinical data analysis. Analysis of the data is also used to develop QI and performance improvement projects, enrollee education initiatives, staff, and provider training. Annually, reports are presented to the QIC, which reports to the Board of Directors.

The annual QI Program evaluation includes a description of completed and ongoing UM, DM, and QI activities that address quality and safety of clinical care and quality of service; trending of measures to assess performance in the quality and safety of clinical care and quality of service; analysis of the results of the QI initiatives, including barrier analysis; and an evaluation of the overall effectiveness of the QI program, including progress toward influencing network–wide safe clinical practices.

The evaluation of the UM Program includes, but is not limited to, an evaluation of effectiveness in resolving utilization and benefit issues, including but not limited to monitoring trends and patterns of key UM indicators for over- and under-utilization and appropriateness of care.

Magellan Complete Care has already implemented service authorization review processes (data collection and analysis) to identify aberrant utilization patterns (under- and over-utilization) for the SMI Specialty Plan. We will continue to identify, monitor, and evaluate aberrant utilization patterns on an ongoing basis and implement processes to address opportunities for improvement.

CRITERIA 6: THE ADEQUACY OF THE RESPONDENT’S APPROACH IN DIFFERENTIATING BETWEEN UM PROTOCOLS…
Magellan Complete Care’s approach for authorization of services begins by treating all requests consistently from the start, including review by the Magellan Complete Care clinical team to determine Medical Necessity Criteria. Authorization of services is consistent with Magellan Complete Care’s Contract with the State of Florida Medicaid coverage policies to determine the frequency and the duration of the requested services. Our policies and procedures allow us to work with enrollees and their providers based on their diagnosis, allowing us to extend the timeframes for services authorization if needed based on medical necessity. All enrollees are treated equally in that regard. If we have an enrollee with special needs like dialysis, bariatric wheelchair, we may work with the provider and go beyond the 60 day contract, or to bring the provider into the network if this is a new enrollee who has been receiving care from a non-participating provider.

Magellan Complete Care has established a review process for determining medical necessity for services. We arrange coverage for all medically necessary services in accordance with the Medicaid contract, and the Medicaid policy requirements, which includes those requirements specifically related to pregnant women, children/adolescents, SMI enrollees and enrollees with HIV/AIDS diagnoses as identified by the Agency and as applicable to Medicaid enrollees.

Magellan Complete Care has an authorization department which is part of the UM Department and is staffed by prior authorization representatives who process all the day-to-day outpatient and inpatient requests for prior authorization.

Magellan Complete Care makes utilization management criteria available in writing, by mail, or fax and hard copy at the office upon request. The criteria used for the basis of an individual service
determination is in the notice of action letters and is also available upon request. The availability of medical necessity criteria is also included in Magellan Complete Care’s Provider Manual.

6.1. Two Examples of UM Protocols
Example 1: Hospital Inpatient Admission

Information is received from the emergency department or a referral from a provider via fax when an enrollee is admitted. The UM Team (concurrent reviewers) arrives at the facility to learn more about the enrollee’s condition and request clinical data in able to establish medical necessity.

The UM Team discusses criteria with the hospital case management as well as discharge planning. The enrollee case is discussed with a UM Manager for review during rounds and with Medical Directors during daily rounds for orientation and review for recommendations. The hospital either receives approval or denial of requested services from the Medical Director.

The UM Team reviews the enrollee’s needs and discusses with hospital case managers and hospitalists. The CMO reviews to ensure appropriate level of care. The UM Team works with the hospital discharge planner from “Day 1” for a safe and smooth transition.

Magellan Complete Care identifies the need of authorizing services utilizing different timeframes. For this reason UM staff follow this protocol:

> Ongoing services are usually authorized for three or six months at a time, some examples are: hospice, dialysis, therapy services, DME, i.e., oxygen
> Magellan Complete Care also takes into consideration the enrollee’s diagnosis and condition, and under some circumstances, might approve certain services beyond protocol

Example 2: One-time Procedure
Magellan Complete Care identifies the need of authorizing services utilizing different timeframes. For this reason UM staff follow this protocol:

> One time OP procedure is authorized for one unit, for a 30 calendar day period:
> A 30 calendar day window is approved to give time for cases requiring rescheduling

6.3. Authorization of Services Needed Long-term (ongoing maintenance services/therapies)
For a procedure requiring long term treatment such as dialysis or chemotherapy, Magellan Complete Care will approve services for a period of six months or longer to accommodate the enrollee needs.

CRITERIA 7: THE ADEQUACY OF THE RESPONDENT’S APPROACH AT ENSURING CONTINUITY OF CARE.
Magellan Complete Care has and will continue to ensure continuity of care, particularly as it relates to special needs populations.

Magellan Complete Care has developed continuity of care standard operating procedures. The goal of these guidelines is to establish a uniform process for Prior Authorization Reviews performed by Licensed Clinical Reviewer (LCR/UMP), also referred to as UMP for the Prior Authorization subdivision of the Magellan Complete Care UM/HS Department.
Magellan Complete Care is responsible for coordination of care for new enrollees transitioning into the plan. In the event a new enrollee is receiving a prior authorized ongoing course of treatment with any provider, we will be responsible for the costs of continuation of such course of treatment, without any form of authorization and without regard to whether such services are being provided by participating or nonparticipating providers.

Magellan Complete Care will reimburse non-participating providers at the rate they received for services rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of thirty days, unless said provider agrees to an alternative rate.

Magellan Complete Care will provide continuation of MMA services until the enrollee’s PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the enrollee’s treatment plan, which shall be no more than sixty days after the effective date of enrollment.

The following services may extend beyond the sixty day continuity of care period, and the Managed Care Plan shall continue the entire course of treatment with the recipient’s current provider as described below but not limited to:

>Prenatal and postpartum care: Magellan Complete Care will continue to pay for services provided by a pregnant woman’s current provider for the entire course of her pregnancy, including the completion of her postpartum care (six weeks after birth), regardless of whether the provider is in Magellan Complete Care’s network.

>Transplant services (through the first year post-transplant): Magellan Complete Care will continue to pay for services provided by the current provider for one year post-transplant, regardless of whether the provider is in Magellan Complete Care’s network.

>Oncology (radiation and/or chemotherapy services for the current round of treatment): Magellan Complete Care will continue to pay for services provided by the current provider for the duration of the current round of treatment, regardless of whether the provider is in Magellan Complete Care’s network.

>Full course of therapy Hepatitis C treatment drugs

7.1. Ensuring Continuity of Care for a Newly Enrolled Enrollee or an Enrollee Dis-enrolling
When Magellan Complete Care is notified of a newly enrolled enrollee or an enrollee who is dis-enrolling from the health plan, at minimum, the following is carried out:

>Obtain appropriate consent from the enrollee to obtain and share demographic and healthcare information

>Collaborate with the enrollee, the health/service provider, and the receiving or sending health plan to obtain/provide enrollee information related to the respective program assessments and service plan/care plan information

>Request/share the most current assessment and service plan/care plan with documentation of same in the clinical documentation system
7.2. Ensuring Continuity of Care upon Provider Termination

Magellan Complete Care provides for continuity of care for the course of treatment in the event a provider agreement terminates during the course of an enrollee’s treatment. We notify enrollees within 60 days of the effective date of provider termination without cause. This includes all enrollees who are in a course of active treatment with the provider, assigned to the provider as a PCP, or has prior authorized care with the provider.

Magellan Complete Care allows the enrollees in active treatment to continue to receive care from the provider until the course of treatment is completed, another provider is selected, or during the next open enrollment period—not to exceed six months after the termination date. Pregnant enrollees are permitted to continue the course of treatment until completion of postpartum care.

If providers are terminated for cause, notification occurs as soon as practicable (not to exceed five business days, but immediately if the enrollee is in imminent danger) and the following continuity of care provisions do not apply.

A terminated provider can refuse to provide care to an enrollee who is abusive or noncompliant. All services provided under the continuity of care provisions will be reimbursed at the rates included in the last active contract.

If enrollees are active in care coordination and a provider is termed, example oncologist termed for cause while enrollee is undergoing active treatment, the care coordination management team will receive a report of all open authorizations associated with that provider. If a care coordinator is already assigned, the assigned care coordinator will reach out to the enrollee, if no care coordinator is assigned, one will be assigned to address the immediate need. The care coordination teams are regionally based, and will work with the provider to ensure the enrollee may complete the current course of treatment or will coordinate the care with another accepting provider. Any authorizations will be updated to reflect the current course of treatment timeframes.

Magellan Complete Care will allow enrollees to continue receiving medically necessary services from a not-for-cause terminated provider and will process provider claims for services rendered to such recipients until the enrollee selects another provider as specified below:

1. For MMA and LTC services, continuation will be provided for a minimum of 60 days after the termination of the provider’s contract for the provision of services

2. For MMA services, continuation will not exceed six months after the termination of the provider’s contract for the provision of MMA services

3. For any pregnant enrollees who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, continuation will be provided until the completion of postpartum care

In a case in which a patient’s health is subject to imminent danger or a provider’s ability to practice medicine or otherwise provide services is effectively impaired by an action by the Board of Medicine or other governmental agency, notice to the provider, the enrollee and the Agency will
be immediate. Magellan Complete Care will work cooperatively with the Agency to develop and implement a plan for transitioning enrollees to another provider.

7.3. Ensuring Continuity of Care
We provide the following example of how our UM Team managed continuity of care (COC) with providers to ensure smooth transition to in-network services are included below. This illustrates how we manage the COC process for Magellan Complete Care enrollee; regardless of the service. We honor the COC for 60 days and work with the enrollee and provider to ensure no interruption of services. We will transition with CC team and work with case management, the enrollee’s caregiver, enrollee, to ensure a seamless transition to the enrollee to review appropriate care in a timely enrollee; we will look for a network provider, otherwise we would extend a single case agreement (SCA) with an out of network provider and ensure COC.

If a single case agreement (SCA) or subcontract agreement is needed, one will be offered to providers who are not willing to enroll in the Magellan Complete Care network. Upon receipt of the request for a single case or subcontract agreement from the out of network provider, the Utilization Management Department will provide the Network Development Department the provider contact information and other relevant data. The Utilization Management Department will inform the provider they will be reimbursed Medicaid FFS payment if the provider declines Medicaid FFS reimbursement, the request is forwarded to the Network Department who will contact the provider upon receipt of the request to initiate the negotiations. If the SCA is not agreed upon, Magellan Complete Care will assist the enrollee in locating another provider to meet the enrollee’s needs.

CRITERIA 8: THE EXTENT TO WHICH THE RESPONDENT PROVIDES A SPECIFIC EXAMPLE...
The Magellan Complete Care successful review processes ensure the appropriate use of services, at the right time, level, and place, to avoid over- or under-utilization.

We provide the following three examples to demonstrate our review processes that resulted in successful interventions to alter unfavorable utilization patterns in the system:

Example 1: Magellan Complete Care received a request for 175 units of Targeted Case Management (TCM) for a three month period to link a 54 year-old female to medical providers to include PCP, ophthalmologist, podiatrist and gynecologist. In addition, the enrollee also needed assistance with applying for food stamps. After 17 days of services under the initial request, the provider requested 100 additional units to be added to initial authorization. Magellan Complete Care’s Utilization Management Professional (UMP) reviewed submitted documentation and noted that the information did not support the need for additional units as there was no modification to the initial service plan and there were no new issues identified. Magellan Complete Care contacted the provider to obtain additional information to support the request. Several issues were identified, including:

> Provider was billing for services that are listed under “Restrictions” in Medicaid Policy; for example, administrative functions
> Amount of units billed were excessive to function identified, as per service notes
> Targeted Case Manager was conducting services out of their scope of service
> Enrollee already had Community Behavioral HS in place
The enrollee was enrolled in our Complex Case Management program and had an assigned ICCM who was already assisting with coordination with medical provider; therefore, there was duplication of services.

The UMP reviewed this case and findings with the Medical Director and Manager and it was determined that there appeared to be overutilization of TCM as evidenced by case notes review. The request was deferred to the Medical Director to determine medical necessity for the additional number of units requested. It was determined that the enrollee had sufficient units already approved to assist with identified issues and a partial denial was issued. A referral was also made for our Case Management department to assist the enrollee in transitioning to a new provider. A referral to the Special Investigation Unit was also made.

Example 2: Magellan Complete Care received a request for pregnant enrollee to receive midwife services for a home birth. The UMP reviewed clinical information submitted and it was noted that the member had a history of Sexually Transmitted Diseases (STD) and a current diagnosis of bipolar disorder with recent psychiatric unit admissions. Even though the request was for a lower level of care, the case was reviewed with our Medical Director, who determined that a higher level of care was safer and needed to reduce the enrollee’s and her newborn’s risks.

Our UM team also reached out to our Case Management team to make sure enrollee’s Case Manager from our maternity program was aware and ensure that the delivery would take place in a hospital.

Example 3: A 58 year-old male was admitted with a fractured hip after a fall. The enrollee was now status-post-hip-replacement surgery. The enrollee’s prior level of functioning was independent; however, due to pain and deconditioning, the enrollee’s current level of function had declined significantly. The injury also impacted the enrollee’s ability to independently perform activities of daily living. The facility initially requested home care for prophylactic anti coagulation therapy and home physical therapy.

Although SNF is not a covered benefit, the plan suggested that the enrollee be stepped down to a SNF as this was the most appropriate level of care for the enrollee to gain independence and return to previous level of functioning. The treating provider agreed with health plan’s recommendation, and requested a SNF. Magellan Complete Care assisted with discharge coordination into a SNF and such service was approved. The enrollee subsequently completed a SNF plan of care and hen returned home with his previous level of functioning.

8.1 Activities to Prevent, Identify, and Report Improper Utilization
Our Precertification Department routinely engages in the following activities to prevent, identify, and report improper utilization, including:

>Weekly staff meetings

>Ongoing staff training:
   >>UM staff is reminded that services requested must be individualized, specific, and consistent with symptoms
   >>The fact that a provider or an enrollee is requesting a service does not make it medically necessary
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

>>The request for service must have the intent to identify and treat a diagnosis, condition, or to alleviate illness
>>Services should also be provided at the most cost effective level of care
>>Staff is also reminded that services must be individualized, specific, and consistent with symptoms, diagnosis, or illness

>Ongoing provider calls to obtain current enrollee information, clinical information, and clarification regarding a request for treatment, and not in excess of the enrollee’s needs
>Ongoing provider education:
>>Provider bulletins
>>Provider meeting and outreach

>Interdepartmental meetings

>SIU referrals

>Ongoing prior authorization review available.

8.2 Successful UM Initiatives, 2016-forward
In addition to the findings described above, the UM review processes that resulted in successful interventions to alter unfavorable utilization patterns in the system during 2016 and forward include the following:

> The use of MCG criteria for medical necessity review for both physical and behavioral health conditions has ensured consistent application of evidence-based guidelines during the review process. We use MCG criteria for most adult and pediatric categories, including specialty referral and outpatient services, inpatient and outpatient surgery and procedures, concurrent review, and discharge planning/transitions of care, DME, and home care.

>MCG provides support to the UM team on a quarterly basis for onsite and webinar educational opportunities which align the UM staff to adhere to consistent guideline usage

>Consistent use of the MCG platform has warranted a positive result in the UM team IRR scoring

>Weekly UM Manager meetings to review the UM department needs and challenges to implement appropriate interventions on a timely manner

>Intensive staff education throughout the year focusing on UM documentation, key performance measure tracking and trending, unauthorized disclosures and HIPAA requirements as well as staff productivity

>The HS workgroup platform has resulted in consistent multi-disciplinary approach to review for future prior authorization reviews, data analysis, under and over utilization patterns, care management, disease management, and community housing opportunities for enrollee placement for transition of care

>Initiation of interdepartmental collaborative work/meetings to identify, address and resolve barriers that may contribute to overall utilization with:
>>Enrollee Services
>>>Transportation
>>>Prior Authorization
>>Case Management and Care Coordination
>>Provider Support Specialists
>>Magellan Rx Management
>>Quality
>>Network
>>>For pre-certification unit, dedicated selected staff to work with high volume offices
>>>Enhanced daily rounds with staff to ensure authorization of appropriate level of care:

>>MD rounds increased with addition of Medical Director resources

>>Initiated daily Pre-rounds with the UM Managers

>>Maintained ongoing interactions with CC/ICCM team
>>>Expanded use of the hospitalist program for both physical and behavioral health
>>>Added several functions in the documentation system to include DRG/Per-diem fields to help staff better identify hospital contracting information
>>>Enhanced process for closing HEDIS gaps while enrollees are in hospital
>>>Delegation oversight that includes but not limited to monthly and quarterly UM report review to ensure that the delegate are in compliant and aligns with Magellan Complete Care protocols
>>>Monitoring prior authorizations, adverse decisions, and turnaround timeframe compliance. This continual monitoring allows Magellan Complete Care to address any aberrancies that arise in a timely manner before they become a UM barrier
>>>Onsite licensed personnel are located at specific hospital locations for behavioral health and physical health to provide support for safe transitions of care, discharge planning, and UM collaboration with facility staff
>>>Health guide visits with hospital facilities occur to help coordinate discharge planning with the facility staff which also includes the enrollee and the enrollee’s caregiver to ensure a safe discharge to the next level of care
>>>Initiated collaboration meetings with several large hospital associations to look at opportunities that would align with accessing their EMR systems. The initiatives warranted a positive outcome of the UM team accessing the EMR platform which decreased burdensome UM review between the facility and UM team. The EMR remote access allows the UM team to obtain direct physical health documents and allows for direct correspondence with the facility UM.
>>>Continued collaboration with the following facilities is occurring to increase the access and use of the EMR: Baptist Health of Jacksonville, Florida Hospital, Jackson Hospital, Lakeland Regional, Orlando Health, St. Vincent, and Tampa General Hospital.
Evaluation Criteria:

1. The extent to which the respondent describes the process and data sources utilized to determine whether a service should be prior authorized, including reviewing complaints or feedback from providers regarding burdensome or unnecessary prior authorization criteria.

2. The adequacy of the processes used by the respondent to determine whether the utilization management criteria selected are appropriate and consistent with policy requirements for a Medicaid benefit.

3. The adequacy of the respondent's approach to ensure the consistent application of review criteria for authorization decisions (e.g., inter-rater reliability studies, and training for plan staff and network providers).

4. The adequacy of the review processes (data collection and analysis) deployed by the respondent to ensure services are not arbitrarily being denied or reduced.

5. The adequacy of the review processes (data collection and analysis) deployed by the respondent to identify aberrant utilization patterns (under and over utilization).

6. The adequacy of the respondent's approach in differentiating between UM protocols for authorization of services that are needed short-term (e.g., one-time authorization) vs. long-term (ongoing maintenance services/therapies).

7. The adequacy of the respondent's approach at ensuring continuity of care, particularly as it relates to special needs populations.

8. The extent to which the respondent provides a specific example of how its review processes resulted in successful interventions to alter unfavorable utilization patterns in the system.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.
SRC# 19 – Utilization Management – Ease of Use (Statewide):

The respondent shall describe the following related to its utilization management systems:

a. A description of how the respondent will ensure that the UM processes are designed so that service authorization requests are completed efficiently and with minimum administrative burden on network providers and enrollees;

b. A description of software capabilities that facilitate ease in requesting service authorization and support data exchanges between providers, subcontractors and the respondent (to the extent any UM functions are delegated);

c. A description of the respondent’s experience meeting timeliness standards for service authorization requests;

d. A description of the approach that the respondent will use to educate enrollees and providers about the process for seeking authorization; and

e. A detailed workflow of how “special service” requests are processed for enrollees under the age of 21 years. Special services are requests that are made to the plan to exceed the limit on a Medicaid covered service or to cover a medically necessary service that is not listed in the Florida Medicaid handbooks/coverage policy or the associated fee schedule.

Response:

OVERVIEW
Magellan Complete Care understands the importance of ease of use for both providers and enrollees in its utilization management (UM) processes and systems. Our goal, like that of the Agency for Healthcare Administration (AHCA), is to minimize the administrative burden on network providers and enrollees, recognizing that doing so reduces delays for needed services. This is particularly important for our enrollees living with SMI, whose needs require careful coordination of physical health, behavioral health, and social support services. Navigating the health care system can be particularly challenging for these enrollees as well as the providers and caregivers who support them. Magellan Complete Care endeavors to automate, streamline and simplify processes wherever possible to support ease of use. This includes making information regarding benefits, procedures, required forms, customer service and care information, etc., readily accessible to the enrollee and provider and easily understood by both.

CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT PROPOSES THE USE OF INTEROPERABLE SYSTEMS...
Magellan Complete Care is committed to supporting integration with interoperable provider systems and other clinical data sources to increase ease of use, enhance efficiency and minimize administrative burdens for our provider partners and enrollees. Magellan Complete Care has a robust system of interfaces to multiple data sources which capture information from other clinical systems. We also have ongoing efforts to increase the use of automated information sources in many areas, including a major technology, data, and analytics effort that is currently underway to create an organization-wide “data lake.” When fully implemented, our new data lake will capture
and aggregate information from all key systems within our organization, as well information from providers and vendor partners. This will allow us to report data across our entire organizational ecosystem, and share pertinent data with important partners. The data lake will ensure consistency across multiple data sources. It will increase our internal efficiency as well as making reporting, monitoring, and management more efficient for our partners. Our goal is to provide seamless integration of important data, increase data accuracy, and reduce duplicative data gathering and reporting efforts for Magellan Complete Care and its partners.

At present, the interfaces we support include:

- Provider electronic health record (EHR/EMR) systems
- Laboratory results files from our two largest laboratory providers (Quest and LabCorp)
- Immunization data from the Florida SHOTS immunization registry
- Current and historic state transactional files, including beneficiary classification
- Florida Health Information Exchange (HIE), including the Electronic Notification System (ENS)
- Magellan Rx Management (MRx – our pharmacy benefits manager)
- National Imaging Associates (NIA – our radiology benefits manager)

Data gathered from these data sources supports engagement of providers in the integrated management of enrollee care; sharing of quality and outcomes data; sharing of enrollee data to drive gap closure, including HEDIS, EPSDT, and care plan gaps; and it is essential to drive continued improvement in quality metrics and clinical outcomes.

Magellan Complete Care’s fully integrated Model of Care encourages active engagement of the provider in managing enrollee health. Data captured from the multiple data sources identified above, as well as internal care and quality management systems, is made available to providers through our provider portal. The provider portal includes outcomes, care gaps, and care plan information for the provider’s assigned enrollees. This provides regular and ongoing information for provider participation in quality and care management, in combination with quality outreach and gap reporting which is provided at regular intervals.

Providers also have the ability to submit prior authorizations through the provider portal. We will be adding the capability to his include pharmacy and radiology prior authorizations. The provider portal also gives providers access to information on the status of prior authorizations, claims, EOBs, and enrollee eligibility information. The portal includes training and care coordination tools, and important information on enrollee participation in DM/CC/CM, enrollee care plans, gap-in-care, results of enrollee outreach and engagement activities, and utilization of services.

In addition to the eligibility and authorization processing, and training materials included in the provider portal, providers also will have access to our Connect Portal which includes information from our enhanced ImpactPro predictive modeling systems, our proprietary segmentation and stratification models, our TruCare care management platform, and our proprietary HEDIS monitoring and outreach system. Availability of this information is critical for active engagement of providers in the care management for enrollees. Information from these systems is made available on the Connect Portal, in addition to being made available to additional parts of the organization such as Customer Service or Provider Support, who engage with both enrollees and providers. This integrated approach to data capture and sharing supports increased efficiency, collaboration, and reduction of administrative burdens across the entire provider-enrollee-health plan system.
1.1 Seamless Integrated Data Capture and Sharing
As of July of 2017, in-network providers are able to see the status of an authorization through the Magellan Complete Care provider portal, including status, authorization number and date of service. In an ongoing effort to enhance our provider experience and support ease of access in obtaining prior authorization, the UM department has a new service taking effect, by which providers will be able to request a prior authorization on the Connect Provider Portal instead of submitting by fax. Once a determination is made, the web portal will provide an immediate update to the decision for the provider to access. For paper authorizations, Magellan Complete Care uses only the prior authorization form adopted by the Office of Insurance Regulation, pursuant to s. 627.42392, F.S.

Magellan Complete Care also worked with several large hospital associations to look for opportunities to allow integrated access of their EMR/EHR systems. The initiative was successful, with the result that the UM team now has access to the EMR/EHR platforms for selected hospital providers. This has decreased burdensome UM reviews between the facility and UM team. The EMR/EHR remote access allows the UM team to obtain direct physical health documents and allows for direct correspondence with facility UM staff. We are continuing to collaborate with other facilities and to expand access and use of the EMR/EHR for other hospitals. Hospital systems currently supporting that access include:

>Baptist Health of Jacksonville
>Florida Hospital
>Jackson Hospital
>Lakeland Regional Hospital
>Orlando Health System
>St. Vincent Hospital
>Tampa General Hospital

This access is an important element for increasing the productivity and efficiency associated with administrative management of medical information. It drives efficient care coordination and avoids delays in authorizations. EHRs/EMRs can also substantially improve the overall quality of health and reduce medical errors through improved care coordination and record sharing. Magellan Complete Care is committed to this continued expansion of seamless integration between interoperable systems, with the goal of increasing both ease of use as well as improving monitoring, reporting and management of outcomes.

In addition to integration of these systems with hospitals, last year Magellan Complete Care undertook an initiative to survey all its major clinic and physician providers to determine whether they had EHRs/EMRs, the types of EHRs/EMRs, and to seek authorization to access those EHRs electronically in support of our HEDIS quality initiatives. Not only did this effort allow us to improve the accurate capture of HEDIS data, it also allowed Magellan Complete Care to create an inventory of available systems and initiate discussions with the various organizations and their technology partners in order to create automated interfaces to those systems. Those discussions are underway, with a goal of increasing the numbers of providers supporting integration and data sharing.

Magellan Complete Care also incorporates electronic data files from our major laboratory vendors Quest and LabCorp on a monthly basis, inclusive of all tests processed by these labs. Importantly,
these lab feeds provide the results of all laboratory tests performed on our enrollees, which are not typically available through claims and encounter data submissions from our providers. In addition to making these data available to providers through the Connect Portal, we also use the data to populate our TruCare medical management system.

Magellan Complete Care incorporates immunization data monthly from the Florida SHOTS Immunization Registry. These data are essential for having an accurate record of immunization for our enrollees, given the fact that immunizations are often received over a span of time that may fall outside of enrollment with our health plan, and because these shots may be obtained at locations outside of a provider office. Similar to our lab data, these data drive accurate identification of enrollee care gaps for both health plan outreach and provider outreach, and ensure accurate reporting for our in-period HEDIS and annual HEDIS reporting.

Magellan Complete Care captures data from two types of State transaction files. Data is, of course, captured from State enrollment systems through receipt and processing of 834 transaction files. These data are used to verify enrollment and determine eligible populations (i.e. administrator denominators for HEDIS and EPSDT/CHCUP measures). These data also provide us with some information on the enrollee’s eligibility classification, which can be useful care management.

Magellan also makes use of the State’s Health Information Exchange (HIE) Electronic Notification System (ENS) which provides real-time or near-real-time access to information on admissions, discharges and transfers. This information is critically important for care management, but also informs our HEDIS inpatient interventions, which identifies and closes enrollee care gaps, including A1c or LDL tests, while enrollees are in the hospital. These data are important for monitoring, reporting and mitigation of preventable events since they provide real-time and near-real time notification of enrollee utilization. These data are used to identify enrollees for discharge management and management of transitions of care, to notify Magellan Complete Care hospitalists and care management staff of an admission, and future plans are to use notification of ER encounter to allow hospitalists to engage enrollees for intervention and education if appropriate.

### 1.2 Integrated Internal Data Capture and Sharing

Data from each of these source systems is used internally to support quality management and improvement activities for HEDIS, EPSDT/CHCUP, and similar performance measures that are implemented within care management, customer service, and with quality outreach staff through the identification of care gaps. We run our customized version of the ImpactPro system daily, providing risk segmentation and stratification of enrollees for care management interventions. These data also populate our Custom HEDIS and EPSDT/CHCUP Application as well as our TruCare care management system. Our HEDIS application is used for daily outreach to enrollees aimed at gap closure. The application, which is also used by Magellan Complete Care outreach vendors, provides reporting and tracking for quality-specific activities focused on gap closure. Enhancements have been made to TruCare to support reporting and tracking on appointment scheduling, in addition to the core care management functions.

Magellan Complete Care’s internal systems were specifically selected and designed to support full integration of data from these varied sources in a single care management platform that minimizes barriers between different parts of the organization, as well as our providers. The TruCare medical management platform is a fully integrated, enterprise-wide system from which all plan personnel can work. The TruCare system is fully integrated and includes functionality for
the eligibility system, claims system view, provider management and credentialing, enrollee services customer management and call tracker (CRM), authorization system, and care coordination (CM)/disease management (DM) system (case management module). Data from this system are also made available to providers, through the Connect Provider Portal.

All relevant departments are working on the same integrated system and performing all their duties in the system. Given our “all services under one roof” approach, our utilization management and authorization or CM/DM staff have everything at their fingertips to fully assess an enrollee and furnish the best possible service. For example, staff have the ability to view the following in one system:

>Complete and up-to-date enrollee demographics
>Complete and up-to-date claims and encounter history
>Enrollee services notes relevant to the requested authorization/assessment/intervention
>Authorization request and approval/denial history
>Any Health Risk Assessments performed by the CM/DM Department
>Gaps in care
>Provider contracts and demographics
>Financial payment records for claims and encounters
>Any other clinical or quality notes entered in the system

The TruCare technology solution is very robust, ensuring Magellan Complete Care personnel can work in one system and have access to all relevant and timely data to perform critical functions. We do, of course, restrict system access to appropriate staff members based on their authorizations and job assignments.

1.3 Integration with External Vendors
Magellan Complete Care is evaluating the ability to capture and display information on prior authorizations which must be submitted to our vendor partners, as well as submittal through a single source. At present those authorizations must be submitted to the appropriate vendor through that vendor’s systems and processes. Communications and follow up on the status of those authorizations is managed my each of these vendors as noted below.

>Magellan Complete Care subcontracts services for dental prior authorization to DentaQuest. Our relationship with DentaQuest includes utilization management for prior authorization review for specific dental services. DentaQuest is also responsible for enrollee and provider notification letters.

>Magellan Complete Care subcontracts with Premiere Eye for prior authorization utilization management of vision services including office procedures, medical/surgical services,
pharmaceutical, and diagnostic services. Premiere Eye is also responsible for enrollee and provider notification letters.

>Magellan Complete Care subcontracts with Magellan Rx Management Pharmacy for specialty pharmacy services. Magellan Rx is responsible for prior authorization of utilization management services for specific pharmaceutical services. This subcontractor is also responsible for enrollee and provider notification letters. Links for submittal of authorizations for this vendor are included on our provider portal.

CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT USES STRATEGIES TO REDUCE ADMINISTRATIVE BURDENS FOR THE PROVIDER...
Magellan Complete Care maintains a UM organization which operates closely with, and as an integral part of all other care management functions. This allows the organization to manage receipt of information and processing of UM decisions rapidly and with minimal delays. Our own internal systems are also integrated to allow expanded capture of enrollee service and utilization information and to empower staff to respond to enrollee and provider needs as they arise. Magellan Complete Care is aware that one of the biggest issues facing health plans today is the lack of integrated systems to closely monitor the health care experience of enrollees and the providers that serve them. It is not uncommon for even the largest and most sophisticated plans to have multiple systems – some of them homegrown and some of them from vendors – that are not integrated with one another or may not even have the latest eligibility and demographic data. This lack of interoperability and integration has the potential to create deficits in knowledge about an enrollee at any given time.

2.1. Strategy to Reduce Administrative Burden for Providers – Streamlined Systems and Processes
Magellan Complete Care continuously pursues strategies to improve operational efficiencies in the delivery and management of care and services for our enrollees and providers. Services managed through the utilization management department and subcontractors that require an authorization for medical necessity are approved through a single, consolidated platform which allows for rapid review and a transparent process. All Magellan Complete Care departments work together collaboratively to support the best decision making for our enrollees and our providers, as well as to minimize the burdens associated serving our enrollees.

The UM team is a unique blend of staff with clinicians who have medical and behavioral health backgrounds such as social workers, LPN, RNs, doctorate level professionals, all of whom understand the population living with SMI. Our integration/collaboration between the UM team and the hand off to the Clinical Coordination Team to manage our enrollees is also unique as both teams focus on quality of service together. This supports a more detailed ongoing understanding of enrollee needs and the ability to respond rapidly to requests for authorizations as they arise.

Magellan Complete Care’s UM Program and dedicated UM staff use our Florida experience as a strong foundation to develop models and approaches to UM that are based on standardized and compliant UM guidelines and review criteria. They also reflect the provider community and a detailed understanding of services, interventions, and outcome goals that best meet the needs of delivering medically necessary services and quality of care for this very complex population.
Service authorizations are requested by providers through the development of the individual plan of service, plan addendums, and treatment plans. Prior authorizations are not required to access emergent or non-emergent eligibility screening or crisis services. Inter-rater reliability reviews are also evaluated to ascertain that UM criteria are applied consistently by staff completing utilization review determinations.

TruCare is our internal automated authorization system, which is part of our fully integrated systems platform that links all key processing, enrollee engagement, care management, and utilization management systems as part of a single platform. Our systems have also recently been enhanced to allow for prior authorization requests to be submitted electronically via Magellan Complete Care Provider Portal, as required in s. 409.967(2)(c) 3., F.S. The authorization request is transferred to TruCare where it is reviewed for medical necessity. For ease of use, everything is within one system to access and exchange data, including fee schedules. We also plan to pursue integration with our vendor partners, allowing providers to enter our provider portal, which would be linked to our delegated vendors, with the ability to enter prior authorization through those links. This added feature will significantly streamline authorization processes for our provider partners, who would no longer need to go to separate sites for these activities.

Magellan Complete Care and delegated subcontractors provide written notice of all approvals, adverse decisions, service limitations and reductions of authorization to providers and enrollees through the approved enrollee and provider notifications. Adverse decisions follow the Notice of Adverse Benefit Determination letter as outlined in 42 CFR 438.210(c). Providers are able to see status of “DENY/APPROVE/PARTIAL APPROVE” on the website, but we notify them via letter first.

The UM Management team, which includes UM professionals e.g., LPNs, RNs, complete daily rounds with managers or team leads and review all inpatient cases to ensure that enrollees have the most appropriate level of care and to ensure the inpatient criteria was applied consistently, and the staff reviewed enrollee rationale, gaps, treatment plan, and discharge planning, as well as any further services the enrollee needs at discharge. Cases that need a higher review are referred to the medical staff and the physician to ensure enrollees meet the level of care, discharge care, and assistance.

The reviewers share the case to confirm all needed information has been captured and documented. This is presented to the medical director to ensure we address all care areas with care collaboration between care coordination and discharge planning. Pre-rounds are also utilized to guarantee that all areas of an individualized transition/discharge plan are addressed, to include the BH/PH integration and care coordination involvement. This is also used as an educational platform for the health services team members to understand how to manage difficult cases, prepare for discharge planning, care transitions and coordination with other enrollees of the health services team.

Magellan Complete Care ensures that all decisions to deny a service authorization request, or limit a service in amount, duration or scope that is less than requested, must be:

> Made by a licensed physician, psychiatrist, or dentist, as appropriate, or other professional as approved by AHCA, who has the appropriate clinical expertise in treating the enrollee’s condition or disease (42 CFR 438.210(b)(3)); and
Determined using the acceptable standards of care, State and federal laws, AHCA’s medical necessity definition, and clinical judgment of a licensed physician, psychiatrist, or dentist, as appropriate, or other professional as approved by AHCA.

Magellan Complete Care will notify the provider and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 CFR 438.210(c); 42 CFR 438.404).

Magellan Complete Care has established and maintains a UM system to monitor utilization of services, including an automated service authorization system for denials, service limitations, and reductions of authorization. We will not arbitrarily deny or reduce the amount, duration, or scope of a required service because of the enrollee’s diagnosis, type of illness, or condition.

Magellan Complete Care also seeks to limit administrative burdens for providers in requesting authorizations through the following additional strategies:
> Automated authorization system through the Provider Portal with quick fill out form
> Easy access to UM staff. The organization maintains a pre-certification team assigned to a phone queue that takes provider calls forwarded by customer service
> Dedicated fax lines are available for inpatient and outpatient providers within each department (concurrent review, precertification, retrospective review, care coordination, appeals, etc.)
> Enrollees and providers have access to our Healthwise health information system on our website. It provides important enrollee information and health education materials through the website for information

Magellan Complete Care subcontracts certain elements of the UM program. The subcontractor is evaluated regarding its ability to meet performance expectations, including capacity to meet NCQA requirements, before executing a formal agreement. The subcontractor agreement delineates the responsibilities of each entity including the specific UM activity that is subcontracted, provisions for enrollee experience data including PHI, process for evaluating the subcontractor’s performance, and remediation steps applied to substandard performance. For any UM services that are subcontracted, the entity will have its own supporting policies and procedures separate from the Magellan Complete Care platform. Oversight includes an annual audit of the subcontractor’s performance by Magellan Complete Care, approval of the subcontractor’s annual UM program and any follow up on improvement opportunities. Significant deficiencies are reported to the compliance department as well as the applicable Magellan Complete Care and Magellan Complete Care committee.

Magellan Complete Care subcontracts services for dental prior authorization to DentaQuest. Our relationship with DentaQuest includes a Utilization Management for prior authorization review for specific dental services. DentaQuest is also responsible for enrollee and provider notification letters.

Magellan Complete Care subcontracts specialized services for prior authorization for advanced (high-tech) radiology, pain management, radiation oncology, cardiac services, sleep disorder services, and musculoskeletal services/surgery to NIA. NIA is also responsible for enrollee and provider notification letters.

Magellan Complete Care subcontracts with Premiere Eye for prior authorization utilization management of vision services including office procedures, medical/surgical services,
pharmaceutical, and diagnostic services. Premiere Eye is also responsible for enrollee and provider notification letters.

Magellan Complete Care subcontracts with Magellan Rx Management Pharmacy for specialty pharmacy services. Magellan Rx is responsible for prior authorization of utilization management services for specific pharmaceutical services. This subcontractor is also responsible for enrollee and provider notification letters.

2.2. Strategy to Reduce Administrative Burden for Providers – Easy Access to UM Staff
The UM department conducts outgoing communications with providers regarding authorizations during the business hours of 8 a.m. and 7 p.m. EST. The Health Services Department has an after-hours toll free phone line available 24 hours a day, 7 days a week for enrollees and providers. Providers may call UM staff who are available Monday through Friday 8:00 a.m. to 7:00 p.m. to answer questions regarding UM decisions, authorization of care, and the UM program. In addition, there is a nurse available 24 hours a day, seven days a week for after-hours services for enrollees and providers.

During business hours, providers are able to call Enrollee Services or the Health Services department using the toll-free number. The call is answered by either a care worker or customer service staff enrollee, and transferred to a member of the clinical team. Outside of business hours, the toll-free number is automatically routed to a national resource team in our Iowa office. Provider calls for Magellan Complete Care are handled by screening for an emergency or crisis, and if none, contacting the on-call nurse for a call-back or warm transfer. Our staff have desktop procedures in place which provide step-by-step processes at a detailed level to avoid authorization review errors.

The Health Services department has both toll-free telephone and telefax numbers and offers TDD/TTY services for deaf, hard of hearing, or speech-impaired enrollees. We also have 711 phone access available. Translation is available at any time.

Telephone lines are staffed with professionals who have access to information and resources needed to provide a timely response. Performance standards are established for telephonic access. Communication protocols for UM are also in place. Staff are identified by name, title and organization when initialing or returning calls regarding UM issues.

Subcontractors follow the Magellan Complete Care operational hours and protocols for the UM staff availability and also have a 24 hour access platform to submit authorization requests.

2.3. Strategy to Reduce Administrative Burdens for Providers – Determinations Made by Qualified Healthcare Professionals
Licensed health professionals and RNs conduct clinical reviews of behavioral and physical health service requests and refer all cases that do not meet established criteria to a Florida licensed physician. UM licensed health professionals may issue approvals for administrative and clinical requests. Our UM process ensures that all decisions to deny a service authorization request, or to limit a service in amount, duration, or scope that is less than requested, are not made solely because of the enrollee’s diagnosis, type of illness, or condition. We also ensure that these decisions are made by health care professionals who have the appropriate clinical expertise in treating the enrollee’s condition or disease in accordance with 42 CFR 438.210(b) (3).
Our strategies to reduce administrative burdens for providers ensure that any limits on services are made on the basis of medical necessity as defined by the state, or are made for utilization control consistent with the terms of the Contract, provided the services furnished can be reasonably expected to achieve their purpose. Decisions for approved services are based only on appropriateness of care, appropriateness of service, and existence of coverage.

Subcontractors follow the Magellan Complete Care operational protocols and are overseen through our contractor oversight processes, which includes but is not limited to monthly and quarterly UM reports to ensure that the delegate is in compliance with all requirements. The reports are submitted to and reviewed by the Health Services Committee and the Quality Improvement Committee. Any aberrations are addressed immediately and any corrective action needed is implemented.

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT HAS DEMONSTRATED EXPERIENCE WITH MEETING TIMELINESS STANDARDS FOR SERVICE AUTHORIZATION REQUESTS.

Magellan Complete Care continues to meet and exceed timeliness standards for service authorization requests. As the current SMI specialty plan, Magellan Complete Care submits a monthly report of the authorization timeliness standards to AHCA as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

Magellan Complete Care currently complies with and exceeds the following standards, measured on a monthly basis, for notifying providers and enrollees in a timely manner. This includes performance by our delegated vendors who report their results monthly. Standards with which we comply include:

(1) The Managed Care Plan shall provide standard authorization decisions within no more than seven days following receipt of the request for service. (42 CFR 438.210(d)(1))

(2) The Managed Care Plan may extend the timeframe for standard authorization decisions up to seven additional days, if the enrollee or the provider requests extension, or the Managed Care Plan justifies the need for additional information and how the extension is in the enrollee’s interest.

(3) The Managed Care Plan shall provide expedited authorization decisions no later than forty-eight hours after receipt of the request for service. (42 CFR438.210(d)(2))

(4) The Managed Care Plan may extend the timeframe for expedited authorization decisions by up to two additional business days if the enrollee or the provider requests an extension or if the Managed Care Plan justifies the need for additional information and how the extension is in the enrollee’s interest.

3.1 Timeliness Results
The prior authorization timeliness data below demonstrates that we are consistently meeting and exceeding AHCA requirements. All targeted metrics exceed the threshold goal of 95 percent. Magellan Complete Care continues to monitor multiple timeliness metrics to ensure compliance with State, federal, and NCQA requirements.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Magellan Complete Care demonstrates compliance with the following standards, measured monthly, for processing authorization requests in a timely manner:

- % of Expedited Requests Processed within TAT (48 Hours): 96.12%
- % of Expedited Requests Processed within TAT (72 Hours): 98.43%
- % of Standard Requests Processed within TAT (7 Calendar Days): 98.81%
- % of Standard Requests Processed within TAT (14 Calendar Days): 99.26%

As presented to the Health Services Committee and the Quality Improvement Committee on a quarterly basis, Magellan Complete Care’s timeliness data demonstrates that we meet and exceed AHCA’s requirements.

3.2 Ongoing Monitoring of Timeliness
The UM department monitors activities through daily rounding with the medical directors for behavioral and physical health to monitor turnaround times for both behavioral and physical health. Activities include:

- Documentation monitoring on a daily basis: daily census report – monitor new admissions, concurrent admissions, and review associated determination timeframes
- Daily TAT report – Report allowing Magellan Complete Care management team to closely monitor TAT of individual UM department cases assigned
- Monthly Vendor Performance Reporting – Reports provide vendor performance against all key contract and regulatory requirements
- Staff Productivity Report (daily, monthly weekly) - provide Magellan Complete Care management team the ability to monitor ongoing staff productivity, to ensure UM criteria are appropriate and consistent.
- Daily Aging Report - review on a daily basis, share with staff as cases are coming due, ensures compliance with state and accreditation TAT requirements.
- Daily pre-rounding with managers:

  >>The UM Management team members, which includes UM professionals such as LPNs and RNs, complete daily rounds with managers or team leads. They review all inpatient cases to ensure that enrollees have the most appropriate level of care and to ensure the inpatient criteria was applied consistently. They also review to verify that the staff reviewed enrollee rationale, gaps, treatment plan, and discharge planning as well as any further services the enrollee needs at discharge. Cases that need a higher review are referred to the medical staff and the physician to ensure enrollees meet the level of care, discharge care, and assistance.

The reviewers share the case to confirm all needed information has been captured and documented. This is presented to the medical director to ensure we address all care areas with care collaboration between care coordination and discharge planning. Pre-rounds are also utilized to guarantee that all areas of an individualized transition/discharge plan are addressed, to include the BH/PH integration and care coordination involvement. This is also used as an educational platform for the health services team enrollees to understand how to manage difficult cases, prepare for discharge planning, care transitions and coordination with other enrollees of the health services team.
3.3 Timeliness Standards
The prior authorization timeliness data below demonstrates significant improvement on key indicators. All targeted metrics exceed the threshold goal of 95 percent. Magellan Complete Care continues to monitor multiple timeliness metrics to ensure compliance with State, federal, and NCQA requirements.

Magellan Complete Care complies with the Magellan Complete Care AHCA contractual following standards, measured on a monthly basis, for processing authorization requests in a timely manner:

1. Magellan will process ninety-five percent (95 percent) of all standard authorizations within fourteen (14) calendar days.
2. Magellan’s average turnaround time for standard authorization requests will not exceed seven (7) calendar days.
3. Magellan will process ninety-five percent (95 percent) of all expedited authorization requests within three (3) business days.
4. Magellan’s average turnaround time for expedited authorization requests will not exceed two (2) business days.

Magellan will make a determination and provide written notice of the determination as outlined by contractual and accreditation requirements

1. Turnaround time monitoring for outpatient (pre-cert) prior authorization requests for both Behavioral and Med/Surg Subdivisions

A. Description: Utilize Key Performance Indicator (KPI) report to audit 100 percent of standard & expedited prior authorizations not processed within Turn Around Time (TAT) timeframes (48hrs) for expedited & (7 days) for standard to determine reasons for missed TAT. Health Services Auditor (HSA) conducts audit to determine trends by staff or process and identifies needed interventions.

B. Frequency: HSA will review KPI report monthly. If KPI report shows pre-cert authorizations (standard/expedited) fall below 95 percent compliance of being processed within timeframe, then HSA will conduct audits to determine reasons/trends.

C. Reporting Frequency:
> If audits are conducted, HSA will analyze, assess, and report audit results on a monthly and quarterly basis.
> HSA will report quantitative/qualitative results to UM director and pre-cert manager (and the pre-cert team if needed). Management collaborates with Magellan Complete Care trainers to schedule remedial trainings, if needed, and identify opportunities for process improvement.
> HSA will provide audit results without delay to UM director and manager if outcomes of the audit present a risk or if audit results indicate trends that need to be addressed immediately.
> HSA will provide team with authorization errors that can be corrected and follow up to ensure compliance with corrections.
> HSA will provide audit results and analysis during quarterly Health Services Committee meeting.

2. Turnaround Time monitoring for Inpatient Concurrent Authorization Requests for Behavioral Health Subdivision
A. Description: Utilize Key Performance Indicator (KPI) report to audit 100 percent of initial/concurrent & concurrent authorizations not processed within Turnaround Time (TAT) timeframe to determine reasons for missed TAT. Health Services Auditor (HSA) conducts audit to determine trends by staff or process and identifies needed interventions.

B. Frequency: HSA will review KPI report monthly. If KPI report shows behavioral health Inpatient authorizations requests (concurrent) fall below 95 percent compliance of being processed within timeframe (72hrs), then HSA will conduct audits to determine reasons/trends.

C. Reporting Frequency:
> If audits are conducted, HSA will analyze, assess, and report audit results on a monthly and quarterly basis.
> HSA will report quantitative/qualitative results quarterly to UM director and IP BH manager (and the IP team if needed). Managers will collaborate with Magellan Complete Care trainers to schedule remedial trainings if needed and identify opportunities for process improvement.
> HSA will provide audit results without delay to UM director and manager if outcomes of the audit present a risk or if audit results indicate trends that need to be addressed immediately.
> HSA will provide team with authorization errors that can be corrected and follow up to ensure compliance with corrections.
> HSA will provide audit results and analysis during quarterly Health Services Committee meeting.

A. Description: Utilize Key Performance Indicator (KPI) report to audit 100 percent of initial/concurrent & concurrent authorizations not processed within Turnaround Time (TAT) timeframe to determine reasons for missed TAT. Health Services Auditor (HSA) conducts audit to determine trends by staff or process and identifies needed interventions.
B. Frequency: HSA will review KPI report monthly. If KPI report shows med/surg IP authorizations requests (concurrent) fall below 95 percent compliance of being processed within timeframe (72hrs), then HSA will conduct audits to determine reasons/trends.

C. Reporting Frequency:
> If audits are conducted, HSA will analyze, assess, and report audit results on a monthly and quarterly basis.
> HSA will report quantitative/qualitative results quarterly to UM director and IP PH manager (and the IP team if needed). Managers will collaborate with Magellan Complete Care trainers to schedule remedial trainings if needed and identify opportunities for process improvement.
> HSA will provide audit results without delay to UM director and manager if outcomes of the audit present a risk or if audit results indicate trends that need to be addressed immediately.
> HSA will provide team with authorization errors that can be corrected and follow up to ensure compliance with corrections.
> HSA will provide audit results and analysis during quarterly Health Services Committee meeting.

Health Services Committee (HSC) and QIC Review of Reports:
The HSC reviews aggregate utilization data for all levels of care, readmission rates, adverse incidents related to the UM process, complaints related to the UM process, high cost services, access to care and enrollee and practitioner satisfaction survey data to determine whether there are any indications of potential under-utilization or over-utilization and the need for additional analysis or intervention. This process may also serve as an opportunity to identify the need for
changes in UM policies and practices to be responsive to enrollee and provider needs. Magellan Complete Care monitors over/under-utilization, timeliness of urgent care/ER services, non-urgent care pre-service, concurrent care, and post service care. The HSC reports its findings and any interventions to the Magellan Complete Care QIC on a regular basis.

CRITERIA 4: THE ADEQUACY OF THE RESPONDENT’S EDUCATION AND TRAINING PLAN FOR PROVIDERS ON THE SERVICE AUTHORIZATION PROCESSES.
Magellan Complete Care has and will continue to offer education and training to providers on the service authorization processes. As part of our ongoing training series and during the mandatory provider orientation, Magellan Complete Care shares information about its authorization protocols, practice guidelines, medical necessity criteria, and detailed review processes. Magellan Complete Care ensures our providers consult and reference the Magellan Complete Care medical policy and clinical review guidelines.

Medical and behavioral health practice guidelines and information for training and education including service authorization processes, are available on the Magellan Complete Care website, under “Provider Tools,” in the Provider Handbook, and through the Provider Newsletter. We fully understand our responsibility to notify the provider and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (42 CFR 438.210(c); 42 CFR 438.404).

Magellan Complete Care utilizes several approaches to ensure that providers are educated and informed on the prior authorization process. Provider training includes the following key components:

1. Initial provider training
2. Periodic webinar refreshers
3. Provider newsletters
4. Provider portal access to handbooks and guides

Providers are also educated via joint operation calls, face to face meetings with UM, and provider network visits. Magellan Complete Care has a provider handbook, prior authorization grid, prior authorization form, prior authorization guide, provider demonstration, provider newsletters, and provider bulletins located on the web site. Provider support service (PSS) staff make onsite visits to work with our providers and answer questions and concerns they may have. The PSS is empowered to address provider issues as they are identified and bring forward any issues that need a multidisciplinary approach. Provider training is also periodically reviewed by our Provider Advisory Committee.

Subcontractor information is also supplied on the web site and within the provider handbook to ensure the providers know where to submit an authorization for these subcontracted services. The subcontractor authorization data is submitted to the UM leadership monthly as part of the subcontractor oversight and any detailed enrollee authorization data is accessible between the entities.

For further support on authorizations, we direct providers to our website to the “Authorizations” tab within the “Providers” tab, for supporting information about authorizations including:
We work with providers in integrated inter-departmental teams to ensure that providers understand and can comply with requirements. These teams include Health Services staff, which includes UM staff, in conjunction with the Provider Support Specialist Team. We meet with providers to ensure they understand AHCA Contract requirements, Magellan Complete Care protocols and related documents, as well as requirements for adherence to the Medicaid Handbook guidelines and fee schedules, to ensure consistency to prevent over-utilization, or fraud and abuse.

The UM department conducts onsite provider education to further educate providers on the distinct UM review process. A power point presentation is supplied to the providers with detailed information on how the prior authorization is requested, reviewed and determined. In addition, our regional Provider Optimization Delivery System (PODS) team responds to provider network management activities. This integrated team is organized throughout the State. Each of these teams is led by an embedded network contract manager, provider relations specialist and a network contract coordinators reporting to a network director. Each of these teams reports to the vice president of network development.

The same teams are responsible for the all physical and behavioral health practitioners, facilities, and ancillary providers within their assigned regions. Each team within the PODS is specifically charged with network contracting, credentialing, provider maintenance, network monitoring and providing technical assistance, site visits evaluations, and providing education to providers in the network, including the service authorizations process.

Our provider education and training model encourages the Magellan Complete Care commitment to high touch and prompt engagement with our physical, behavioral health providers, facilities and ancillary services. When we identify a need for additional training, we use our Provider Support Specialists to educate our providers. We also discuss requirements for training with the Provider Advisory Board.

It is very important that our facility providers have one contact directly to our UM team enrollees. Magellan Complete Care provides our facilities with a UM contact list to ensure communication is conducted in a timely manner. This allows the facility to address any questions on the UM process or any other concerns immediately.

We provide the following examples as opportunities to demonstrate our responsibility to create “easy to use” service authorization processes:

4.1 Example #1: JOC/Working with Providers with Guidelines and Protocols
During a JOC meeting with our provider, the discussion arose surrounding the peer-to-peer (PTP) review process. Discussion around streamlining the process occurred because the provider did not have one contact to the Plan when requesting a PTP. Magellan Complete Care discussed
and determined that the best approach would be to create a position dedicated to this function. The inpatient coordinator/peer-to-peer review coordinator arranges the PTP review with provider(s), contacts the provider to obtain pertinent information, sets up with the PTP with the Medical Director who made the initial decision, and verifies the best time to coordinate the call in a timely manner to discuss enrollee’s case.

4.2 Example #2
When AHCA released the mandated prior authorization form, our UM leadership led the training of this form to our providers. A training example form was established to help provide assistance on how the form needed to be completed. Specialized training was conducted directly with the high volume providers on the use of the new prior authorization form from AHCA. We proactively sent emails and called providers to inform them about the use of the new form. Education was also provided to the PSS team so that they could educate their assigned provider groups. Information was also supplied in the provider bulletin – under “Provider Reminder” section.

4.3 Example #3: Easy access to UM
Magellan Complete Care has a designated employee in the UM department who is the point of contact for residential psychiatric treatment reviews (i.e., Statewide Inpatient Psychiatric Program, Specialized Therapeutic Group Care). This dedicated employee is qualified by training and experience to manage this population and assist in the process of placement, manage the case from a coordination and utilization management standpoint and coordinate so the enrollee’s discharge planning commences timely.

The providers have ease of access to send requests for prior authorization directly to this staff member and to receive electronic authorization information. They can also submit inquiries and discuss cases as needed. This staff member manages caseloads specific to this population and is the point of contact with outside agencies.

Magellan Complete Care has developed strong, durable, and mutually beneficial relationships with network providers by utilizing targeted provider onsite outreach and trainings, webinars, provider support site visits, and prompt day-to-day issue resolution. This approach in turn, positively affects provider understanding on the service authorization process.

CRITERIA 5: THE EXTENT TO WHICH THE RESPONDENT ENSURES TRANSPARENCY IN SERVICE AUTHORIZATION PROCESSES (E.G., MAKES AVAILABLE ALL UTILIZATION MANAGEMENT PROTOCOLS AND CRITERIA IN AN ACCESSIBLE LOCATION FOR SERVICE PROVIDERS).

As the current SMI specialty plan provider, Magellan Complete Care UM staff have expertise and experience in physical, behavioral health care services and a deep understanding of our enrollees’ unique needs. Participating providers and UM decision-makers are required to help ensure that UM decisions are based only on the appropriateness of care and service and the existence of coverage. UM determinations are made by qualified healthcare professionals and appropriately licensed professionals supervise all medical necessity decisions.

Information on our UM protocols and criteria are made available to all providers through our provider portal, provider handbook, provider training materials and regular face-to-face support delivered by our provider support specialists. We also provide instructions for authorizations for all delegated subcontractors. As noted previously, we will be adding links from our provider portal to all vendors, including information on UM protocols for each, so that this information is readily available for all delegated entities from this single site. Currently, we provide those links for Magellan Rx and for NIA.

Magellan Complete Care’s UM process ensures that all decisions to deny a service authorization request, or limit a service in amount, duration or scope that is less than requested, are not made
solely because of the enrollee’s diagnosis, type of illness or condition, and are made by health
care professionals who have the appropriate clinical expertise in treating the enrollee’s condition
or disease in accordance with 42 CFR 438.210(b) (3).

As with our entire system of delivery and care management, our UM practices and policies have
been specifically adapted to support the broad base of services required to support our enrollees
and the complexity of their care needs. This includes the use of standard clinical protocols such
as MCG (Milliman Care Guidelines) as well as our own proprietary guidelines that that are adapted
for the combined behavioral health and physical health needs of our enrollees.

Magellan Complete Care also leverages the experience of Magellan Health, Inc., (“Magellan”) our
parent company and affiliates, which have successfully administered UM services for Medicaid
eligible populations for over 40 years, managing and delivering health benefits to Medicaid
beneficiaries living with serious mental illness in multiple states. Our programs and operations
have been designed with these specific needs in mind. Our staff are uniquely qualified and trained
to understand the needs of these enrollees and the providers who serve them. Magellan Complete
Care ensures that any limits on services are made on the basis of medical necessity as defined
by the State or for utilization management, consistent with the terms of the Contract, provided the
services furnished can be reasonably expected to achieve their purpose. Decisions for approved
services are based only on appropriateness of care, appropriateness of service, and existence of
coverage.

Magellan’s medical necessity criteria (MNC), which are based on current scientific evidence and
clinical consensus, are used in making medical necessity determinations. We review the criteria
annually, taking into consideration current scientific evidence and provider feedback, and revise
them as needed. We also align these criteria with AHCA’s medical necessity standards and
practice protocols.

Medical necessity criteria and associated UM protocols are made available to any interested party
on the MCCofFL.com website or by hard copy upon request by calling Enrollee Services at 1-
800-327-8613.

Magellan Complete Care has clinical resource references located on our website for providers to
access. These resources include:

> Clinical UM Guidelines
> Behavioral Practice Guidelines
> Behavioral Medical Necessity Criteria
> CMS Behavioral Health Tool Kit
> Medical Practice Guidelines
> Medical Records Review
> Prenatal Practice Guidelines
> Preventive Practice Guidelines
> Substance Use Disorders
> 2017 Florida Best Practice Recommendations for Women of Reproductive Age with Serious
Mental Illness and Comorbid Substance Use Disorders

Our subcontractors provide protocols and guidelines to our providers upon request, although as
noted previously, we will be providing access to that information through our provider portal in the
future. The Pharmacy Florida Medicaid preferred drug list (PDL) is established by AHCA, and
criteria are accessible on the State website.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Our protocols for developing, reviewing, adopting and annually evaluating clinical criteria is based on a formal and systematic review of nationally recognized standards, and we take into consideration our SMI population and local practice patterns. Every change is communicated to providers through fax blasts, bulletins, and posted online to make sure the provider has sufficient time to adapt to the new process.

CRITERIA 6: THE EXTENT TO WHICH THE WORKFLOW DESCRIBING THE RESPONDENT’S PROCESS FOR HANDLING “SPECIAL SERVICE” REQUESTS...
Magellan Complete Care has and will continue to handle “special service” requests consistent with EPSDT requirements; see [General SRC #19, Attachment 1: Special Services Workflow]. We follow EPSDT criteria and follow the same process we use for exceptions. For EPSDT Magellan Complete Care covers all services as long as those services meet medical necessity criteria. Magellan Complete Care provides all medically necessary services for its enrollees under age 21. This is the case even for non-covered services or services with limits. As long as the child’s services are medically necessary, services have no dollar limits and no time limits, such as hourly or daily limits. Providers must request a prior authorization which will be reviewed for medical necessity. If medical necessity criteria are not met, the request will be forward to a medical director, for approval or denial. Magellan Complete Care has a Special Services Coordinator who is a UM lead or manager with specific EPSDT training to we ensure we handle these in compliance with federal EPSDT guidelines.

Magellan Complete Care also has protocols for reviewing non-covered services such as services that are not listed in the service-specific Medicaid Coverage and Limitations Handbook or fee schedule; services not covered by the plan; or services for which the amount, frequency, or duration of the service exceeds limitations specified in the service-specific handbook or corresponding fee schedule. Magellan Complete Care Prior Authorization Department defers these types of special circumstances to a medical director for possible benefit exception. For non-par providers, Magellan Complete Care follows the out-of-network (OON) protocol. If no other provider is available, the request will be deferred to a medical director for possible benefit exception.

Magellan Complete Care has developed a process for authorization of any medically necessary service to enrollees under the age of twenty-one (21) years, in accordance with Section 1905(a) of the Social Security Act, when:

> The service is not listed in the service-specific Medicaid Coverage and Limitations Handbook or fee schedule, or is not a covered service of the plan; or
> The amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.

Magellan Complete Care provides comprehensive and preventive care and services for individuals under the age of 21, in accordance with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program consistent with the EPSDT requirements. Treatment services for enrollees under the age of 21 which are not otherwise covered under the State Plan can be covered for a child through EPSDT in accordance with Social Security Act Section 1905(a), and if determined by Magellan Complete Care as medically necessary.
Magellan Complete Care will provide coverage through EPSDT for medically necessary benefits for children outside the basic Medicaid benefit package including, but not limited to: Extended behavioral health benefits, nursing care (including private duty), pharmacy services, treatment of obesity, neurobehavioral treatment, and other individualized treatments specific to developmental issues where it is determined that otherwise excluded service/benefit for a child is a medically necessary service that will correct, improve, or is needed to maintain (ameliorate) the child's medical condition.

Magellan Complete Care ensures that there are supportive policies and procedures on the review process for EPSDT services. These policies are reviewed on an annual basis or more often as needed. The UM process for EPSDT eligible children and youth are taken into consideration in the following ways:

a. When benefits are quoted, they are never quoted as non-covered but instead the enrollee or provider are informed that the service must undergo a medical necessity review.

b. All service requests for children and youth are accepted upon intake.

c. Services falling under EPSDT are not denied as a non-covered service or as a covered services that has maximized the benefit limit. These services would only be denied as not meeting medical necessity under the federal definition.

d. All services not meeting medical necessity for children and youth under age 21 e.g. benefit coverage determinations falling under EPSDT are reviewed by a medical director.

e. All other UM processes are followed in a compliant manner including intake of information, gathering of information, timeliness standards and notifications to the enrollee and provider.

f. Magellan Complete Care will cover medical services (even if experimental or investigational) for children per EPSDT guidelines if it is determined that the treatment or item would be effective to address the child's condition. We will base the determination whether a service is experimental must be reasonable and based on the latest scientific information available.

6.1. Example of a Special Service Request and Coordination for a Child
A 16-year-old child with a history of child abuse was displaying sexual acting out behavior. An evaluation was completed and a recommendation was made for him to receive sexual offender treatment. The child received residential psychiatric treatment in Florida; however, there were no programs available in Florida for this specialty that could meet the enrollee’s needs.

At that time, our integrated residential treatment specialist/coordinator, in conjunction with care coordination, worked toward finding and easing the process of placing the child out of state. A single case agreement was completed with a sexual offender program in Indianapolis, Indiana.

At the time of discharge, there were difficulties with discharge planning due to a court order not letting him return home due to children he perpetrated on living in the same home. We provided continued coordination from Magellan Complete Care to make sure a step-down facility accepted him in state. After continued efforts, all Florida group homes denied his admission due to different reasons such as legal requirement of not being able to be around younger children, enrollee’s age at time of discharge (17 years old), and overall not being able to meet his treatment needs.
Coordination with outside agencies and programs continued, and Magellan Complete Care was able to place this young man in a specialized therapeutic group home in the same state he completed his residential treatment. Transition to the group home was successful after he completed his sexual offender treatment. Magellan Complete Care followed and worked with this child for over two years.

Evaluation Criteria:

1. The extent to which the respondent proposes the use of interoperable systems that will seamlessly integrate information from providers to the respondent and its subcontractors (to the extent any UM functions are delegated) and the extent to which the respondent describes how that information will be used to enhance care coordination services and to ensure there are no delays in authorization or gaps in care.

2. The extent to which the respondent uses strategies to reduce administrative burdens for the provider (e.g., software capabilities) in requesting authorization and its approach is streamlined with little to no redundancies between and across departments which could contribute to delayed service authorizations.

3. The extent to which the respondent has demonstrated experience with meeting timeliness standards for service authorization requests.

4. The adequacy of the respondent’s education and training plan providers on the service authorization processes.

5. The extent to which the respondent ensures transparency in service authorization processes (e.g., makes available all utilization management protocols and criteria in an accessible location for service providers).

6. The extent to which the workflow describing the respondent’s process for handling “special service” requests is consistent with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.
SRC# 20 – Care Coordination (Statewide):

The respondent shall describe its approach for identifying, assessing, and implementing interventions for enrollees that present with the following:

- Complex medical and/or behavioral health needs;
- High service utilization;
- Intensive health care needs; and
- Consistently accessing services at the highest level of care.

The respondent’s approach shall include:

a. A description of the algorithm used to identify and stratify eligible enrollees by severity and risk level;

b. A description of minimum contact frequencies and contact type for each severity and/or risk level;

c. A description of the maximum caseloads for each case manager (ratio requirements) and support staff;

d. A description of evidence-based guidelines utilized in the care coordination approach, including interventions deployed to improve enrollee engagement and improve treatment adherence; and

e. A description of performance metrics used to evaluate the efficacy of the care coordination, including cost-savings, reduction in the use of higher cost services, etc.

Response:

OVERVIEW

Magellan Complete Care of Florida’s Serious Mental Illness (SMI) Specialty Plan was created for the sole purpose of developing, delivering, and managing state-of-the-art integrated medical and behavioral health services for Medicaid recipients ages six and older who are diagnosed with or in treatment for a SMI. Magellan Complete Care serves our enrollees and their families through a care coordination system that is person-centered, community-focused, and evidence-based. To ensure the care and services provided to our enrollees are individualized, coordinated, fully integrated, and cost-effective we use a person and family-centered approach that includes the holistic evaluation of each enrollee’s circumstances.

Our system of care integrates community-based services and ensures access to timely care from primary, behavioral health, and specialty care that is skillfully coordinated to improve health outcomes, reduce duplicate services, and deliver enrollee-centered health care and wellness activities. Through our Integrated Health Neighborhood™ (IHN), our care coordination system is designed to support regional needs as well as to provide enrollee-specific support. Our experience as the State’s first SMI Specialty Plan serving Florida’s enrollees who are living with SMI, combined with more than 40 years of providing a tailored spectrum of behavioral health
The demonstrated efficacy at the heart of our care coordination system stems from systems-level integration of behavioral and physical health services; disease- and condition-specific expertise; and a focus on population health and wellness. We excel in the development of innovative strategies to combat vulnerabilities linked to social determinates of health (e.g., employment, housing, food security, health literacy, access to transportation, and education level) that further compromise the health status of our enrollees. This experience allows AHCA to have confidence that the needs of its most vulnerable subpopulations are being addressed in a proactive and holistic fashion.

**CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT'S ALGORITHM AND RISK STRATIFICATION APPROACH IS WELL-DEFINED...**

Magellan Complete Care provides care coordination/case management (CC/CM) to eligible enrollees appropriate to the needs of persons meeting the SMI Specialty Plan eligibility criteria. We have developed, implemented, and maintain an AHCA-approved CC/CM program specific to the enrollees living with serious mental illness (SMI) who we serve. Magellan Complete Care ensures our CC/CM staff meet or exceed all requirements related to qualifications and experience for the provision of services as defined. We comply with and have incorporated within our integrated system of care AHCA’s clinical program requirements, applicable NCQA Standards, and applicable State and federal regulations and requirements. Magellan Complete Care ensures that in the process of coordinating care, each enrollee’s privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. 45 CFR Part 164 that specifically describe the requirements regarding the privacy of individually identifiable health information.

Our CC/CM programs are based on a uniquely designed risk and needs assessment methodology that incorporates multiple data sources and allows us to stratify our enrollees by behavioral health (BH), physical health (PH), and social risks and requirements. Enrollees are assigned to CC/CM programs of interventions and supports that reflect their combined complexity and need, and/or likelihood of high utilization. Our CC/CM model, referred to within Magellan Complete Care as the integrated care case management (ICCM) model, incorporates solutions for enrollees who are more stable and easier to reach and engage as well as enrollees who are difficult to find, hard to reach and challenging to engage. Our integrated care case managers (ICCMs) use the Case Management Society of America’s Case Management Standards of Practice and National Association of Social Work Case Management Guidelines.

Magellan Complete Care has sufficient CC/CM staff who are qualified by training, experience and certification/licensure applicable to the Specialty Plan population. Staffing ratios and mix of skill sets varies based on enrollee need and complexity based on our risk stratification and segmentation methodologies as well as utilization and gaps in care data. Our senior medical director and behavioral health medical director, oversee the CC/CM program, along with our vice president of health services, quality director, utilization management director, and director of population health. In addition, the locally based leadership team is supported by a team of national team clinical subject matter experts.

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Magellan Complete Care sees the continuum of care and the support provided to enrollees through CC/CM as a fluid treatment pathway, which enrollees may enter at any level to be moved to more or less-intensive settings and different levels of care or case management (CC/CM) as their changing clinical needs dictate. Our active, regular engagement with enrollees in CC/CM allows us to monitor and adjust care plans and the intensity of enrollee engagement and support as enrollee health improves or degrades. Our approach to risk stratification and segmentation of our enrollee population reflects that approach to continuous data capture, monitoring, assessment, and analysis for assignment of enrollees based on changing needs.

Identification of enrollees for CC/CM starts at the earliest stages immediately after enrollment, beginning with our analytics team reviewing available enrollee diagnostic information and claims data to proactively sort the enrollees based on prioritized needs whenever possible. New enrollees receive a welcome call and introduction to the health plan. Our CC/CM team immediately follow up with the completion of Magellan Complete Care’s SMI-tailored health risk assessment (HRA), which includes components that identify key areas of risks and the unique needs of the SMI population who are also presenting with other complex physical and social health needs. In addition to basic clinical information, the information captured includes health habits, living situation, and social connectedness, which are important predictors of outcomes for individuals living with SMI.
We use this information, clinical judgment, and team input to assign enrollees to a level of CC/CM that is most appropriate based on enrollee need, risk, and complexity. Using the HRA, ongoing clinical assessments, regular data capture, and predictive modeling, we gather in-depth clinical information about enrollees that can be used to identify and prioritize both short- and long-term CC/CM needs.

Magellan Complete Care has designed its CC/CM model around a “no wrong door” approach for enrollees to access CC/CM services throughout their tenure with the plan. Enrollees can be referred for any of the programs at any time. Enrollees who experience a critical event or diagnosis receive timely integrated, complex CM services. To minimize the time between when an enrollee’s need is identified and when the enrollee receives services, we have multiple avenues for enrollees to be considered for CC/CM services, ranging from input from nurses on the telephonic Nurse Line, to hospital discharge planners, to enrollee self-referral.

Many Magellan Complete Care enrollees present with physical health and/or behavioral health comorbidities. These comorbidities can further complicate their ability to engage and diminish their quality of life as well as their ability to adhere to treatment plans. Results of our own internal analyses of our enrollees show that 50 percent of our enrollees have at least one physical health comorbidity and 42 percent have more than one behavioral health diagnosis. This complexity demands that we regularly monitor indicators of enrollee health and stability, as well as utilization patterns and trends, pharmaceutical data, and lab data.

Magellan Complete Care has a three-tiered process for both enrollee stratification/segmentation, and development of enrollee interventions. These include:

1. Enrollee onboarding and health risk assessment (HRA) at enrollee on-boarding
2. Ongoing, data-driven segmentation/stratification for Population Health and Wellness/DM/CC/CM assignment
3. Annual assessment of enrollee characteristics and needs

1.1 Enrollee Onboarding and Health Risk Assessment
An essential element to enhanced care coordination is using an assessment and planning process with the enrollee, and the unique needs of those living with SMI, at the center. Screening for behavioral health, substance use disorders, social determinants of health, and physical health concerns begins at the time of enrollment using the Magellan Complete Care Initial Clinical Assessment. This standardized assessment tool is an SMI-tailored HRA that includes components to identify key areas of risks and needs of the SMI population.

The core domains of the HRA include:

> Living situation
> Hospital/office visit history
> Substance abuse history
> Social activity/social connectedness
> Preventive test history
> Chronic physical and behavioral health condition history, and
> Rating of health
We use the SMI-specific HRA along with additional data to screen enrollees, score their level of risk, document those risks, and stratify enrollees for assignment to the various levels of care management and planned interventions. We also employ enhanced, branching assessments that cover a broad range of SMI, substance abuse, serious emotional disturbance (SED) for children and youth, medical, and psychosocial conditions in order to broaden the scope of CC/CM assessment and ensure a comprehensive and personalized care plan.

The assessments are used to develop a list with each identified problem mapped to appropriate goals and interventions, which are specific and actionable. Enrollee choice and self-determination is incorporated into care planning. Examples of some of the key domains included in the initial clinical assessment are as follows:

- Medication adherence
- Assessment of life planning and self-directed care activities
- Physical, psychosocial, cognitive, and functional needs
- Comorbidities
- Pregnancy / prenatal / perinatal / postpartum
- Cultural needs assessment
- Ability to perform activities of daily living (ADLs)
- PCP and specialists
- Behavioral health and substance abuse screening
- Clinical history, including condition specific issues and medications
- Mental health history
- Collaborate with long-term care (LTC) providers to determine long term services and supports (LTSS) needs and what services are currently being receiving
- Evaluate caregiver resources and social supports
- Utilization history
- Fragility

Planned interventions are person-centered, individualized and disease-specific. For example, behavioral health gaps in care have different goals than substance abuse or physical health gaps in care. Interventions also take into account the enrollee’s psychosocial status and support system. The enrollee’s plan of care includes a plan for self-management that is tailored to the enrollee’s behavioral health condition, preferences and supports. e.g., caregiver support, peer support, health guide (HG), and ICCM support.

Magellan Complete Care’s HRA can be administered in person or telephonically. Once the Care Management Team is informed that an individual is enrolled in the plan, staff reaches out to the enrollee through written materials, telephonically and face-to-face, to welcome them to the plan, and gather the HRA as well as documenting our new enrollee interview. Together, these tools are used for a baseline understanding of the enrollee’s recent health history and current needs. All enrollees in an institutional setting receive a face-to-face evaluation, if possible.

Our goal is to complete an initial assessment within 30 days of enrollment for most enrollees living in the community and within 15 days for enrollees living in an assisted living facility (ALF) or other institution. We use health guides and peer support specialists to help locate individuals who are homeless or otherwise hard to find. The baseline information collected through administration of the HRA form allows Magellan Complete Care to stratify the population and identify those who are at greatest risk. Relying on a unique scoring system that assigns different values to higher
risk elements, such as ER use and presence of chronic and disease-specific conditions such as hypertension, Magellan Complete Care stratifies the population into multiple risk categories (Ultra-High, High, Moderate, Low, and Wellness and Prevention) based on the self-reported responses on the HRA. The risk level guides the level of optimal care management that addresses each person’s specific needs. Enrollees who are stratified as moderate or high risk will have additional clinical needs assessment completed to determine whether they meet criteria for participation in a DM/CC/CM Program and to provide information for care planning.

HRAs, which are updated on an annual basis or when an enrollee experiences a key trigger event such as an inpatient admission, provide important insights into identifying the needs of enrollees and opportunities to support enrollees in managing their conditions. This information supplements the monthly data identified through our predictive modeling process and the ongoing, real-time identification through utilization management, enrollee and provider referrals, and other referral sources. Enrollees who are newly identified as eligible for a DM Program are then referred to the appropriate program via the clinical information system for follow-up and outreach.

1.2 Ongoing Segmentation/Stratification for Enrollee Population Health and Wellness, DM/CC/CM Assignment
Magellan Complete Care uses multiple tools to identify enrollees at risk and refer them to the appropriate care coordination or provider programs based on their level of risk. On an ongoing basis, methods to screen enrollees and identify risks may include the health risk assessment process and scoring, utilization and Rx reports and patterns, direct referral, or having special high-risk conditions or social dynamics.

Magellan Complete Care has licensed ImpactPro to enhance our predictive modeling capabilities. We have modified the tool to incorporate behavioral health conditions, social support status and other issues that are unique to this population. The tool assesses future utilization and assigns each person a likelihood of hospital admission and other health service utilization based on previous claims and other data, including enrollee-reported information. The model relies on the use of a more robust data set than most models, including:

- >Enrollment information (age, gender)
- >Medical and behavioral claims (diagnoses, costs of care, events)
- >Outpatient pharmacy claims
- >Lab results
- >Information from clinical systems
- >Selected health risk assessment data

In addition to identifying the top-tier risk population on a monthly basis for possible DM/CC/CM management, ImpactPro also identifies gaps in care that can be used to improve clinical care and outcomes and mitigate the risk of increased utilization.

Enrollees are evaluated for physical health, behavioral health, and social risks. They are then segmented and stratified by the nature, severity and complexity of those risks. We also capture and consider social determinants for predictive modeling, risk stratification, and identification of appropriate interventions. When creating predictive models of inpatient risk, as well as analyses of drivers of HEDIS measure compliance, Magellan evaluates enrollee response information on the health risk assessment indicating whether the patient has stable housing and/or lacks transportation to medical appointments. If a patient does not have a health assessment, we use
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the United States Census Bureau geocoder tool to link enrollee addresses with census tract via latitude and longitude. Factors related to the patient’s area of residence are included in models to create a SocioEconomic Burden Score (SBS).

The SBS incorporates household size, marital status, educational attainment, primary language spoken, disability status, participation in the labor force including withdrawal from labor due to disability, and presence of children under the age of 18 in the home. In 2018, the score will be expanded to include crime statistics for the region in which patients reside. These factors are not exact measurements of the social determinants of health but are used as proxies of patients who face unstable housing, dangerous living environments, challenges with childcare and lack of economic parity due to an inability to access the workforce. The higher the patient’s SBS, the more social risk factors the patient tends to have, which contributes to a reduced likelihood of remaining adherent to medications, and increased likelihood of inadequate access to care.

Going forward, the DM and ICCM teams and our quality teams will also leverage the SBS to help drive the selection of appropriate action outside of enrollee identification. We have found the score to be an important factor in improving the accuracy of our predictive models and our driver analyses, and we believe it can do the same for defining enrollee personas and identifying the best interventions given those enrollee characteristics. We will use the patient’s SBS score to drive appropriate prescriptive tasks for our intervention teams to complete with the enrollees (e.g. if a patient appears in an area of high crime, with high rates of single parent households, then we should be ensuring we review access to childcare as a potential barrier to access to healthcare). We are also planning to further enhance the model by identifying metrics associated with food insecurity, which has been shown to be associated with outcomes for specific chronic illnesses such as hypertension and diabetes.

Based on the results of these analyses and ongoing CC/CM activities, our enrollees are stratified into the following risk categories, with the level of support and intervention varying depending on that enrollee classification. Our program uses a combination of administrative data and predictive modeling as well as real time referral sources to identify enrollees with targeted diseases who are eligible for DM/CC/CM programs. Administrative data is produced through regular reporting procedures that are followed each month, and the data is reviewed at least monthly to identify individuals with targeted diseases. This data is used to:

> Identify enrollees who meet criteria for a specific condition and comorbidities using HRA, claims, Rx data, etc.
> Score enrollee risk and support needs based on results of key inputs evaluated using our predictive modeling algorithm
> Stratify enrollees into prevention and wellness, low, moderate, high-risk, ultra-high risk, and monitor risk categories based upon medical and behavioral health risk

As of June 2017, Magellan Complete Care had approximately 3,240 enrollees participating in CC/CM. Members are stratified into the following risk categories:

> Ultra-High Risk/Enhanced Care Coordination is identified as an enrollee who is likely to admit within 90 days
> High Risk is identified as an enrollee who is in need of short-term case management for identified short-term needs that are easily resolved within a defined period of time. This category also
includes enrollees assigned to our disease specialty teams (congestive heart failure, high-risk diabetes, mood disorders, schizophrenia, high-risk pregnancy, sickle cell disease, first episode psychosis). This risk category is further broken into the following sub-groups:

>>Short-Term Management: Individuals with a short-term need easily resolved in a limited period of time

>>Disease state Specialty Team: Individuals at high-risk who have diagnoses included in one of our disease specialty teams (schizophrenia, bipolar disorder, CHF, high-risk diabetes, sickle-cell disease, high-risk pregnancy, and first-episode psychosis in youths and adolescents)

>Monitor Risk is defined as an enrollee meeting High or Ultra High risk criteria who is unable to be reached or has refused intervention. These enrollees are assigned to a CC health guide for monitoring and follow-up at regular intervals. Monitor risk will also include enrollees who are showing evidence of rising risk, including excessive ER or other acute services use, changes in medication therapy, etc. This enrollee segment is actively monitored and flagged for more intensive intervention by a health guide (or CHW, as that program is developed).

>Moderate Risk criteria are identified as:

>>Score of 1-4 on HRA

>>Navigational/coordination needs that may necessitate monthly follow-up for a few months, until enrollee is stable and/or has all needed outpatient services in place

>>If the enrollee’s needs are more condition-specific, with moderate educational and coordination needs and qualifications for one of the case management assisted DM programs, for management by a Wellness Specialist

>Low Risk criteria are defined as follows:

>>Score of 0 on HRA

>>Minimal needs identified

>>Step-down cases from case management or CCM programs

>>Individuals with a single, well-controlled disease state who are provided with self-care and health education support

>Wellness and Prevention criteria are defined as follows:

>>Score of 0 on HRA

>>Minimal needs identified

>>No physical health comorbidity

>>No more than two (2) BH diagnoses

It is important to note that enrollees may move between stratification levels, although our goal is to move toward stabilization and sustainable management of the enrollee’s health, with enrollees graduating to less intensive intervention levels as those goals are achieved. Step-up/down criteria to move to a different level of care management are as follows:

1. 90 Days Community Tenure: 0 incidents of ER or Inpatient Utilization for 90 days

2. Enrollee refused care management. In this instance enrollees will be contacted at regular intervals, based on their illness and complexity, to determine if they are interested in participating. Magellan Complete Care maintains an opt-in policy for our CC/CM programs
3. CC health guide unable to contact for 14 days after the program opening is completed and 3 outreach attempts. As with item 2 above, we will continue to attempt to engage the enrollee at regular intervals. We will also attempt to engage enrollees if they present as an inpatient or in the ER.

4. Enrollee is compliant with outpatient treatment and has demonstrated progress towards care plan goals.

Magellan Complete Care uses the TruCare care management system to coordinate care for all enrollees, including those who have the most complex health needs. TruCare is the Magellan Complete Care application providing clinical systems support for UM, case management, health promotion, care transitions, DM, and care coordination tasks that has been customized for our population base. TruCare integrates with our claims processing and provider data applications to enable health services staff to assess enrollee needs, complete care coordination plans, and authorize services.

We document all enrollee contacts as well as all elements of care management processes and services in the TruCare system. Information sent to us by the providers, facilities, and other treatment team enrollees is uploaded and attached to each enrollee’s record. This provides for a comprehensive tracking of all activities, information, services, treatment plans, discharge plans, etc., related to the enrollee.

System support for enrollees in complex case management operates seamlessly within TruCare, establishing a single platform for Magellan Complete Care staff across the whole continuum of care (both behavioral and physical), and encompassing all care settings. TruCare effectively tracks enrollee programs and case artifacts in one place. When baseline assessments are completed for an enrollee, the TruCare system provides the ICCM with prompts to create a care management plan for the enrollee.

The system also provides a list of recommended problems and interventions for a user to select from when building the care management plan, based on the enrollee’s assessment responses. The problems and interventions are based on opportunity areas for care management to focus support. For instance, if the enrollee responds on the initial assessment that he/she often forgets to take his/her medications, a problem of “medications” will be recommended for the user to select from when building the enrollee’s individualized care plan.

1.3 Annual Assessment of Enrollee Population Characteristics and Needs

Magellan Complete Care, at a minimum, annually assesses the characteristics of its enrollee population, and sub-populations to identify changes in underlying enrollee characteristics, disease-burden, and risk levels. As noted previously, enrollees are evaluated for physical health, behavioral health, and social risks.

Our segmentation and stratification model will be updated based on changes in key risk factors, outcomes or drivers of utilization. We regularly analyze the results of our interventions to determine which are most effective overall and with specific enrollee sub-segments, and will modify both our segmentation and stratification models, as well as our interventions to drive improved outcomes. We also analyze our populations to determine which characteristics are most commonly associated with key gaps in care, patterns of high or inappropriate IP or ER utilization, or use of high-cost, high-complexity services. For example, our analyses have shown that...
enrollees who are homeless or have co-occurring substance use, typically drive much higher IP and ER utilization. Enrollees on multiple psychotropic medications experience similar patterns. Not surprisingly, enrollees with higher levels of primary care engagement display the results.

The information gathered through these processes is used to refine our segmentation and stratification model, as well as DM/CC/CM programs, including changes needed in clinical programs, planned interventions, staffing mix/level, etc. Our Population Assessment analytical map includes the following key elements:

1. Data Inputs:
   a. Authorization system data
   b. Medical and Rx claims
   c. Enrollee demographics (age, gender, language, ethnicity)
   d. HRA and other enrollee attributes (e.g., homelessness, etc.)
   e. Fast-tracked referrals from enrollee, providers, agencies, stakeholders

2. Processing Engine and Data Mart:
   a. Available data is then driven through our proprietary processing engine that identifies: gaps in care, enrollee risks and assignment to risk category, HEDIS gaps, key clinical dashboard metrics, etc.
   b. A detailed clinical profile for each enrollee, including their risk status and prioritization, is then made available to DM/CC/CM and QI staff via reporting systems and online clinical dashboards

3. Reporting System:
   a. Data generated through our processing engine and data mart are made available to CC/CM staff in a web browser
   b. Data can be filtered at both an individual and population level
   c. Population reports are used to stratify enrollees for intervention, assess utilization and cost trends, etc.

4. We support multiple methods to segment and stratify populations for intervention and program design, including:
   a. Age (adults, children, adolescent, etc.)
   b. Language, race and ethnicity
   c. Geographic distribution
   d. Income and living situation (e.g., homelessness)
   e. Diagnoses (including chronic conditions, injury, type(s) of SMI, etc.)

The outcomes from these analyses are available to staff on an ongoing basis to identify needed interventions, etc. However, most importantly, these analyses are used on an annual basis by Magellan Complete Care’s Health Services Department, Care Coordination and Quality Improvement workgroups for the following key activities:

> Annual program evaluation and population assessment
> Review of case management structure and resources
> Recommendations for program refinements
> Recommendations for case load revisions
> Recommendations for program focus and direction
> Design of provider performance improvement and value-based payment models
>PCP and PBHP assignment

These analyses and resulting activities are a regular and important part of refinement of our understanding of enrollee risks and needs, and development of programs to respond. On an ongoing basis and at least quarterly, the leadership team reviews the data analysis and results of key metrics which are directly linked to Quality of Care, Cost of Care, and HEDIS initiatives.

CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES DATA SOURCES THAT ARE INCORPORATED INTO THE RISK STRATIFICATION PROCESS...

As noted in the section above, Magellan Complete Care has developed a stratification and segmentation model that is uniquely designed for our complex SMI population, and which uses data from many sources. [General SRC #20, Attachment 1: Magellan Complete Care Risk Stratification Model] for a process flow which visually describes our model.

Due to the unique characteristics and challenges of the population living with SMI, we have found that risk stratification cannot be done solely through claims analysis, particularly when claims data are unavailable or there is a lack of an extensive history of claims. Enrollees are identified for CC/CM through the HRA, population risk and care gap analytics, transitions of care, clinical programs such as disease and population management, as well as through enrollee referral by themselves, caretaker, provider, or community partners.

The HRA is administered within 30 days of enrollment for new enrollees, annually for existing enrollees, and for re-enrollees if they have been out of the plan for more than 30 days. The HRA can result in immediate referral to CC/CM if the enrollee meets specific criteria for assignment to one of the programs. The HRA is scored and incorporated into our predictive analytics.

If an enrollee transitions from another health plan and is in CC/CM, we automatically place them in the appropriate program. Enrollees who are receiving intensive services such as inpatient or subacute care, including subacute behavioral health conditions, are referred to CC/CM through the transition of care process.

Population risk and HEDIS care gap analytics are also used to prospectively identify enrollees for care management:

>Based on medical, behavioral, pharmacy, and psychosocial data (such as the Inpatient Daily Census)

>Annual health risk data is reviewed as a part of the population assessment process. This report provides us with an overview of the demographics, health status, specific lifestyle risks, and disease burden of its population

>We developed a proprietary predictive model for EPSDT-eligible children and teenagers aged 4-20 specific to individuals and those with SED

>We also developed a proprietary predictive model for adults aged 21+ with SMI and comorbid physical health conditions
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GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

>Additionally, there are critical components of information that can only be provided by self-report
by enrollees. These include health habits, living situation and social connectedness, which are all
important predictors of outcomes for the SMI population. Our model uses clinical judgment and
team inputs to assist with appropriate risk level assignment. The cultural diversity of our employee
team also allows us to understand the specific needs of our enrollees in the different regions.

Our system of care reinforces and prioritizes recovery, stabilization, health maintenance, optimal
safety and quality, and independence. We work toward these goals by partnering with our
enrollee, their natural supports and providers. Our recovery expertise and sound evidence-based
practice approaches have been used in the development of our behavioral health program
approaches.

The elements of our approach to the management of high need enrollees include identifying
health risks, biopsychosocial, and chronic care needs, as well as assessing the enrollee,
designing an individualized plan of care to proactively address the most immediate needs,
engaging the interdisciplinary care team, and proactively identifying and monitoring enrollee
changes or triggers that might destabilize the enrollee’s illness.

Based on this ongoing analysis, we have developed targeted screenings and interventions
specifically focused on:

> Schizophrenia
> Mood disorders
> SUD/AUD
> Care transitions
> Excess emergency department utilization
> Homelessness
> Interaction with the criminal justice system
> Hospital admissions/readmissions
> High risk pregnancy
> Children and adolescents
> Specialized complex diseases such as sickle cell, diabetes, heart failure, respiratory disease,
etc.
> Disease management focus on diabetes, hypertension, cancer, and asthma

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT’S APPROACH INCLUDES THE
USE OF PREDICTIVE MODELING.
As noted above, Magellan Complete Care’s own innovative predictive modeling tools are key for
our ongoing stratification and segmentation of enrollees for CC/CM interventions. We use a
customized version of the ImpactPro predictive modeling tool that has been modified to capture
behavioral health, social support factors, and other issues that are unique to the SMI population
and important for identifying risks. These modifications allow us to more accurately predict
demand for and use of higher acuity, complex services and increasing enrollee risks of
destabilization. We have built models specific to both pediatrics and non-pregnant adults, with
each encompassing population specific factors. This is necessary because a model which mixes
adults and children together does not perform well for children and youth.
Unlike standard, off-the-shelf predictive modeling tools such as base ImpactPro product which primarily focuses on claims data with its associated time lags, our enhanced version of the program captures information that is often more timely and more indicative of enrollee risk and complexity. Our predictive modeling tools use data from multiple additional data sources including utilization, care plan gaps, HEDIS/EPSDT gaps, pharmacy, admission, discharge and transfer data, and HRA information that includes physical health, behavioral health and social determinant information. Our predictive modeling tool can also be dynamically adapted as we identify new indicators for enrollee characteristics that indicate rising risks, likelihood of increased utilization, or increasing enrollee complexity.

Risk stratification categories are driven by the results of our predictive modeling tool and are specifically focused on those enrollees demonstrating increasing risks for inappropriate utilization including:

- Unplanned inpatient utilization
- Inappropriate ER utilization
- Potentially preventable events
- Inappropriate ancillary service utilization
- Patterns that may indicate destabilization

Our goal is to identify enrollees and engage them in management and support before those indicators of decomposition translate into poor clinical outcomes or inappropriate use of services. In addition to the more traditional predictive modeling described above, Magellan Complete Care recognizes the complex drug regimens many of our enrollees are on, and the many potential issues that can arise from drug-drug interactions. For that reason we also perform regular analysis of pharmaceutical data through our Magellan Rx organization. Those analyses are focused on identifying patterns of inappropriate or harmful subscribing; risks of drug-drug interactions; and under and over-utilization.

This analysis and predictive modeling is used as part of our medication therapy management (MTM) programs to work with the CC/CM team, providers, and enrollees to educate on appropriate use, and make changes to therapy regimens. This information can be particularly important and useful in identifying increasing enrollee risks due to not filling required prescriptions, risks of drug-drug interactions, or inappropriate use. For example, through these analytical and predictive modeling tools Magellan Rx has been able to substantially reduce the number of psychotropic medications taken by individual enrollees, or to identify non-FDA approved usage of psychotropic medications by children and youth. Magellan Complete Care internal analysis shows that 84 percent of children on 4+ psychotropic medications, and 73 percent who were on 5+ medications in 2014 are no longer on that number of medications. For our adult enrollees, 84 percent who were on 6+ psychotropic medications, 79 percent who were on 5+ medications, and 74 percent were on 4+ medications, are no longer on that number of medications. This type of pharmaceutical monitoring and reconciliation is critically important for our enrollees living with SMI, given the often significant effects from drug-drug interactions, or increased risks of physical health side effects of these medications.
CRITERIA 4: THE EXTENT TO WHICH THE RESPONDENT’S FREQUENCY AND INTENSITY...
Since being awarded the opportunity to serve and support our enrollees in the SMI specialty health plan, Magellan Complete Care’s dedicated care coordination and medical teams have focused their efforts on fully understanding the unique needs of this very complex population. Our enrollees often present with not only a serious mental illness but also with multiple chronic physical health conditions and/or co-occurring illnesses. Our enrollees are also likely to be faced with challenges in accessing the supports and services they need in the areas of their social determinants of health as well.

We have used that detailed understanding along with ongoing study and analysis of our enrollees, their patterns of utilization, and outcomes to develop a robust and uniquely designed segmentation and stratification model that captures data from multiple data sources and is uniquely tailored to the specific risk factors for our very complex SMI population. That model allows us to assign each enrollee to the intervention and care management category that is right for him or her, and which affords the greatest opportunity for successful engagement with enrollees and optimal outcomes improvement.

We also build on the deep expertise and unique experience of our company in delivering behavioral health programs in Florida and for Medicaid programs across the country. This experience has allowed us to develop a range of unique programs specifically tailored to managing and delivering quality fully integrated care and care coordination for individuals with SMI along with other complex, physical health and co-occurring illnesses. As a committed partner with AHCA, Magellan Complete Care has successfully implemented numerous new and innovative clinical programs. We continuously review and enhance our CC/CM programs based on the needs of the population, the capabilities of the provider community, and best practice guidelines for integrated medical and behavioral health interventions to support enrollee stability, resiliency and recovery.

Magellan Complete Care is committed to the philosophy of providing individualized and person-centered treatment in the most appropriate, least restrictive level of care necessary to provide safe and effective treatment to meet the individual's biopsychosocial needs while supporting improved health outcomes and a pathway to recovery. Our integrated care case management (ICCM) model recognizes the interplay between our enrollee’s behavioral health, physical health, and social risks and needs; their conditions and treatments; focusing on management of the “whole person’s” health needs. Our ICCM teams include professionals with knowledge and expertise in all biopsychosocial domains. Most of our medical directors have previously been chief medical officers (CMOs), including in Medicaid, making the breadth and depth of our knowledge and expertise unique for a plan of this size. Our programs and systems have been designed to support regular collaboration and communication across the continuum.

The ICCMs are skilled in establishing trusting relationships where the enrollee is at the center of the process along with the support of the enrollee’s family, caregivers, and providers. The ICCM collaborates with these stakeholders to complete the assessment and care planning process, ensuring the greatest degree of success to meet the enrollee’s goals. Our ICCMs demonstrate passionate and dedicated care for our vulnerable populations. Our ICCMs and the other participants of the care team live in the communities where enrollees live, and they have established relationships with local providers and community resources. Enrollees and providers have access to ICCMs 24 hours each day, 7 days each week.
We operate a call center which has a single 24/7 toll-free number for assistance and includes crisis calls with a warm transfer to the Nurse Line when needed. As part of business continuity, call center staff can work remotely in case of unplanned events such as natural disasters. The call center has trained staff operating the telephone lines to assist enrollees for changing providers, obtaining transportation, scheduling interpreters in 200 languages, accessing an ICCM or care team enrollee, and obtaining needed services.

We believe individuals should have a choice in the services and the type of support they receive as part of the CC/CM process. Whenever possible, we strive to work with the enrollee at the center of, and as an active participant in, their respective care planning activities. At each level of care management, the care plan is individualized, active, and takes into consideration the patient’s stage of readiness to change, to participate in treatment, and the appropriate, clinically-indicated interventions. We also consider natural community supports as a way to individual our planning to augment covered services.

We offer as [General SRC #20, Attachment 2: Care Coordination and Complex Case Management Program Description] the AHCA-approved document which outlines our overarching Care Coordination/Case Management Program model and approach. Separate and detailed Utilization Management, Behavioral Health, Perinatal, Childhood Check-Up (CCHUP), Behavioral Health, Integrated Health Home, Disease Management, and other condition specific program documents have been developed as an adjunct to this document. Magellan Complete Care of Florida has developed a library of policies, procedures, and process flows which complement the CC/CM approaches.

As discussed above, the level of care management intervention will depend on the risk level into which the enrollee is stratified. Magellan Complete Care designates care coordination teams that include the enrollee or designated representative as well as the primary medical and behavioral treating providers. The composition of the care teams at the various levels is discussed later in this section. In addition to the levels noted above, high-risk individuals with certain diagnoses may be assigned to one of our specialty care teams (discussed later in this section) or one of our specialized health homes that are discussed in MMA SRC 3.

The care plan is developed with input from the enrollee and supports interventions are tailored to the specific needs of the individual. Every effort is also made to include the enrollee’s treatment preferences including language, culture, providers, and location when developing the care plan and in coordination of care.

Enrollees are assigned to an integrated care case manager (ICCM) who is determined to be the most appropriate match based on clinical expertise, region, cultural linguistic experience, and anticipated case complexity. However, the enrollee can change ICCMs at any time should the enrollee or the caregiver identify a need to do so. An important step in improving outcomes for the enrollees living with SMI is the identification of individuals who have the highest risk needs, and for which gaps in care need to be addressed or closed.

4.1 Categories of CC/CM Management
Based on the results of this analysis, enrollees are assigned to CC/CM management categories as follows:
4.1.a Wellness and Prevention Risk Category
Enrollees who are at the lowest level of risk are assigned to a Population Health Team, which is responsible for monitoring utilization and outcomes trends. The Magellan Complete Care Population Health Team assists enrollees with their assignment to primary physical and behavioral health providers (PBHP) and to a primary care provider (PCP) to facilitate connection and engagement, monitor and address gaps in care (including HEDIS or other metrics), and provide preventive and primary care. The Population Health Team also assists enrollees in accessing services within the community they reside as a key part of our IHN approach which is described further below.

Magellan Complete Care recognizes that our enrollees may, at times, have difficulties engaging with the healthcare system and their health plan. Therefore, we use multiple methods to inform enrollees of the programs available to them, to assign CC/CMs, and to introduce the enrollee’s team if appropriate given the enrollee’s risks. These include the Welcome Kit, telephone contact and face-to-face contact in a variety of settings. For children and teens, the responsible party for the enrollee is notified. These enrollees also receive appropriate health education; related enrollee materials to support their self-care; access to Healthy Behaviors Program materials and incentives; and Magellan’s proprietary Cobalt Computerized Screening and Cognitive Behavioral Therapy platform, which is available on multiple technology platforms. We also recognize that engagement with the health plan is very personal and a decision with which the enrollee must be comfortable. We inform the enrollee of his or her right to make changes through the Welcome Kit, enrollee handbook, and website. Customer Service staff can also take a request from an enrollee. In addition to the direct enrollee supports noted above, an essential component to the success of the Magellan Complete Care system of care is the integration and collaboration with community agencies and providers on an ongoing basis. Magellan Complete Care strives to achieve the least amount of disruption to each enrollee’s existing support system. We accomplish this by collaborating with community supports as an extension of the existing enrollee’s care team.

An important element of managing our enrollee’s care and health plan experience is the Integrated Health Neighborhood (IHN). The IHN, which is customized by region, is an integral part of each enrollee’s CC/CM team. Our goal to improve enrollees’ care, quality of life and health outcomes can only be achieved within the context of where the enrollees live – within neighborhoods and communities. Our IHN team members live and work within the communities where our enrollees reside and are important participants in supporting enrollee stability and their paths to recovery.

At the foundation of our care coordination system is the understanding that our enrollees’ ability to live vibrant, healthy lives and to sustain recovery and resiliency are intrinsically tied to multiple economic and social factors beyond the health and wellness continuum. The social determinants, resources, and conditions within an enrollee’s immediate environment may impede their ability to achieve health and wellness goals. Magellan Complete Care’s goal to improve enrollee care and health outcomes can only be achieved within the context of where the enrollees live – within Florida’s neighborhoods and communities.

To this end, we created the IHN, where relationships and collaborations with community partners enable us to effectively coordinate care with the community supports and services that the enrollee knows and trusts. The IHN is Magellan Complete Care’s model for supporting close collaboration with community partners, allowing us to customize care and services for our enrollees at the regional and community levels. IHN teams naturally bridge language and cultural
barriers to more effectively and efficiently facilitate access to services in order to support our enrollees and families where they live, learn, work, and play. Moreover, the IHN approach reflects an existing statewide infrastructure working across the health and social services systems in Florida to support and enhance the relationships among enrollees and their families, caregivers, and guardians (as applicable); their providers; and community partners to assist enrollees in achieving their health, wellness, and self-management goals.

Magellan Complete Care today coordinates and ensures continuity of care through our regional IHN teams, who are dedicated to each of the regions we serve. These region-based IHN teams work in close collaboration with providers and community partners across the continuum of care and services to ensure the best outcome for enrollees and their families. IHN team members have first-hand knowledge of community strengths, resources, services, and service gaps. IHN team enrollees include ICCMs, health guides, peer recovery support navigators, family support specialists, and community outreach specialists supported by housing specialists, employment specialists, clinical pharmacists, medical directors, and others.

We created the IHN concept, which includes relationships and collaborations with community partners who enable us to effectively coordinate care with the community supports and services the enrollee knows and trusts and which the provider delivery system can easily access. The IHN is our vehicle to drive close collaboration with community partners, allowing us to customize care for our enrollees and to provide a seamless, one-stop system of services and supports.

The IHN model also naturally bridges language and cultural barriers and more effectively and efficiently facilitates access to services to support our enrollees and families where they live, work and play. In rural areas, the IHN has the ability to use the latest Telehealth and Telemedicine techniques to ensure that enrollees residing in rural areas receive the care and services needed at all times. Virtual health care applications which enrollees can access at local libraries, agencies, and/or health care offices are also used.

4.1.a.1 Collaboration with Primary BH and PCPs to assist with Population Health Approaches

Our Magellan Complete Care Population Health Team collaborates and communicates with the PBHP and PCP who are responsible for overseeing the delivery and quality of the direct clinical services that the enrollee receives, ensuring these services are medically appropriate and coordinated. Other provider specialists may participate on the care coordination team when the enrollee has a complex condition that requires specialist input and consultation.

PBHPs and PCPs also have access to the Provider Portal that presents enrollee care data (including gaps in care) and care planning information in addition to Magellan’s proprietary Cobalt Computerized Screening and Cognitive Behavioral Therapy (CCBT) platform. Cobalt facilitates regular screening for behavioral health (depression, OCD, anxiety, sleeping disorders, pain management), and substance abuse (illicit drug, alcohol, opiate) in the provider’s office, and provides automated risk stratification and identification of appropriate treatment options based on screening results. Enrollees can then use the CCBT platform to complete clinically validated and peer-reviewed cognitive behavioral therapy programs if recommended based on screening results.

4.1.b Low to Ultra-High-Risk Enrollees

Enrollees with at least one physical health comorbidity, more than two behavioral health diagnoses, or who meet our risk stratification criteria as previously described are managed at
more active levels of engagement, ranging from disease management to case management or complex care coordination. Our multidisciplinary Magellan Complete Care ICCM teams carry out procedures required in care coordination, complex case management, and other related care management programs. [General SRC #20, Attachment 3: Care Teams Table] shows the structure of our care teams for enrollees at the various risk stratification levels.

The Care Coordination Team includes:
> The enrollee or designated representative
> The primary behavioral and medical treating providers
> Health guide
> ICCM if indicated by the enrollee’s circumstances

Additionally, the following individuals are available to the team at all times:

> Clinical pharmacist
> Peer support specialist
> Medical directors (with physical and behavioral health expertise)

As noted previously, through the use of stratification algorithms, the frequency of meetings and type of participants on the team vary, addressing the specific needs of the enrollee. Enrollees can call the Nurse Line anytime for assistance as a back-up after hours, on weekends or if they are unable to otherwise reach their assigned case manager, including when their assigned case manager is on paid time off.

Staffing ratios and contact frequency requirements, and types of outreach at each of the risk stratification levels are as follows:

4.1.c Low Risk Enrollees
> Individuals with a single chronic physical health diagnosis, capable of self-management

> Enrollees who have one of the four disease management conditions, are followed by the wellness specialists (WS) who prioritize the needs of the enrollee based on the condition (asthma, hypertension, diabetes, and cancer):

>> Population-based programs are monitored and managed by a health guide who collaborates on an ongoing basis with enrollee services and the CM team to ensure that appropriate targeted outreach and campaigns are being conducted
>> Technology and automated dialers, etc., are used to augment the engagement of the enrollee.
>> Low Risk Enrollee Team - WS
>> Enrollees per Team - The wellness specialist is assigned up to 750 enrollees. (1:750)
>> Enrollee Contact Frequency Requirements<<
>> WS will claim referral from DM queue, conduct chart review for eligibility, and outreach enrollees within 48 hours, if criteria is met.
>> Two attempts will be made to outreach enrollees within 14 days. If unsuccessful, a Trying to Reach You Letter (TTRYL) will be mailed. The third attempt will be made 2 weeks after TTRYL is sent.
>> If unable to reach enrollees after the 3rd attempt, case owner or manager will be notified for follow up and/or reassignment, if applicable.
>> Total time frame for outreach will be 6 weeks.
>> Specialty assessment will be completed for each targeted condition.
>>Care plan will be completed.
>>Educational materials will be mailed to enrollees by care workers.
(Resource used is Healthwise)
>>The wellness specialist will follow up with the enrollees every 3 months or as needed.
>>As enrollees’ goals and desired outcomes are met, enrollees will be transitioned from WS DM and reassignment will be requested for a new case owner.
>>If enrollees’ risk level escalates while managed by WS DM, reassignment will be requested.

4.1.d Moderate Risk Category
>Individuals with a single chronic physical or behavioral health diagnosis requiring light case management support
>>Moderate Risk Enrollee Team - Care coordination health guide (CC HG), who is always supervised by a registered nurse or licensed social worker

>>Enrollees per Team - CC HG carries a caseload of up to 90 enrollees.

>>Enrollee Contact Frequency Requirements
>>>Call the enrollee within 48 hours of receiving task/referral
>>>Make 3 attempts over a 2 week span - attempts should consist of 2 phone calls and a task to send out “Trying to Reach you Letter”, as the 3rd attempt

>>If enrollee is reached and agrees to case management, CC HG will enroll the enrollee in case management program, in the program summary in Trucare.

>>CC HG will verify case type is accurate under Case Summary in Trucare

>>CC HG will create referral for care management under Referral Summary in Trucare.

>>Establish goals and a care plan within 60 days of enrolling the enrollee in case management program

>>Monthly follow-up should be completed, to assess enrollee’s progress

>>Consult case with regional manager, if enrollee’s clinical condition changes.

>>If enrollee is doing well, case can be consulted for step down to low risk level

>>If enrollee meets criteria for a higher stratification, case should be consulted with regional manager to move up to high risk level.

>>If unable to reach enrollee after 3 attempts, CC HG will consult case with regional manager for possible home visit or step-down due to lack of contact.

4.1.d Monitor Risk Enrollees
>Individuals identified for CC/CM who cannot be located, or who have refused assistance
>>Monitor Risk Enrollee Team care coordination care worker (CC CW) who is always supervised by a registered nurse or licensed social worker
>>Enrollees per team: There is a revolving list of “monitor rise” enrollees that the CC CW works on each day.

>>Enrollee Contact Frequency Requirements
>>>The CC CW completes the referral screen and case management program enrollment in Trucare.
>>>The CC CW uses the Care Coordination Summary Report to identify “monitor rise” enrollees. The CC CW completes an outreach call every 30 days. The CC CW creates a task to complete the next outreach attempt in 30 days if unable to contact the enrollee. Outreach to “monitor rise” enrollees is ongoing every 30 days. The CC CW will document outreach attempts using the Phone Call Coordination Note Type in Trucare.
>>>If a “monitor risk” enrollee readmits, the discharge health guide (DC HG) will complete the Day 2 welcome home call (WHC). The CC HG will complete the Day 7 WHC. If Day 7 WHC is successful, the CC HG should offer referral to Complex Case Management. If enrollee agrees, the CC HG will task the regional manager for ICCM assignment.

4.1.e. High-Risk Enrollees
>Enrollees who fall into the high risk categories and who are identified as needing special assistance due to their complexity, risks, or special circumstances, may also be supported by health guides who act as the enrollee’s advocate for navigating Magellan Complete Care’s integrated system of care. The health guide is community-based, where they can help the enrollee make and keep appointments with behavioral and physical health providers, and provide follow up after appointments and coordinate with community agencies and other resources, as needed. The health guide helps the CC/CM team in ensuring that the care coordination plan is implemented as designed.

>>High Risk Enrollee Team: The ICCM is the primary point of contact for the enrollee and is supported by other team enrollees including: CC health guide, peer support specialist, recovery support specialist, and care transitions health guide.

>>Enrollees per team: The ICCM carries a caseload of up to 50 enrollees (1:50). The care coordination health guide carries a caseload of up to 90 enrollees (1:90). The peer recovery support navigators, who are certified by the Florida Certification Board, carry a caseload of up to 15 enrollees (1:15).

>>Enrollee Contact Frequency Requirements: A comprehensive assessment is completed within 30 days or less of enrollment to the High Risk CC program. The care plan is completed within 60 days of enrollment to the High Risk CC Program. The care plan is initiated within 30 days of enrollment to the High Risk program and is completed within 60 days of enrollment to the High Risk CC Program. The ICCM’s minimum contact frequency is 1x/month for High Risk enrollees. The High Risk enrollees’ contact frequency is always based on acuity and enrollee needs.

4.1.d.1 Additional High Risk Assessment and Care Planning Contacts Information
As part of on-boarding of new enrollees, ICCMs will complete the initial clinical assessment, any specialty assessments, obtain AUDs as appropriate, and complete the care plan for high risk enrollees within 30 days of CCM Program enrollment.

Ensures Care Plan include prioritized PH/BH goals, considers the enrollee’s and caregiver’s goals, preferences, identifies barriers to meeting goals, and develops with the enrollee a plan for self-management and a plan for schedule of communication and follow-up.
Documents information in TruCare assessments/notes, uploads all documents to the enrollee’s case.

In cases where the ICCM is unable to reach the enrollee after 3 outreach attempts within 14 days, the ICCM will begin a care plan, identify barriers, and develop interventions to make contact with the enrollee. If the enrollee has not been engaged for the completion of the ICA or care plan after 14 days, the Regional Manager will be notified for program closure. The ICCM will create task for TTRY letter.

4.1.f Ultra-High Risk Enrollees
Our system of care has continued to evolve since the implementation of the SMI specialty plan as Magellan Complete Care has further expanded and defined services to meet the complex, specialized needs of our enrollees. While we have continued to expand more traditional programs for such areas as disease management (DM) and utilization management (UM), we have also recently implemented a paradigm shift in our CC/CM approaches, focusing on the establishment of a fully integrated approach that incorporates complex case management (CCM) and disease state specialty teams.

Our specialty teams focus on assisting enrollees with both short- and long-term care coordination and case management activities, along with reducing unnecessary resource utilization and reducing preventable admissions. We have developed these teams based on our ongoing analyses of enrollee characteristics, key drivers of outcomes and utilization, and increasing understanding of which interventions have the greatest affect for improving enrollee outcomes and overall health. The disease state specialty teams are focused on the following illness categories: high risk diabetes, high risk pregnancy, congestive heart failure, respiratory disease, sickle cell, schizophrenia, and first episode psychosis.

The teams are equipped with analytics and information which guide focused case management efforts in addition to emergency department diversion (EDD) activities. For our highest risk enrollees (Ultra High Risk Level), we have decreased the ICCM caseloads to 1:25 creating the capacity for individualized clinical activities, including:

> Complete in-home assessments and evaluating the home environment
> Increase coordination with medical management to focus on skilled and unskilled care
> Increase time for ICCMs to accompany enrollees to PCP visits and collaborate on the plan of care
> Improve coordination with Magellan Rx to evaluate and improve medication adherence
> Coordinate with partner vendors for DME and home health services
> Lead the discharge planning process and complete post-discharge follow up
> Assist homeless enrollees to access short/long-term housing programs

These specialty programs will further enhance and supplement our case management and care coordination programs to target specific diagnoses that pose the greatest risks for our enrollees. As part of this paradigm shift, Magellan Complete Care has further enhanced its health risk assessment, predictive modeling, and risk stratification processes to identify those enrollees at greatest risk of physical or behavioral health destabilization.
We serve a very complex population, including those enrollees who may present with a primary diagnosis of SMI, SED, and SUD, who also have complex medical and additional behavioral health issues. Enrollees who have multiple chronic conditions are designated as high-risk enrollees and receive complex and enhanced care coordination services.

>>Ultra-High Risk Enrollee Team: The ICCM is the primary point of contact for the enrollee and is supported by other team enrollees including: CC health guide, peer support specialist, recovery support specialist, and care transitions health guide

>>Enrollees per team: The ICCM carries a caseload of up to 50 enrollees (1:50). The care coordination health guide carries a caseload of up to 90 enrollees (1:90). The peer specialists and recovery support navigators carry a caseload of up to 15 enrollees (1:15).

Note: There is also a current caseload pilot for ICCMs in two regions with maximum caseload of 1:25.

>>Enrollee Contact Frequency Requirements: NCQA Complex Case Management contact requirements are adhered to. A comprehensive assessment is completed within 30 days or less of enrollment to the Ultra-High Risk CC program. The care plan is initiated within 30 days of enrollment to the Ultra-High Risk program and is completed within 60 days of enrollment to the Ultra-High Risk CC Program. Ongoing enrollee contacts are made based on enrollee need. The ICCM’s minimum contact frequency is 1x/month for Ultra High Risk enrollees. The Ultra High Risk enrollees’ contact frequency is always based on acuity and enrollee needs.

As part of on-boarding of new enrollees, ICCMs will complete the initial clinical assessment, any specialty assessments, obtain AUDs as appropriate, and complete the care plan for high risk enrollees within 30 days of CCM Program enrollment.

Ensures Care Plan include prioritized PH/BH goals, considers the enrollee’s and caregiver’s goals, preferences, identifies barriers to meeting goals, and develops with the enrollee a plan for self-management and a plan for schedule of communication and follow-up.

Documents information in TruCare Assessments/notes, uploads all documents to the enrollee’s case.

In cases where the ICCM is unable to reach the enrollee after 3 outreach attempts within 14 days, the ICCM will begin a care plan, identify barriers and develop interventions to make contact with the enrollee. If, after 14 days, the enrollee has not been engaged for the completion of the ICA or care plan, the Regional Manager will be notified for program closure. The ICCM will create task for TTRY letter.

Our chief medical officer (CMO) and behavioral health medical director oversee the entire health services staff conducting behavioral health screening. All clinical and non-clinical staff are trained upon hire for HIPAA privacy, confidentiality, and all Magellan Health, Inc. required compliance training.

Please refer to [General SRC #20, Attachment 4: Health Services Organizational Chart].
Licensed registered nurses, licensed behavioral health clinicians, and licensed social workers conduct screenings. Magellan Complete Care designates care coordination teams to carry out procedures required in care coordination, complex case management, and other related care management programs. The care coordination team includes the enrollee or designated representative, the primary behavioral and medical treating providers, a health guide, and if indicated by the enrollee’s circumstances, an ICCM.

A clinical pharmacist, peer support specialist, and medical directors (with physical and behavioral health expertise) are also available to the Care Coordination Teams at all times. The Nurse Line is available to enrollees 24 hours a day/7 days a week and is staffed by ICCM.

Depending on the enrollee’s needs, the care coordination team enrollees may include:

>Peer Recovery Support Navigator:
   >>A Certified peer support specialist who is trained in applying resiliency and recovery principles and tools such as wellness recovery action plans, a wrap-around process, family and person-driven care, and systems of care that use these skills to provide emotional support and to inspire hope for the future
   >>They model and assist enrollees in making lifestyle improvements and the self-management of chronic conditions
   >>Peer support specialists provide additional outreach to individuals who require assistance to obtain access to and engage in needed services.

>Pharmacist:
   >>Participates as needed to review the medications the enrollee receives and in collaboration with the prescribing physicians on the team, is responsible for identifying potential over or under utilization, potential drug disease interactions, and optimal therapeutic regimens
   >>Consults on complex cases where there is risk to the enrollee due to potential drug interactions between drugs for chronic medical conditions and psychotropic medications
   >>Uses sophisticated analysis of claims data to identify gaps or potential concerns.

>Integrated Care Case Manager (ICCM):
   >>Either an RN or a masters-prepared mental health or social work professional, is engaged for all High Risk enrollees including the sub-population identified to receive complex case management
   >>Responsible for developing the care coordination plan consistent with the enrollee’s health care needs and goals
   >>Monitors and intervenes for enrollees with complex situations and ensures implementation of the care plan
   >>Actively involved at times of care transition, including but not limited to planned and unplanned admissions, and works in conjunction with the enrollee’s health guide to ensure care plan communication between all providers and enrollees.

>Care Worker:
   >>Non-clinical staff enrollee, is responsible for supporting the care coordination teams
   >>Activities may include, but are not limited to, mailing of letters/educational materials, obtaining authorizations for disclosure of protected health information, assisting with referrals, scheduling appointment, scheduling case conference meetings and assisting with other basic care coordination activities
Wellness Specialist:
> Nursing or a combination of health education and deep clinical expertise in chronic DM
> Responsible for the development and operation of population-based programs for enrollees with
> chronic conditions, the preventive care program, and initiatives which support healthy lifestyles
> Engages with individual enrollees who have a targeted health condition
> Motivates enrollees to learn and adopt self-management techniques to maintain their health
> and wellness
> Serves as an expert resource for Magellan Complete Care staff, providers, and community
> agencies

We also look for the following blended staff structure of RNs and clinician qualifications:

> Psychiatric background from RNs
> Specialized training in psychiatric conditions
> Work experience in behavioral health understanding of physical health side (co-occurring
> disorders, socioeconomic factors, homelessness, poverty, access to care, lack of support system)
> Target and recruit talent pool that has sufficient experience and expertise in SMI to effectively
> work with the population, while still understanding the medical comorbidities
> Principles of recovery and resiliency for staffing, program development, UM, QM

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Enrollee Story: Integrated Care Case Manager’s Expertise for Effective Service Coordination---

One of our ICCMs coordinated care for a 46-year-old male, Ultra High Risk enrollee diagnosed
with depression, bipolar, SUD, and schizophrenia along with asthma, COPD (Severe),
emphysema, and congestive heart failure (CHF).

Our ICCM has been working with and collaborating with vendors, providers, and other team
enrollees (DCHG) to coordinate care for enrollee. This enrollee has been admitted on an inpatient
basis nine times in 2017 alone, all for respiratory issues and for CHF. This enrollee is a homeless
enrollee with no income, and had no providers in place.

When this enrollee was first assigned, the ICCM referred enrollee to Healthcare Financial for
financial assistance to see if enrollee could get financial assistance for housing. Healthcare
Financial said that enrollee would not qualify for assistance due to enrollee not having continuity
of care with PCP or psychiatrist. A major barrier the ICCM had with this enrollee was
communication.

This enrollee lived in a dumpster and did not have a phone. During one of his IP admissions, the
DCHG was able to get enrollee a Safelink phone. The second to last admission, the enrollee was
taken to the hospital for severe respiratory issues (exacerbation of COPD), and lost all his
belongings including his new Safelink phone at the dumpster.

The hospital social worker, DCHG, and the ICCM were able to coordinate residential housing at
Better Way at Miami since enrollee came out positive for cocaine use.

The enrollee was at Better Way for a few days before being admitted again for his COPD. This
time enrollee was going to be discharged with an oxygen concentrator, but Better Ways could not
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take enrollee back with oxygen since they are not equipped to handle this request. Magellan Complete Care would not pay for the oxygen, therefore, Jackson agreed to pay for the oxygen concentrator as well as placement at Livewell Courtyard Plaza ALF for 30 days.
ICCM is now working with enrollee to see a PCP, PBHP, and completed another Healthcare Financial referral (which was denied again due to the enrollee appears as disabled in the system). Per Healthcare Financial, if enrollee shows as disabled, they are unable to assist with the application and the enrollee needs to apply directly with DCF. The ICCM completed an urgent TCM referral with Chrysalis so they can assist enrollee with the application process for financial assistance and housing as well. This is a fragile enrollee who needs extensive medical care, thus cannot afford to be homeless. If enrollee becomes homeless again, he will be in the hospital repeatedly due to his continual need of oxygen. For this reason, ICCM is working urgently with this enrollee to come up with a future plan for financial assistance and housing.

4.1.f Self-management Practices
Magellan Complete Care provides an ICCM or other support staff enrollee who meets with the enrollee either face-to-face or telephonically, to review the care coordination program and contact information, including name and information for reaching the ICCM and other enrollees of the care team. This same information is included in the enrollee Welcome Kit received upon enrollment. The ICCM and care team enrollees instruct the enrollee on placing the contact information in an easily accessible place for the enrollee, family, and caregivers. Magellan Complete Care of Florida works closely with the enrollee to ensure that the enrollee agrees with the ICCM and care team enrollee assignment.

The ICCM and care team enrollees use a person-centered approach to engage enrollees about available services and supports in order to help achieve optimal health, wellness, and self-management goals. The ICCM and care team enrollees also explain the support provided to the enrollee for self-direction and self-management.

However, we understand from previous experience that there will be enrollees who decline care coordination services. The ICCM will explain our role is to support the enrollee in accessing services and supports to meet his or her goals. The ICCM provides the enrollee with contact information with each interaction.

Self-management support and development of self-management plans and/or relapse prevention plans are typical topics for CC/CM care plan goals and interventions, including:
>ICCM supports the enrollee with self-management skills to access care by arranging for peer support and education

>ICCM also assists in accessing community support agencies who offer education and training on self-management skills

>A Certified peer support specialist who is trained in applying resiliency and recovery principles and tools such as wellness recovery action plans, a wrap-around process, family and person-driven care, and systems of care that use these skills to provide emotional support and to inspire hope for the future:
>>They model and assist enrollees in making lifestyle improvements and the self-management of chronic conditions
>>Peer support specialists provide additional outreach to individuals who require assistance to obtain access to and engage in needed services

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The case managers and health guides coordinate care for the enrollee by focusing efforts on proactive care management interventions to prevent the unavoidable including facilitating enrollee self-management capabilities.

As stated elsewhere, Magellan Complete Care builds our CC/CM programs around the concepts of the Four Quadrant Clinical Integration Model developed by the National Council for Community Behavioral Healthcare. That model describes the enrollee management and delivery focus and levels of integration for management of care in terms of physical health complexity and risk, and behavioral health / SUD complexity and risk. Care management, interventions and supports and services can then be targeted to different populations, based on their needs. The Four Quadrant Model describes a framework for segmenting and stratifying enrollees with SMI as well as the need for a bi-directional care coordination and delivery approach, addressing the need for primary care services in behavioral health settings as well as the need for behavioral health services in primary care settings.

Magellan Complete Care also shares in the Substance Abuse and Mental Health Services Administration’s (SAMHSA) establishment of the resiliency and recovery-oriented systems of care (ROSC) to enhance prevention, treatment, and recovery services. These elements, along with social determinants, are incorporated throughout our case management/care coordination programs and are integrated as part of our broader outreach and enrollee support efforts.

Magellan Complete Care provides the full continuum of care for enrollees with co-occurring behavioral health, substance use disorders, comorbid medical conditions, and pregnancy. “Meeting the enrollee where they are” is important as we recognize that interventions such as deploying ICCM and health guides in the community as part of our Integrated Health Neighborhood (IHN) lead to increased access and adherence to individual care plans. Recognizing this need, we decreased the caseloads for ICCMs so they could spend more time out in the field, more often. Health guides go with enrollees to scheduled appointments, arrange transportation and pick up medications if necessary. Our approach is tailored to the needs of the enrollee, including coordination of housing and food availability.

Building on the deep experience we have gained by providing integrated care to SMI enrollees in the specialty plan, our integrated, flexible, and comprehensive system of care continues to evolve to further expand and define services to meet the specialty needs of our highest-risk enrollees. This model reflects our enrollee’s unique needs as well as the understanding of Florida behavioral and physical providers’ capabilities, services and resources that we have gained since the launch of the program.

Recognizing those unique needs and requirements, we have recently implemented a paradigm shift in our care coordination and case management approaches, focusing on the establishment of complex case management (CCM) and disease state specialty teams, including:

- Sickle cell disease
- Depressive disorder
- Schizophrenia
- Transplants
- High risk pediatric programs
- First episode psychosis (adolescents and young adults)
>Disease management for chronic medical conditions that manages these conditions in an
integrated fashion, incorporating both BH and SA
Two dedicated teams or management of children, adolescents and young adults, as well as one
additional team for pregnant women
>Pharmacy clinical programs emphasize psychopharmacology expertise and prioritizing
identification of psycho-pharm gaps in care
Our screening process is integrated into the clinical programs which make up our Magellan
Complete Care Model of Care for CC/CM, care transition, DM and population health protocols.
Behavioral health screenings occur at multiple “touch” points in the enrollee’s continuum of care,
including but not limited to interaction with enrollee services and case management, primary care
providers and specialists visits and Nurse Line calls.
Our Model of Care is built upon the principles of:

>Medical, behavioral, and psychosocial integration
>Recovery and resiliency
>Self-management and self-directed care
>Evidence-based medical and behavioral health care
>Transparency
>Shared decision making
>Ensured access to care
>Case management
>Care transition management
>Disease management, condition management, and population health approaches
>Health and wellness prevention

Our integrated biopsychosocial care coordination model also includes providers as active,
engaged participants in the enrollee’s care team, allowing for the easy exchange of information
that is important for the success of the enrollee’s care plan and achieving improvement goals.
Our system of care, including our CC/CM process, is built upon the following components:
>Multivariate, data-driven assessment of enrollee risks, complexity and need
>Stratification and assignment of enrollees to the appropriate level of support based on their risks
and complexity

>Person-centered planning process built around concepts of shared decision-making

>Multi-level, evidence-based, fully integrated biopsychosocial care management that includes:
>>Prevention and wellness
>>Self-management and self-directed care, built around concepts of recovery and resiliency
>>Disease management/condition management
>>Case management
>>Care transition management and supports
>>Complex medical, behavioral and psychosocial care coordination

>Transparency of outcomes and performance with regular reporting, analysis, and refinement of
programs and interventions
CRITERIA 5: THE EXTENT TO WHICH THE RESPONDENT’S APPROACH INCLUDES INNOVATIVE STRATEGIES...

Magellan Complete Care believes our fully integrated model of care delivery and management is an important innovative element of our programs. As the first integrated behavioral health and physical health plan for SMI enrollees that has been built to scale for a large population, we have built an entire integrated system that incorporates physical health, behavioral health and social supports, and identification of enrollee risks and needs in each area. Our model is built around understanding the complex interplay of all those needs; designing interventions to effectively address those needs; and finding and engaging enrollees who often experience social instability that makes them difficult to track.

Our integrated model includes many innovative elements not found in other plans, including:

> Fully integrated (biopsychosocial) care management teams
> Fully integrated (biopsychosocial) programs and protocols that address the whole person and the interplay of physical health, behavioral health, and social vulnerabilities in health, wellness, and illness management
> Integrated Health Neighborhood (IHN) which incorporates peer support, health guides, housing specialists, employment specialists, recovery support specialists, and others for outreach, engagement and assistance in removing barriers to care and enrollee health
> Integrated Health Homes which incorporate co-location of biopsychosocial services in single locations
> Enrollee engagement models that exploit all available enrollee touchpoints to deliver fully integrated services and supports
> Provider engagement models that encourage and support all providers in being an active and important participant in care planning and management, and an important enrollee touchpoint for engagement and support
> Use of multi-channel media to engage, educate and manage enrollees, including smartphones, Computerized Cognitive Behavioral Therapy (CCBT), smart screening technology, social media, and messaging

Our fully integrated system of care and care management is built on a strong foundation of continuous quality improvement which is driven by detailed, robust, and statistically valid design and evaluation of enrollee interventions that is quality and outcomes focused. Our goal is to continuously refine the entire system and all its key components to delivery care and outcomes for the vulnerable SMI populations we serve, that are equal to or better than those for individuals without SMI.

5.1 Provider Delivery System Innovation: Integrated Behavioral Health Pilot Program

Magellan Complete Care continually works with our provider partners to enhance and evolve the delivery model to support the integrated health care needs of our enrollees. This continued evolution contributes to the strength and innovation in all the regions we serve, and expands the availability of care for individuals throughout the state. An example of one of our community integration programs is our Integrated Behavioral Health Pilot Program with Jackson Health System, which was launched in February of 2017 in Region 11. This pilot program is vertically integrated with Magellan Complete Care’s CC/CM program.

Primary accountability for the process of ICCM coordination and follow-up of ambulatory and inpatient care and service needs is at the plan level with our chief medical officer and behavioral
health medical director as well as many others involved – our specialty plan includes psychiatrists and physicians who work together. The ICCM has primary accountability for developing and maintaining a care plan with the enrollee as well as communicating with the enrollee and providers about the plan’s status, and in working with the enrollee’s health guide to assist in making and attending required ambulatory appointments. For enrollees living in an assisted living facility, the ICCM will also consider the coordinating agreement in place and the enrollee’s community living support plan.

As we move forward with ICCM coordination and follow-up for ambulatory and inpatient care needs and services, we will continue to create fully integrated workflows, shared workflows, and shared teams. Magellan Complete Care is committed to continued collaboration with our enrollees, providers, and AHCA in the refinement and improvement of our integrated approach to managing the whole health of the SMI enrollee.

5.2 Jail In-Reach Program
Magellan Complete Care is partnering with Miami-Dade County on the Jail In-Reach Project. The project is a collaborative effort among community partners that seek to improve the assessment, referral, diversion, and care coordination among individuals with SMI, and possible COD that are reentering the community from the criminal justice system. The proposed project will create a specialized Jail In-Reach Team that will be guided by a shared commitment to cross-system collaboration and division of responsibilities among criminal justice and community partners to:

> Gather and review information to make determinations about eligibility for diversion programs
> Develop and implement evidence-based transition and reentry plans emphasizing continuity and coordination of care
> Monitor ongoing linkages to evidence-based treatment and services in the community
> Measure outcomes to facilitate performance improvement

The target population for this program is adults with SMI who are frequent recidivists to the justice and acute care treatment systems. The project has set a goal to screen a minimum of 400 individuals annually.

5.3 Homeless Housing Initiative
Magellan Complete Care’s Homeless Housing Initiative is not only an organizational program identity, but also a philosophy. The core tenets of the program recognize:

> Recovery, which is “a process of change, through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential,” is unable to be achieved without a home
> Stable housing is an essential determinant in the health outcomes of our enrollees
> Homelessness ultimately affects our organization’s ability to provide timely, cost-effective care to meet the needs of our enrollees

At a basic level, housing provides safety and access to basic needs; laying a foundation for engaging enrollee in healthy lifestyle and development. Recognizing these issues, Magellan Complete Care launched a homeless housing initiative in 2015 that included the following action steps:

> Community Outreach Specialists (COS) developed regional community housing resource guides

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COS developed regional housing work flows that outlined each region’s homeless housing application process
>COS participated in regional Continuums of Care (CoC) meetings
>COS developed regional monthly housing meetings to discuss housing opportunities with Magellan Complete Care Care Coordination clinicians
>Established HMIS agreements with many of the CoC
>Developed staff expertise in completing VI-SPAT (Vulnerability Index-Service Prioritization Decision Assistance Tool)
>Developed reporting mechanisms within enrollee care management record to identify homeless enrollees
>Developed relationships with state and local housing agencies and organizations
>Met with providers to develop partnerships to expand and/or create housing opportunities
>Developing data reports to identify cost savings from housing the homeless

Our efforts to date have resulted in over 50 placements since late 2015 and have yielded tangible results for our enrollees as demonstrated by the enrollee story below.

~~Enrollee Story: Joseph (name changed to protect privacy)~~

Our enrollee Joseph is a 59-year-old man who had been chronically homeless for the past three years. Before receiving stable housing, he survived outdoors in parks and behind stores; sleeping on benches to avoid the dampness, dirt, and bugs on the ground. Joseph also used hospitals when he “couldn’t take it anymore.” The emergency room would provide respite, a hot meal, a climate-controlled environment, safety, and a good night’s sleep. He was admitted into a hospital seven times in the last half of 2015. Joseph reported having suicidal ideations as a result of his homelessness. He expressed feeling worthless and no longer could find meaning in his life. Joseph talked about ending his life and had a specific plan to do so. He did not have any social supports.

This all changed when Joseph’s Magellan Complete Care health guide found a new permanent supported housing project targeting homeless disabled individuals in West Palm Beach. His health guide completed the referral paperwork for the Goodwill Industries program and he was approved within two weeks. Joseph left the hospital and moved into his own apartment on Christmas Eve. Since that time, he has not been hospitalized. Joseph is now independently scheduling and attending his behavioral and physical health appointments. He reported being reluctant to attend appointments in the past due to feeling ashamed of his appearance. Joseph has made friends in the neighborhood and has recently re-established a relationship with his brother. One of his favorite things to do is spend time at the beach which is walking distance from his apartment.

CRITERIA 6: THE ADEQUACY OF THE RESPONDENT’S DESCRIPTION OF EVIDENCE-BASED INTERVENTIONS...

Magellan Complete Care’s CC/CM and DM programs are informed by input from those most closely involved – Florida residents with SMI, their families and supports, and the professionals who provide behavioral and physical health treatment. Enrollee satisfaction highlights from data based on Magellan Complete Care Florida Experience of Care Surveys for both adults and minors in 2015 and 2016 include the following:

>General satisfaction with Magellan is 91.62 percent for minors, and 89.96 percent for adults
>Satisfaction is improving over time, from 82.6 percent in 2015 to 87.3 percent in 2016
>89.3 percent of respondents feel Magellan is helping them take care of their illnesses
>95 percent of respondents indicated that the place where services were received was good for them (6 percent improvement over 2015)
>18 percent improvement for minors in the ease of getting care for their child – from 76.3 percent in 2015 to 90.26 percent in 2016

6.1 Evolution of Our Model of Care
Before Magellan Complete Care was created as an SMI specialty plan, Magellan Healthcare managed the Florida Agency for Health Care Administration/Child Welfare Prepaid Mental Health Plan from 2006 to 2015, as the Managing General Partner of the CBC Partnership. Many of the clinical and UM staff transitioned to the current program, bringing their knowledge and Florida experience. We also draw on Magellan corporate resources and expertise in behavioral health from many decades of contract implementations. When needed we are able to involve Magellan corporate resources, especially when we use project managers, data analysts, and clinical intervention teams.

As we have gained even more experience with our enrollees, providers and community stakeholders, we have worked collaboratively with them and with AHCA to evolve our Model of Care in support of the unique needs of the populations we serve. This collaborative, enrollee-centered approach to develop effective solutions to manage the health of our SMI enrollees continues and grows to the present day. This Florida-specific experience as a partner for AHCA and our enrollees differentiates us from any other health plan.

As Magellan Complete Care has grown, our data analytics, understanding of enrollees, and intervention effectiveness have also become more sophisticated, allowing us to drill down further into subpopulations with unique or very specific needs. This has allowed us to continually improve and optimize clinical programs and develop targeted, new clinical initiatives to meet the needs of individuals and specific subpopulations.

Magellan Complete Care embeds and operationalizes analytics in all parts of our programs to create insight that leads to the evaluation of changes that we make to enhance CC/CM. Some of the results of the data analytics have led to paradigm shifts within the care coordination department, leading to better outcomes and more effective programs overall for the enrollees. Examples of some of the refinements we have made to our programs include:

1. Targeting High and Ultra-High-Risk Enrollees
   > Expanded and defined services to meet the specialty needs of these groups of enrollees
   > Enhanced predictive modeling and ER Diversions
   > Use of financial models to identify and target high cost enrollees
   > Focus on enrollees identified through predictive machine modeling with a likelihood to admit to an inpatient facility within a 90-day period. The predictive model will allow care managers the opportunity of early intervention and prevention of an inpatient admission
   > Decreased ICCM caseloads will create more capacity for enrollee care

2. High-Impact, Targeted CC/CM: Targeted the initial phase of the CC/CM shift to Regions 10 and 11. Our analysis and ongoing service in these regions allowed us to identify that these remained the highest cost regions with poor performance in admissions/readmissions. Further analysis showed us that contributing factors included inappropriate Baker Act admissions, lack of medication and treatment compliance, and chronic homelessness.
3. CC/CM Statewide and Regional Specialty Teams: These multidisciplinary teams were developed for those enrollees who could benefit from a special program focus, with the goal of improving outcomes and reducing preventable admissions:

>Statewide specialty teams are focusing on the following disease states: diabetes, CHF, sickle cell, schizophrenia, mood disorders, substance abuse, bipolar disorder, pain management, depression, maternity, and enhanced care coordination

>>Sickle Cell Disease (SCD) Team is currently a statewide specialty team managing 150 enrollees with sickle cell disease. The SCD Team will soon offer referrals to enrollees to the Broward Center of Excellence, a hospital home established for enrollees in Region 10

>>Statewide Transplant Team is a dedicated ICCM team managing all transplant cases

>>Diabetes Team is currently in development. ICCMs will partner with our vendor Kersch to collaborate and manage High Risk Diabetic enrollees and focus on reducing preventable admissions. Program started in January 2017

>>Schizophrenia, Mood Disorder, First Episode Psychosis, and CHF Specialty Teams are being implemented in 2017

4. Local/regional teams focused on interventions with enrollees identified as at-risk through our analysis of our enrollees, and assessments of the need for interventions and supports, we have decreased ICCM caseloads to 1:25 to create capacity for individualized clinical activities. Activities include:

>Completing In-home assessments and evaluating the home environment

>Increasing coordination with Medical Management to focus on skilled and unskilled care

>Allowing more time for ICCMs to accompany enrollees to PCP visits and collaborate on care plan

>Improving coordination with Magellan Rx to evaluate and improve treatment adherence

>Coordinating with partner vendors for DME and Home Health Services

>ICCM will be able to lead discharge planning process and complete post-discharge follow up

>Assisting homeless enrollees to access short/long term housing programs

>Transitioning non-impactable enrollees

5. Monitoring Non-Engaged Enrollees: We have also created a monitoring program for enrollees who are not engaged in CC/CM Special Teams but who continue to meet established criteria. Through this program we monitor enrollees whose cases should be referred back to regional teams for monthly monitoring and follow up by case owners. Monitoring risk criteria and related processes have been established and this program is currently ongoing. We are also continuing support in Regions 6 and 11 from Integra for outreach and engagement of difficult to locate enrollees.

Magellan Complete Care has also been actively collaborating with our provider partners to build health home models built on the SAMHSA/CMS models for integrated behavioral health/physical health delivery of care that was developed and launched as part of healthcare reform. Magellan Complete Care’s goal is transformation of the system of care, with the goal of ultimately shifting care coordination and quality improvement resources to the point of care. Innovations in support of those goals include:
>Integrated Behavioral Health Home (IBHH) Pilot Program with Jackson Behavioral Hospital (Region 11). The IBHH will be vertically integrated with CC/CM program and will include:
>>Enrollee referrals would be coordinated by designated specialty team
>>Focus on management of high users
>>Collaboration with IBHH on plan of care

> Hospital Homes which are similar to IBHH, and which are built around hospital centers of excellence for delivery of all physical health and behavioral health care services. We are partnering with inpatient providers to develop hospital home programs for enrollees throughout the state. They also incentivize providers to focus on coordination of all aspects of care:

>Referrals for specialty care
>Coordination of outpatient and inpatient treatment including substance abuse

We also collaborate with and have extensive programs with several Magellan Complete Care partners including:

>DME vendor Reliacare supports specialty and regional teams statewide starting January 2017. Reliacare will support the utilization and care coordination teams to improve urgent access to DME and home health services for enrollees.

>Magellan Rx supports enrollee treatment adherence goals by completing medication reconciliation activities

>QMC hospitalists support care coordination by identifying enrollees with preventable ER admissions and diverting these to the appropriate outpatient level of care

The current enrollees continue to present with complex physical health, behavioral health, and psychosocial conditions, with populations ranging from maternal, pediatric/adolescent, and adult to end-of-life. We establish detailed key performance metrics and clinical dashboards for all of our programs. Those dashboards are monitored and used as a key management tool in our ongoing program management. [General SRC #20, Attachment 5: Clinical Dashboard Overview], provides additional detail about this important tool.

Because all of our enrollees are diagnosed with SMI, Magellan Complete Care continuously analyzes all available enrollee data to determine factors that affect enrollee health, because they may trigger destabilization of the enrollee’s mental or physical health or signal that an enrollee is decompensating in an area of functioning.

6.2 Specialized QI Program
Magellan Complete Care uses an enterprise-wide and fully integrated approach to carry out key quality improvement, HEDIS, and clinical performance measure activities. The health services team collaborates with the quality team to ensure that quality improvement and HEDIS initiatives are fully integrated with the clinical enrollee-facing programs. Our employees are educated on targeted quality, HEDIS, and quality measures. Current and new initiatives are discussed at the cross-functional oversight and operational meetings to determine which key initiatives will be the focus for improving the key measures. Outcome measures are determined by the results of the HEDIS and state-specific performance results. The quality, HEDIS, and performance
improvement strategy uses a multi-faceted approach incorporating clinical, data, and provider-based efforts.

Enrollee-facing staff enrollees carry out HEDIS and quality measure initiative calls encouraging enrollees to obtain care and preventive services they need to improve overall health and to establish a medical/behavioral health home. In addition, Magellan Complete Care has developed both provider and enrollee incentive programs (discussed elsewhere in this proposal) specifically targeting enrollee gaps in care related to quality and HEDIS measures.

---Enrollee Story: Alice (name changed to protect privacy)---
Since July 2014, we have provided services for our enrollee Alice, a 53-year-old who is in a comatose state with a tracheostomy, peg tube, and Foley catheter in place.

Alice also has a LTC plan case and case manager through Molina Healthcare. The current assigned ICCM has worked with her since September 2016. The ICCM has specifically been coordinating care through Alice’s daughter, who holds her healthcare proxy. Alice has a history of seizures as per the proxy and was previously given the diagnosis of schizophrenia. She was in a car accident many years ago that led to her current medical state.

Alice’s daughter has elected to keep her mother in the home environment despite alternate level of care options provided by the health plan as well as recommended by treating physicians. The ICCM has had to work with not only ensuring that our enrollee Alice received appropriate medical follow up but also respecting the rights and wishes of her family.

Services offered/recommended:
> Hospice Care: Alice’s daughter refused this service, stating that in the past she had agreed, but since her mother’s condition had not worsened, the proxy stated that her mother does not meet hospice criteria

> Nursing Facility: The holder of the healthcare proxy refused this service, stating that she wants to maintain her mother in the home and is not trusting of quality of care in nursing facilities

> Home Health Care: Alice’s daughter had discontinued this service several times due to her dissatisfaction with various home health agencies. However, after continued collaboration and conference between Alice’s daughter and the ICCM, our enrollee currently has home health in place under her LTC plan

> Durable Medical Equipment: Our enrollee is now receiving needed supplies through the LTC plan. However, there were instances where the LTC plan was not acknowledging its role in covering this benefit. Therefore, the ICCM served as an advocate for enrollee’s needs.

Coordination of Care Activities:
Collaboration with Alice’s daughter, who holds her healthcare proxy: ICCM has provided education on health plan processes, redirection on priority needs, assistance with medication issues, guidance on covered Magellan Complete Care benefits, and education on LTC-MMA responsibilities, in addition:

> ICCM has escalated several medication denials to Magellan Rx and also communicated with point of sale pharmacy
ICCM has reached out to the LTC plan to discuss LTC-MMA plan responsibilities and worked to partner on ensuring enrollee received needed medical supplies and services.

ICCM has connected with current and past treating providers to obtain a history of enrollee’s medical needs.

ICCM did extensive research to locate both in-network and out-of-network providers that would see the enrollee in the home setting for not only primary care but also specialty care needs.

ICCM also used the support of the provider support specialist to outreach to providers and encourage their assistance with enrollee’s care.

ICCM coordinated with in-network and out-of-network providers as well as our Utilization Management Department to secure needed single case agreements and obtained clinical information on present needs and treatment progress.

ICCM facilitated staffing among Magellan Complete Care Medical Director, network director, and LTC Plan leadership to achieve consensus on health plans’ roles in supporting the enrollee’s plan of care.

ICCM presented case to medical director during weekly rounds and also used supervision with clinical manager for guidance and feedback.

**CRITERIA 7: THE EFFICACY OF THE RESPONDENT’S APPROACH IN ACHIEVING COST SAVINGS...**

Through our tenure as the current SMI specialty plan provider, we have demonstrated the value of CC/CM and DM interventions in improving enrollee outcomes. We present major findings from a study of outcomes associated with participants and non-participants in these programs. For purposes of this analysis, enrollees were grouped as follows:

- Those enrolled in CC/CM, DM (treatment)
- Those who we were unable to contact/never touched (control)

We analyzed data from 1/1/2015 through 9/15/2016 to allow time for completion of program for the enrolled group and six months of post-discharge claims including three months of claims runout. Only enrollees who were continuously eligible for the duration of the study are reflected in the data (12 months for the not enrolled/engaged group or 12 months plus time in case management for the enrolled/engaged group). We studied adults (aged 21+ years) and studied children/youth independently.

We operationalized the study design based on the following criterion:

- **RISK:** High risk (2+ comorbid conditions and 3+ any cause admissions)/moderate risk (either 2+ comorbid conditions or 3+ IP any cause admits)/low risk (< 3 IP any cause admits)

- **COMORBID CONDITIONS:** Sum of clinical indicators included in this analysis:
>>Use of DME, sickle cell, cancer, hypertension, CHF/cardiovascular disease, substance use disorder, alcohol use disorder, asthma, schizophrenia, transplants, HIV/AIDS, bipolar, eating disorder, major depressive disorder, COPD, congenital birth defects, and diabetes

>ENGAGED/ENROLLED: To count as enrolled, an enrollee must have had a care plan, received contact from case managers at least 10 percent of the time they were enrolled in their case management program, and had an outcome of “goals met” or “change in clinical status or condition” for one of these reasons: program completed, reached maximum gain, change in clinical status/condition, pregnancy-terminated, or pregnancy-delivered.

In adults, inpatient (any cause) admissions were reduced more for the engaged/enrolled group than the not engaged and enrolled group, including:

>Any cause admissions for the enrolled group were reduced by 49 percent. This reduction was statistically significant (over time and between enrolled and not enrolled enrollees, and was present at all risk levels:
  >>Low risk admissions for the enrolled/engaged enrollees decreased by 47 percent
  >>Moderate risk admissions for the enrolled/engaged enrollees decreased by 36 percent
  >>High risk admissions for the enrolled/engaged enrollees decreased by 38 percent
  >>>All readmissions were statistically significant (over time and between enrolled and not enrolled)

In adults, all-cause ER use decreased for both the engaged/enrolled group and not engaged and enrolled group, but these groups were not statistically, significantly different; any cause admissions for the enrolled group were reduced by 34 percent.

Rates of ER use for physical (non-trauma) causes decreased more for the enrolled/engaged enrollees than for not enrolled/engaged enrollees, including:
  >Low risk admissions for the enrolled/engaged enrollees decreased by 82 percent
  >Moderate risk admissions for the enrolled/engaged enrollees decreased by 85 percent
  >High risk admissions for the enrolled enrollees decreased by 68 percent
  >All re-educations were statistically significant (over time and between enrolled and not enrolled)

Enrollees who were enrolled and engaged in CM had longer periods of community tenure than any other group (as compared to those not enrolled, those who were enrolled but had staff contact 0, or less than 50 percent of the time during their enrollment):
  >The hazard rate for enrolled and engaged enrollees is statistically significantly lower than the other groups) enrolled enrollees spend more time in the community
  >The health rate for those enrolled and engaged is 37 percent lower than those who are not enrolled
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

1. The extent to which the respondent’s algorithm and risk stratification approach is well-defined and incorporates data elements other than diagnosis.

2. The extent to which the respondent describes data sources that are incorporated into the risk stratification process that is used for new enrollees.

3. The extent to which the respondent’s approach includes the use of predictive modeling.

4. The extent to which the frequency and intensity of the care coordination services (i.e., maximum caseload and minimum contact requirements) are aligned with the respondent’s risk stratification process and proportional to the clinical and psychosocial needs of the target population.

5. The extent to which the respondent’s approach includes innovative strategies for addressing the unique needs of highly resistant or difficult to serve populations.

6. The adequacy of the respondent’s description of evidence-based interventions in achieving improved outcomes and enhancing enrollee engagement.

7. The efficacy of the respondent’s approach in achieving cost savings, cost avoidance, emergency department diversion, increased utilization of ambulatory care settings, etc.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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SRC# 21 – Coordination of Benefits (Statewide):

The respondent shall describe the strategies utilized in care coordination with other plans and insurers (e.g., Medicare) to provide necessary services for its enrollees when the third party payer is the primary insurer. The respondent shall include information on its approach in the following circumstances:

a. Florida Medicaid does not cover the service, but it is available through the third party payer;

b. Florida Medicaid and the third party payer cover the service, but Medicaid is only liable for the coinsurance/copayment expenses. In this scenario, the respondent shall identify any differences in its approach if the enrollee is dually eligible for Medicare and Medicaid;

c. The third party carrier benefit limit is exhausted and the service is now a Medicaid expense. In this scenario, the respondent shall identify any differences in its approach if the enrollee is dually eligible for Medicare and Medicaid; and

d. The service is not covered by the third party but is available through Florida Medicaid.

Response:

OVERVIEW
Magellan Complete Care ensures that all needed care is coordinated and provided for enrollees regardless of payer. That is our commitment and priority. Our approach to coordinating benefits and services includes early identification of enrollees who are dually eligible, comprehensive assessment of individual needs and preferences, and effective coordination and planning of services and supports. Our person-centered, community-focused, and evidence-driven approach to the coordination of benefits is built on experience, best practices, and lessons learned from serving individuals in Medicaid managed care specialty plans, managed long-term care (MLTC), fully integrated dual advantage (FIDA), and dual eligible special need plans (D-SNP) programs.

We have systems and processes in place that are invisible to the enrollee and their families and that enable coordination of comprehensive benefits, care and services, regardless of payer. Our cost containment department is dedicated to coordination of benefits and detecting third party liability (TPL). Our highly configurable systems and processes minimize AHCA expenditures by maximizing other coverage parameters available in the claims system. Our claims processing system includes checks and balances to adjudicate claims with other insurance coverage to ensure that Medicaid is the payer of last resort. To minimize involvement of the enrollee, we work directly with the other payers and our providers to coordinate other coverage and resolve any issues.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Criteria 1: The Adequacy of the Respondent’s Approach When:

1.1 Overview of Capabilities
Magellan Complete Care has mechanisms in place to identify enrollees who have other coverage including:

>AHCA enrollment files: The process begins with the receipt of the 834 enrollment file. Coordination of benefits (COB) information from AHCA is systematically loaded into our Facets health plan administration system and we verify the other coverage if any discrepancies are found. Information from the verified eligibility file feeds to downstream systems, such as our TruCare care management system, Total Member Record (TMR), and other integrated Magellan Complete Care systems. COB is included in our eligibility file to select vendors that pay claims.

>Subcontractor: Magellan Complete Care employs the services of a coordination of benefits subcontractor, Health Management Systems, Inc. (HMS) to augment the capabilities of our internal Cost Containment Department. We share membership files with HMS, and perform data matches for other insurance carriers. If other insurance is found on the contractors’ databases, a file is created and loaded into our databases for future coordination and savings efforts.

We validate TPL data we receive from HMS by systematically matching the enrollee’s information in the TPL files received from HMS with the corresponding identifiers on the enrollee’s record in our Claims Adjudication and Payment System (CAPS), our eligibility and claims adjudication system. Once validated, we notify AHCA in the monthly reporting process via the secure data transfer already in place.

>Data mining: Magellan Complete Care identifies other coverage by data mining through our claims system. An enrollment specialist validates TPL when the information is received on a claim, with either the third party and/or the enrollee to ensure we are coordinating benefits appropriately. We also data mine using diagnosis and trauma edits to identify potential subrogation cases. Once coverage is verified, the enrollee’s record is updated in the system to cost avoid claims payments going forward.

The system automatically adjudicates the claim for enrollees with other coverage if the primary payer remittance advice (RA) is attached to the claim. If the RA is not attached, the claim pending or denies based on the information contained within the enrollee’s eligibility record. A dedicated, experienced team within our claims operations department processes the claim according to established COB processing guidelines.

>Providers: We routinely request other insurance information when interacting with providers.

>Enrollee: Other coverage is also identified through new enrollee welcome calls or from Magellan Complete Care team members, such as care coordinators or customer service associates. When this occurs, the information is sent to an enrollment specialist to verify coverage.

>CMS coordination of benefits agreement (COBA) files: Daily COBA files identify Medicare primary payments.
CAPS is programmed using “order of benefit determination” logic, assuming Medicaid is the payer of last resort. The system carries effective and termination dates for coverage so that there is a historical record for claims payment purposes.

CAPS generates monthly COB reports listing enrollees’ files that have been updated within the prior month and comparing them against any claims that may have been paid during that month when benefits were not coordinated. If overpayments are identified, an auditor in the COB department then reviews the enrollee’s claims history through CAPS, identifies all potentially overpaid claims, and initiates the overpayment recovery process.

Once other insurance information is validated, we notify AHCA in the monthly reporting process via the secure data transfer already in place.

1. 2 Processes When Florida Medicaid Does Not Cover the Service, but It Is Available through the Third Party Payer

Operationally, if a claim for services is received, and the service is not covered by Florida Medicaid but is covered by another payer, the claim will deny as not a covered benefit. The exception is if the claim is for a medically necessary service as a result of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) referral, the claim would process through normal claims processing. In this scenario, Magellan Complete Care will pay the claim and work to recover from the other carrier if it is a benefit covered by that payer.

Magellan Complete Care addresses non-Medicaid-covered services required by enrollees, but which are available through a third party payer, through our care management processes and our customer service staff. Magellan Complete Care offers the same level of care coordination and case management to ensure that all needed care is provided for enrollees regardless of payer. All Magellan Complete Care staff are trained on policies and processes related to third party coverage. Customer service and care managers have access to a tool listing third party or other funded covered services including Medicare, Medicaid long term care, and through Florida’s managing entities. We approve medically necessary Medicaid services to make sure services are available to the enrollee. Care managers often access non-Medicaid covered services such as residential services or Florida Assertive Community Treatment (FACT) by coordinating with the points of contacts at the managing entities to arrange for treatment.

We attempt to outreach to all enrollees to complete an initial welcome call and health risk assessment (HRA). With the enrollee’s/family’s permission, when a higher level of care coordination is required, such as when an enrollee is enrolled in case management or during transitions in care, our care coordination team collaborates with any identified care coordinators (e.g. Medicare Advantage) and providers even if they are out of network. On a weekly basis, the care coordination management team reviews reports of enrollees with other coverage who had services denied due to the service not being a Medicaid covered benefit, crossover claims, and/or the benefit limit of the other payer has been exhausted. This report provides insight into enrollees who may require follow-up by the care coordination team. All services and supports are incorporated into the enrollee’s care plan, including services not covered by Medicaid. If an enrollee requires a service that is not covered by Medicaid, the care coordination team works with the enrollee to determine if the service is covered by the other payer. Through these processes, Magellan Complete Care of Florida works to ensure enrollees receive all necessary services and supports.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

1.3 Processes When Florida Medicaid and the Third Party Payer Cover the Service, but Medicaid Is Only Liable for the Coinsurance/Copayment Expenses
Magellan Complete Care of Florida participates in the Medicare Crossover Program which supports claims adjudication for Medicaid beneficiaries who are liable for coinsurance/copayments on their Medicare coverage. The Medicare Crossover Program requires that after Medicare pays the provider for the service, Medicare then crosses the claim over to Magellan Complete Care of Florida for payment of cost-sharing amounts. Medicare payments sent to providers indicate when a claim has been crossed over to the Medicaid program, so providers do not bill Medicaid separately. Once the claim has been processed by Medicare and crosses over to Magellan Complete Care, remaining payments for coinsurance/copayments would be processed through our normal claims adjudication processes.

For commercial payers, the providers receive their primary payment from that payer then submit the explanation of payment (EOP) and claim to Magellan Complete Care of Florida for payment of deductibles and coinsurance, up to and not to exceed the Medicaid fee allowed, or whichever is less. Claims submitted without the EOP will be denied if primary payer coverage is identified in our system. The provider may then resubmit the claim with the required documentation.

1.4 Processes When the Third Party Carrier Benefit Limit Is Exhausted and the Service Is Now a Medicaid Expense
If a Medicare or other payer covered benefit limit is exhausted, we coordinate the enrollee’s Medicaid benefit to continue care when medically necessary up to the Medicaid benefit limit. We authorize all medically necessary care to make sure the services are available to the enrollee. Our process requires that providers first submit a claim to the primary payer. Once the denial is received showing the benefit limit has been reached, the provider submits the claim to Magellan Complete Care with the EOP for the remaining balance for processing. Magellan Complete Care would then process the claim for additional benefits if the TPL’s liability has been exhausted and the enrollee has Medicaid coverage, following our standard claims processing logic. Services that do not require prior authorization would be processed through normal mechanisms.

1.5 Processes When the Service Is Not Covered by the Third Party, but Is Available through Florida Medicaid
Magellan Complete Care’s CAPS system is configured by procedure code for specific Medicare services, to bypass COB edits in those instances when Medicare does not cover a service, but Florida Medicaid does. When a provider bills for the services on the bypass list, the system will allow adjudication through normal claims processing.

For other payers, Magellan Complete Care would become aware that the service is not covered through the provider claims submittal process for enrollees with TPL, as described above. If the service does not require prior authorization, the system configuration edits would allow processing of the claim through normal claims processing. If we have not already identified the service as non-covered by the third party payer through the provider’s claims submittal and the service does not require prior authorization, the claim would be suspended for review. It would then be processed according to standard claims logic once reviewed and we had verified that third party coverage was not available.

If the service requires prior authorization, Magellan Complete Care care management staff would work with the enrollee and the provider by following our authorization protocol. If the service has been requested by a provider who is not in the Magellan Complete Care network, the enrollee
would be given information for the providers in their geographic location to assist the enrollee in receiving their care in an expedient fashion. Once it is determined TPL does not apply to payment for certain Medicaid-covered services, future claims for those services can be paid by Magellan Complete Care without first pursuing TPL, and using standard claims logic.

CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT’S APPROACH INCLUDES:

2.1 Documentation of Effective Communication Strategies to Reduce Confusion for the Enrollee

Our local and national experience has taught us the value of establishing strong linkages, effective collaboration, and clear communication to efficiently coordinate services and supports, ensure enrollees understand their health plan coverage, and know how to use it. We have established standard operating procedures to address communication with local Medicare Advantage plans and accountable care organizations that address processes and timeframes for sharing information and coordinating care in compliance with MIPPA (Medicare Improvements for Patients and Providers Act).

Our approach to coordinating Medicaid and Medicare/other payer services includes early identification of enrollees who are dually eligible, comprehensive assessment of individual needs and preferences, and effective coordination and planning of services and supports. That approach includes:

> Magellan Complete Care welcome calls and welcome letter: We call and welcome all newly enrolled enrollees as early as allowed. Calls are made by trained representatives asking specific questions about other insurance (including Medicare) and providers they currently visit. We also ask if they have a Medicare Part D card and if so, ask for plan information. If they are in a Medicare Advantage plan, we ask them to describe the information on the ID card, and whether they have a care coordinator, along with the name and contact information. During the call, we request their consent to gain access to their health information and to share that information with the Medicare plan and providers to assist in coordinating care. Enrollees with Medicare coverage also receive information in their Welcome Packet outlining coordination of benefits for enrollees that are dual eligible.

> Customer Service: Magellan Complete Care customer service agents are trained on the various mixed services protocols for various third party plans. The staff provide education to enrollees on which payer covers a particular service and links the enrollee to their care coordinator to access the service and prevent duplication of services. Magellan Complete Care staff have access to Plan websites, AHCA website and other public resources to help identify non-covered services.

> Magellan Complete Care Enrollee Handbook: The Enrollee Handbook provides information on the coordination of benefits and outlines in general, services covered by Medicare Parts A, B, C, D, MMA and LTC. The handbook gives direction to enrollees to call customer service for questions regarding non-covered services or for information on how to obtain non-covered services. We provide information in the enrollee handbook and through other enrollee touchpoints to reinforce that providers cannot bill the enrollee for services rendered, with the exception of cost sharing and patient responsibility where applicable.

> Provider Messaging to Enrollees: Provider education is aligned with our standard operating procedures to ensure consistent messaging to enrollees. We train providers on coordinating care for enrollees who are dually eligible. Training includes covered services, prohibitions against balance billing, and coordinating care and services. Our provider network staff are trained as the
subject matter experts in this area and provide ongoing assistance as needed. Prohibitions against balance billing are also included in our provider and vendor contracts.

Magellan Complete Care ensures that our network providers are well-informed and educated in using the provider portal and other available information sources, to ensure accurate, timely billing and payment for their practices. Providers also receive training on billing requirements and limitations through in-person sessions, newsletters, provider manuals, remittance advices, authorization requirements, etc. As part of our quality management; complaints, grievances, and appeals; and compliance processes, we regularly monitor results for any potential patterns that may suggest a lack of understanding on the part of a provider. If such a pattern is detected, interventions may include face-to-face education through our provider relations managers (PRM), escalating to corrective action plan (CAP), potential withdrawal from the network, and/or reporting to the appropriate agency.

Magellan Complete Care Care Coordination Messaging: Our care coordination team frequently educates enrollees on covered services and non-covered services. When a non-covered service is needed by the enrollee, the care coordinator assesses other funding sources which may cover the service and works to link the enrollee to those sources to receive the needed treatment.

2.2 Processes Used To Identify Non-Covered Services By The Primary Insurer For Individual Enrollees

Magellan Complete Care has mapped Medicare Part A and B covered services against Florida Medicaid covered services to develop a bypass list of Medicare non-covered services. For Medicare Advantage (MA) plans, enhanced benefits vary. Our care coordinators work directly with the MA plan to identify covered services to ensure there is no duplication of services and benefits or confusion on payment.

For other payers, as noted above, the primary mechanism for identifying non-covered services by the primary insurer is through our claims submittal process for providers. Providers are required to submit an EOP with the claim, when TPL has been identified either by the enrollee or through Magellan Complete Care’s COB vendor. If TPL has been identified, non-covered services would be identified through the EOB and would be processed as described above.

Magellan Complete Care customer service agents and care coordination staff are also trained on the various mixed services protocols for various third party plan coverage such as long term care. The staff provide education to enrollees on which party covers a particular service and link the enrollee to their third party coverage plan to access the service and prevent duplication of services. Based on the enrollee’s type of third party coverage and on the training received by the Magellan Complete Care staff, they are well-equipped to identify non-covered services by the primary insurer. Magellan Complete Care staff have access to plan websites, the AHCA website and other public resources to help identify non-covered services.

(a) Processes used to streamline ongoing authorization and payment of services once the initial determination has been made that a service is not covered by the primary insurer or the benefit from the third party insurer has been exhausted.

2.3 Processes Used To Streamline Ongoing Authorization And Payment Of Services Once The Initial Determination Has Been Made That A Service Is Not Covered By The Primary Insurer
We authorize all medically necessary care to make sure the services are available to the enrollee. If the requested service does not require authorization claims, the claim would be processed as noted above, with authorization and payment being driven by the EOP submitted by the provider.

If the provider did not request a prior authorization and one is required, the provider can request a retrospective review. If the service is medically necessary, the claim will be adjusted and paid.

>For retrospective reviews, our procedure is as follows:

>>Retrospective review is not available for outpatient and elective ambulatory services that required prior authorization and for which precertification did not occur before providing the service. Exceptions include: hospice, dialysis, SIPP. In network providers are informed about the precertification process via Magellan Complete Care web, provider bulletins, JOC or during face to face meetings.

>>For non-PAR provider:
In cases where the practitioner or facility failed to obtain the appropriate authorization or provide the required notification, we will review the documentation for MNC to determine medically necessity services

>>Retrospective/Post service Review Process for Inpatient Admissions through the (ER) ONLY: Hospitals are required to notify the plan of all emergency inpatient admissions within 24 hours, but no later than ten (10) days from date of admission. If provider submits notification > 24 hours but within 10 days from admission AND enrollee has already been discharged, the medical record will be forwarded to the Retrospective Review (Retro) Team. If the complete record is received, the retro team will review without a claim on file. If notification is incomplete (i.e. face sheet only), the provider will be redirected to submit a claim along with medical records. Hospitals must submit a claim with medical records if notification > 10 days. Once the claim with medical records has been received, the claim will be denied for no authorization and the medical records will be submitted to the Health Services Department to review for medical necessity. If the claim is submitted without medical records, the hospital must submit the medical records to the address provided on the EOP within 35 days from the date on the EOP.

>>>Timeframe: Retrospective decisions are made within 30 calendar days from receipt of the request and are based on the clinical information submitted at the time of the request.

CRITERIA 3: THE EXTENT TO WHICH RESPONDENT’S DESCRIPTION SPECIFICALLY ADDRESSES ….
Magellan Complete Care has dedicated enrollment specialists who support the care coordination team and providers to improve care coordination when Medicare is the primary insurer. The enrollment specialists are subject matter experts who coordinate with Medicare Advantage plans and Medicare providers to:

>Offer coordination of benefits (COB) guidance consistent with the terms of the Florida Medicaid program and AHCA Agreement, including verification of enrollment in Medicare plans.

>Assist with applying for other benefits (for example, Medicare Part D or veteran coverage). Magellan Complete Care has engaged vendors who assist in identifying enrollees who may be
eligible for Medicare and VA coverage, and who will assist the enrollee with securing both MA, Part D, and VA coverage.

>Ensure that services covered and provided under Magellan Complete Care’s AHCA Agreement are delivered without charge to enrollees who are dually eligible for Medicaid and Medicare. We will ensure that providers understand that they are prohibited from balance billing and should submit claims for coverage of co-pays. We follow-up with any providers who balance bill, correct the error, and provide additional training. We also educate enrollees about not paying bills from providers, but to call our call center to discuss any bills they may receive.

>Collaborate with Medicare payers and providers, and Medicare Advantage Plans as appropriate to coordinate care and benefits of enrollees who are also eligible for Medicare, as described in our response to the next question.

>Serve as subject matter experts on all aspects of Medicare benefits and coverage.

>Assist with monitoring and tracking reports of all dual eligible COB activity within our management information system.

Easily Accessible Data for Other Coverage: All information related to other health care coverage is maintained in our enrollment and clinical management systems and is readily accessible by our staff.

Assessing enrollees who are dually eligible: We know that every enrollee who is dually eligible requires different levels of assessment and care planning depending on their type of coverage and individual needs and circumstances. To best understand their needs, we will call all enrollees and perform initial needs screening to:

>Confirm any other coverage, including the name of any Medicare Advantage plan.
> Inquire about current providers, care coordinators/care managers, and treatment plans.
>Conduct an initial health risk assessment to identify any unmet needs, service gaps, or need for service coordination identifying any additional condition-specific, comprehensive needs assessments.

Magellan Complete Care also coordinates Medicaid and Medicare services by creating comprehensive care management and service plans that address individual needs and preferences and include the actions necessary to coordinate with Medicare coverage. All Magellan Complete Care enrollees receive fully integrated care regardless of their benefit package/structure. Our responsibility is to make this a seamless integration by using the tools, technology, and provider relationships to meet enrollees’ overall health and wellness goals. For example, when we identify enrollees who are covered by Medicare and who are receiving inpatient acute/psychiatric care, we communicate with the enrollee’s health plan while they are hospitalized to coordinate their discharge plan and ensure a warm hand-off to our care coordinators after discharge. This activity facilitates the resumption of the enrollee’s care plan upon their return to the community.

Magellan Complete Care is committed and has the processes in place to support the seamless delivery of enrollee care, regardless of payer(s), while ensuring compliance with all AHCA contract, and other regulatory requirements. Our goal is ease of use for both enrollees and
providers, while ensuring capture of information for other coverages and timely and accurate processing of claims based on those findings.
Evaluation Criteria:

1. The adequacy of the respondent’s approach when:
   
   (a) Florida Medicaid does not cover the service, but it is available through the third party payer.
   
   (b) Florida Medicaid and the third party payer cover the service, but Medicaid is only liable for the coinsurance/copayment expenses.
   
   (c) The third party carrier benefit limit is exhausted and the service is now a Medicaid expense.
   
   (d) The service is not covered by the third party but is available through Florida Medicaid.

2. The extent to which the respondent’s approach includes:
   
   (a) Documentation of effective communication strategies to reduce confusion for the enrollee (e.g., strategies used in enrollee materials).
   
   (b) Processes used to identify non-covered services by the primary insurer for individual enrollees.
   
   (c) Processes used to streamline ongoing authorization and payment of services once the initial determination has been made that a service is not covered by the primary insurer or the benefit from the third party insurer has been exhausted.

3. The extent to which respondent’s description specifically addresses special processes in place to improve care coordination, including provider communications, and service provision for dual eligibles when Medicare is the primary insurer.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.
SRC# 22 – Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Statewide):

The respondent shall describe its approach to education and monitoring of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements, including:

a. A description of outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements and to improve compliance with the periodicity schedule and treatment recommendations that are identified as a result of a screening.

b. A training plan that includes descriptions of strategies that will be used to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the plan (case management, utilization management, provider relations, etc.) as well as subcontractors.

c. A description of the monitoring approach that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the plan and with subcontractors.

d. A plan for ensuring greater transparency among external stakeholders (e.g., advocacy groups) in the respondent’s approach towards coverage of the EPSDT benefit.

Response:

OVERVIEW
Magellan Complete Care of Florida is a first-of-its-kind fully-integrated health plan for individuals with serious mental illness (SMI). The plan provides integrated bio-psycho-social delivery and management of care for this extremely complex and vulnerable population. At its inception, it was not expected that the plan would have significant numbers of enrollees under the age of twenty-one (21). Although an estimated one-quarter of children are diagnosed with mental illness in a given year, the presence of serious mental illness is not as common in those age cohorts since many SMI diagnoses are made as individuals reach the teen and young adult years. The most common childhood mental disorders are anxiety disorders, depression, and attention deficit hyperactivity disorder (ADHD). We also often see serious emotional disturbance (SED) and autism. In teens, more frequently than in younger children, addiction, bipolar disorder, and less often, early onset schizophrenia (often seen in first episode psychosis in teens and young adults) may manifest.

The distribution of our population of enrollees under twenty-one (21) years of age speaks to these trends. Magellan Complete Care serves approximately 16,000 enrollees under age 21. Of those enrollees, one percent are ages 4-6, 18 percent are ages 7-12, 46 percent are ages 13-17, and 35 percent are 18-20. The complexity of addressing children and young adults with SMI is different, but just as great as the challenges of managing care for adults. Although they may not experience as much homelessness and similar social connection issues and may not have as much advanced chronic physical illness, they are not exempt from these issues. Children and young adults with SMI may often live in challenging home and family conditions, as well as suffering from conditions such as asthma and diabetes.
Our own internal analysis of Magellan Complete Care enrollees under age 21, shows that both asthma and diabetes increase enrollee risk and complexity, and are tied to higher utilization, particularly for the Emergency Room (ER). Adverse Childhood Experiences (ACEs), which includes physical, sexual and emotional abuse; physical and emotional neglect; experiencing a mother treated violently; substance misuse within the household; household mental illness; parental separation or divorce; and, experience with an incarcerated household member has become a significant area of focus for Medicaid agencies and Substance Abuse and Mental Health Services Administration (SAMHSA). Childhood experiences of this type can exacerbate existing illness and make treatment and management more challenging.

CRITERIA 1: THE ADEQUACY OF THE RESPONDENT’S APPROACH RELATED TO OUTREACH AND COMMUNICATION STRATEGIES …
Recognizing the issues and limitations many of our enrollees face, as well as the much higher numbers of child and youth enrollees than was originally anticipated, Magellan Complete Care launched a comprehensive effort to develop targeted programs for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT/CHCUP) as well as other child/youth specific care management and quality interventions. Magellan Complete Care recognizes that EPSDT/CHCUP is an essential component of Medicaid services for enrollees under age 21, providing comprehensive and preventive health care services and ensuring that all conditions identified as part of the preventive health services are thoroughly evaluated and treated.

In addition to the expanded programs described above, as part of our continued efforts to grow our processes and structures to better support our enrollees and drive continuous improvement in quality and outcomes, we also look to leverage important partnerships that we have established with best-in-class organizations so we may continue to learn, grow, and innovate in our overall system of member engagement and management. As part of those ongoing efforts, we are partnering with, and have engaged Shared Health, a wholly-owned subsidiary of Blue Cross Blue Shield of Tennessee which has a rich history of working within the communities they serve, and conducts greater than 500 community events a year to reach their Medicaid population across the state. An important area of focus for Magellan Complete Care in continuing to achieve population health improvements and to improve enrollee engagement and satisfaction is reach a greater percentage of our members. We believe our partnership with Shared Health will be a significant element in driving the successful expansion of those programs, including EPSDT/CHCUP and programs for outreach and education of our enrollees under 21 years of age and their guardians.

Magellan Complete Care believes that the addition of Shared Health as an important partner in these efforts, when combined with the deep understanding of our population and the mechanisms that drive successful interventions that we have developed in the several years we have offered this specialty health plan, will yield continued significant improvements in quality, outcomes, and satisfaction for our enrollees.
We recognize that the EPSDT/CHCUP program, which is governed by Title XIX of the Social Security Act and the Code of Federal Regulations, Title 42, Part 441, Subpart B, is key to ensuring that children and adolescents receive appropriate preventive, medical, dental, mental health, developmental and specialty services. Our programs include robust outreach and education for enrollees, caregivers, providers, staff and key external stakeholders, as well as continuous monitoring and reporting of EPSDT/CHCUP and other care gaps. Our EPSDT/CHCUP programs and approach incorporate key EPSDT/CHCUP objectives:

> Early assessment and identification of problems
> Periodic health checks at age-appropriate intervals
> Screening for physical, mental development, dental, vision and other health issues to detect potential problems
> Diagnostic testing to follow up when a risk is identified, and referral to specialists where appropriate
> Treatment to control, correct or reduce medical, behavioral, and development problems that are found

We recognize the importance of the EPSDT/CHCUP program for detecting and treating health problems early to limit downstream medical and mental health issues and provide children and youth with a solid foundation to be healthy, thriving adults.

Our EPSDT program supports the primary care provider/patient relationship, emphasizing recommended routine pediatric care; monitoring and closure of gaps in care; prevention of complications through evidence-based practice guidelines, helping members access and engage in care, and evaluating clinical and psychosocial outcomes on an ongoing basis. The program incorporates risk stratification and segmentation that includes indicators of social risk which can also be combined with ICD-10 data indicating neglect or abuse, allowing Magellan Complete Care to target its interventions to address those additional risks that may complicate preventive care and treatment adherence or increase health risks. Our programs include population-based and individual approaches for engaging members/guardians in preventive care in combination with tailored approaches for managing enrollee’s physical, behavioral, and/or developmental health conditions.

Magellan Complete Care’s EPSDT/CHCUP program incorporates ongoing monitoring of enrollee compliance with program requirements; caregiver, enrollee and provider education and outreach to understand program benefits and recommendations; easy-to-read materials available through multiple sources; caregiver, enrollee and provider support to close gaps in care and access required services; motivational and emotional support; individual resources in alignment with the enrollee’s conditions, needs, and readiness for change; and, targeted outreach and community engagement to increase program awareness and engagement. Magellan Complete Care maintains a dedicated Utilization Management (UM) staff person with primary responsibility for review and approval of EPSDT/CHCUP services to ensure required care is provided in a timely and appropriate manner.

Our core process incorporates the following key elements:

Enrollee Identification and Notification: Magellan Complete Care’s goal is to quickly identify enrollees eligible for the EPSDT/CHCUP program and provide information on program features and benefits. Activities include:
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

> We identify members for EPSDT/CHCUP services through monthly enrollment files received from the State.
> We then conduct data mining as part of our standard analytic processes, also on a monthly basis to identify gaps in screenings and care.
> Through our ImpactPro predictive analytics engine we generate a monthly report identifying enrollees who have not had an EPSDT visit, dental visit, vision assessment, lead screening, or immunizations in accordance with the AAP periodicity schedule and guidelines.
> As part of new enrollee onboarding all new enrollees under 21 are contacted to inform them of EPSDT/CHCUP services and are offered assistance with scheduling appointments and transportation.
> Enrollees are provided education on the importance of preventive care and recommendations of the program. This information is provided in the enrollee welcome call and new enrollee packet.

Ongoing monitoring and outreach to close gaps in care: We continuously monitoring enrollee compliance with program requirements and conduct outreach to close gaps-in-care. Activities include:

> Magellan Complete Care conducts ongoing monitoring of gaps in care through our Quality Improvement and Care Management programs, using analytics, utilization and care monitoring.

> We identify the enrollee’s caregiver who is permitted to engage and receive information on the enrollee’s care.

> Enrollees and their caregivers are provided periodic reminders and evaluation of adherence with appointments. This may include printed materials sent directly to enrollees and caregivers, newsletters, messaging, and updates to enrollee website.

> Magellan Complete Care will conduct direct outreach by phone or in-person to enrollees and their caregivers to encourage program compliance, address barriers to engagement, and assist in overcoming those barriers.

> We complete referrals to other departments, support groups and community resources based on enrollee needs.

> We identify enrollees who are two-months behind periodicity screening schedule and outreach up to two times for education and to offer assistance with appointments and transportation, if needed.

> Magellan Complete Care provides case management assistance to enrollees with special health care needs who require extensive coordination of medical specialty and behavioral needs.

> Provider training and support: Magellan Complete Care considers our provider network to be an important partner for increasing awareness and enrollee engagement for EPSDT/CHCUP services. Activities include:
   >> As part of new provider training they are educated on program benefits and requirements; billing; and reporting.
   >> Providers receive program reminders through provider newsletters and ongoing education.
   >> Magellan Complete Care reinforces evidence based practices through provider engagement with our care management program and through our clinical Provider Support Specialists (PSS).
Program information and training is available on the provider website.

Providers receive gap-in-care reports for enrollees needing services. This reporting is provided in printed form and on the provider portal (for the provider’s enrollees).

Magellan Complete Care collaborates with providers for enrollee outreach and to support the removal of barriers to adherence to program requirements. Magellan Complete Care will also be expanding the use of additional collaborations with providers, including clinic days, health fairs, and similar group activities targeted at increasing awareness and enrollee adherence with EPSDT/CHCUP requirements. We have already employed this strategy very effectively with a number of CMHC’s and will be expanding this program as part of our Integrated Health Home (IHH) program, elements of which are described in greater detail below.

Community outreach and education: Magellan Complete Care will be expanding its community outreach and engagement strategies to enhance our engagement with community organizations, schools, and advocacy groups that are specifically targeted at children and youth. As noted previously, our number of enrollees under age 21 has increased significantly relative to original expectations. As these numbers have increased those larger numbers have made broad community efforts a more feasible solution for reaching our enrollees. We are looking to expand these efforts and take a greater leadership role in expanding awareness of the importance of EPSDT/CHCUP, particularly for children and adolescents with SMI and related health issues.

Efforts to outreach and educate all eligible enrollees/guardians about the importance of EPSDT/CHCUP and the benefits it provides is an important element of our EPSDT/CHCUP program. Outreach and education begin at the time of enrollment and continue throughout enrollment in the plan. Details of our specific outreach and education efforts include:

Initial Outreach and Education

New enrollee calls: We outreach to each new enrollee/guardian to complete an initial Health Risk Assessment (HRA) that includes a discussion of benefits, and education about the benefits of EPSDT/CHCUP. When available, we use previous medical records to identify the status of EPSDT/CHCUP visits and enrollee gaps in care.

Unable to reach letter: After two attempts to call the enrollee/guardian, an “unable to reach you letter will be mailed.

Enrollee Handbook: Our enrollee handbook and Welcome Kit include information about the importance and timing of EPSDT/CHCUP visits and immunizations.

Ongoing Outreach and Education

Periodic mailings: EPSDT/CHCUP postcards are mailed to children and young adults to remind them of needed care.

Customer service calls: Customer Service Specialists (CSS) are alerted to gaps in care via TMR, the CSS documentation system. When an enrollee/guardian calls in, the CSS will offer assistance in making the EPSDT/CHCUP appointment and transportation if needed.

Outreach calls: We implement outreach campaigns to members to provide education and offer assistance in making the EPSDT/CHCUP appointment and transportation if needed.

Member website: Our enrollee website provides general information about available services and programs, a downloadable copy of the enrollee handbook, and information about the importance of preventive care.
>>Enrollee newsletters: On a quarterly basis member newsletters are available to each of our enrollees. These newsletters cover a variety of topics including EPSDT/CHCUP services, lead screening and immunizations.

>>Mother Baby Connections Program: Our Health Services Department ensures choice of a pediatrician for the newborn and educates about the importance of EPSDT/CHCUP and assists with making the initial appointment as needed.

>>Additional written materials: HealthwiseTM materials, with information on recommended preventive and routine care, as well as the EPSDT/CHCUP program, are included in campaign and available on the website.

>>Reminder notices: For persistently non-adherent enrollees (e.g., two (2) months behind on EPSDT/CHCUP visits), we will outreach to each enrollee at least two times encouraging them to make an appointment, and offering assistance with scheduling and transportation, if needed. Health Guides, with support from Community Outreach Specialists, may meet individually with enrollees in the community and in their homes when we are unable to contact an enrollee by phone.

>>As part of our newly expanded focus on population health and wellness we are also expanding the use of text reminders for enrollees and their guardians, as well as use of social media to educate and remind enrollees of the program and its services. These types of tools are widely used, and have proven effective, in Medicaid programs throughout the country. We have previously had discussions with the AHCA about expanded use of these capabilities, while still meeting AHCA expectations for enrollee privacy. We will work with the AHCA to develop programs and messaging that meets those dual goals.

>>Special outreach for enrollees designated as ultra-high and high-risk: All enrollees assigned to the high and ultra-high-risk case management program are evaluated for gaps in care by their assigned Intensive Care Case Manager (ICCM). ICCMs will facilitate needed appointments, referrals, and transportation.

>>Gaps-in-care, including EPSDT/CHCUP are also identified in enrollee records and are highlighted for customer service, quality, and care management staff for follow-up with enrollees when they call in with questions or requiring services.

>>Providers also receive gap-in-care reports for all their assigned enrollees, and are engaged by Provider Support Staff (PSS) who assist in identifying barriers to closing those gaps and overcoming those barriers.

CRITERIA 2: THE ADEQUACY OF THE ENROLLEE ENGAGEMENT APPROACH AND STRATEGIES THAT WILL BE DEPLOYED TO IMPROVE COMPLIANCE...

As noted above, Magellan Complete Care uses multiple data sources to identify enrollees eligible for EPSDT/CHCUP services, and associated gaps in recommended care. This includes both EPSDT/CHCUP-designated screening and care requirements and gaps in care based on Magellan Complete Care clinical guidelines and enrollee care plans. We identify and outreach to all new enrollees by phone, to complete a Health Risk Assessment (HRA) at enrollment. Where clinical data is available at enrollment (typically because the new enrollee was previously been in case management), that information is provided to our ICCM team for enrollee assessment and outreach. We make two attempts to contact the enrollee/guardian by phone. If we are unable to reach the enrollee/guardian by phone, they are sent a letter indicating the plan is trying to reach them.

Magellan Complete Care is also capturing and analyzing data from the following sources monthly:
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Immunization data from Florida SHOTS Registry
Testing data from our laboratory vendors
Admission, discharge, transfer data from HIE
Medical and behavioral health claims data
Pharmacy claims data
Vision claims data

Historically, Magellan Complete Care has also been able to capture and monitor dental claims data through our vendor and contracted provider relationships, which will change under this ITN which includes the carve-out of dental services. Once the AHCA has made its selection of dental providers Magellan Complete Care will work to establish appropriate interfaces and data sharing protocols, which will allow us to continue capturing this important information. We recognize the importance of good oral health, particularly for our SMI enrollees who may experience other vulnerabilities. We are committed to capturing and monitoring required EPSDT/CHCUP and other care information, in support of our fully-integrated care model for our enrollees.

These varied data sources are then used to identify enrollees with EPSDT/CHCUP gaps in care, and outreach to members. The use of data from the SHOTS registry is particularly valuable since new enrollees may have previously met immunization requirements or may have received those services through other sources. Once we have identified gaps in required services, we outreach to enrollees through mailings, phone calls and in-person visits for those enrollees who are persistently delinquent in receiving required care, or who are designated as high-risk or ultra-high-risk in our predictive modeling and segmentation/stratification model.

We also produce a monthly EPSDT/CHCUP performance report to measure progress in closing EPSDT/CHCUP care gaps. Through our disease (DM) and care management (CC/CM) processes, we also monitor treatment of conditions that are discovered during preventive exams. Enrollees having a chronic condition may be enrolled in either DM or CC/CM depending on level of risk and complexity. DM/CC/CM staff will also work with the provider and enrollee to secure necessary referrals for specialty or other care if that need is identified, and will work with the enrollee or caregiver to address any barriers that may inhibit compliance.

Magellan Complete Care’s membership is very complex and vulnerable, so we use all available enrollee touch-points to engage the member, make them aware of gaps in care, and assist them in scheduling required appointments, and transportation to those appointments if required. Information concerning EPSDT/CHCUP gaps in care are available to customer service and care line staff, so that the enrollee/guardian can be informed and engaged to address gaps-in-care during those calls. Care gap information is also made available to providers, as discussed below.

On an annual basis, and as part of our quality management processes, Magellan Complete Care maintains a dedicated team to identify and close EPSDT/CHCUP gaps-in-care. This includes live outreach calls, face-to-face outreach, and home visits where necessary. We also partner with a vendor, Engaging Solutions, to field outreach and live calls, and have established partnerships with local communities, schools, juvenile justice and advocacy organizations. We evaluate the performance of our EPSDT/CHCUP program on an annual basis to identify barriers to performance and identify actions required to address those barriers. Quality initiatives aimed at addressing those barriers are integrated as part of our annual Quality Improvement Plan. We have also developed enrollee and provider incentive programs which are currently awaiting AHCA approval. As part of this ITN response we are also proposing expansions of our existing provider
incentive programs to enhance provider engagement and support continued progress in increasing rates of compliance for EPSDT/CHCUP services.

One of the very innovative approaches to engage enrollees in the healthcare process has been a unique take on traditional “clinic days”. MCC’s enrollee population frequently access services through CMHC’s. Magellan Complete Care has developed focused partnerships with Community Mental Health Centers (CMHC) to co-locate MCC care management staff within the CMHC when MCC enrollees are there receiving routine behavioral healthcare with the purpose of addressing preventative care needs such as EPSDT/CHCUP. We meet the enrollees where they are, and integrate the MCC team into the CMHC’s to optimize outcomes, increase education regarding preventative care and link enrollees to their providers. Magellan Complete Care will continue to expand this approach to leverage the CMHC’s specialized experience and best practices working with children, youth and families to address preventative integrated health needs.

We have found this to be an effective way to educate and gain enrollee compliance for a larger number of enrollees. As part of our newly implemented Integrated Health Home program we will be expanding the number of CMHC’s with the capabilities to provide both behavioral health and physical health services, allowing us to further expand the use of our “clinic day” model.

CRITERIA 3: THE ADEQUACY OF THE RESPONDENT’S TRAINING AND EDUCATION...
Magellan Complete Care is committed to ensuring staff, providers and vendors are aware of requirements and their obligations under for EPSDT/CHCUP and receive regular training using multiple mediums for communication. Training materials are made available to staff, providers and vendors, both in print and online. Staff and providers receive training in EPSDT/CHCUP requirements and expectations when contracted or hired. Compliance with EPSDT/CHCUP program requirements, training of providers and staff, and reporting on performance against program requirements are part of our vendor contracts. Vendors are required to report on program results, and monitoring of those results, including training, is part of our vendor reporting, monitoring and oversight activities.

Magellan Complete Care providers receive additional periodic training in EPSDT/CHCUP program requirements, regular program mailings and reminders, and gap-in-care reports (both paper and online) identifying gaps in performance against EPSDT/CHCUP program requirements. Providers are also informed about and reminded of program requirements as part of our ongoing quality efforts and through provider financial incentives for activities under the program. Our vendors are equally engaged, providing regular, ongoing training, printed materials and reminders. Information on those training programs, including program content, is provided to Magellan Complete Care as part of our regular vendor oversight and quality monitoring activities. As an example, our Vision Vendor, Premier Eye Care, recently complete AHCA training on EPSDT/CHCUP for UM and QI team members. Vision providers within their network are provided access to EPSDT/CHCUP training through Premier’s provider portal. Premier providers do screenings on children when they see them. EPSDT/CHCUP training is also included in regular training cycles for Magellan Complete Care staff. Staff, providers and contracted vendors have continual access to training through our Healthwise Health Education portal.

New hires receive training in EPSDT/CHCUP program requirements and Magellan Complete Care outreach and engagement. Training is also renewed on an annual basis, reflecting any changes to outreach and engagement models, incentives, goals and strategies. [General SRC
EXHIBIT A-4-a  
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

#22, Attachment 1: Child Health Check Up Program (CHCUP)] provides information on the content of that training. Magellan Complete Care’s TruCare care management platform also includes information and prompts for required EPSDT/CHCUP services to provide staff with continuous education and reminders on requirements for the program, including required services and documentation.

Our provider services and health services outreach and support staff also outreach to all providers with identified EPSDT/CHCUP-eligible enrollees to provide education on requirements and expectations of providers for EPSDT/CHCUP services. In addition to information on program expectations and requirements, training and outreach includes information on the use and availability of gap-in-care reporting (print and online); billing requirements; coding guidelines; and information on the obligations of a provider after performing an EPSDT exam if a condition is identified. [General SRC #22, Attachment 2: CHCUP Program Leave Behind] is an example of the leave-behind reminder materials for providers. Information about EPSDT/CHCUP requirements and programs is provided in-person by Provider Support Specialists (PSS) during office visits, online via the Magellan Complete Care website, in provider newsletters, and as part of ongoing provider training sessions.

Magellan Complete Care provides the same level of training to Primary Behavioral Health Providers, where many of our enrollees have greater engagement. As part of our integrated health home program (IHH) we will also be assigning Primary BH providers to the IHH’s, and these providers will have responsibility for meeting EPSDT/CHCUP requirements. The PSS team will also provide training to the BH providers on EPSDT/CHCUP to educate case manager and clinical staff in the CMHC’s (BH providers) about their role in addressing EPSDT/CHCUP needs and actions to impact.

Program information and training materials are also available to all providers through our Provider Portal. Provider education begins with the initial provider orientation, at which affected providers are also given copies of our clinical guidelines, and preventive health guidelines, including information for accessing American Academy of Pediatrics (AAP) Bright Futures. Our Provider Handbook also includes information on EPSDT/CHCUP program and requirements, immunizations, Vaccine for Children (VFC) Program, and lead testing requirements.

CRITERIA 4: THE ADEQUACY OF THE RESPONDENT’S MONITORING APPROACH...
As noted above, Magellan Complete Care uses multiple data sources to monitor, track and report compliance on a regular and ongoing basis. This includes capturing services and utilization information (including vision) on a continuous basis, generation of monthly reports identifying enrollee gaps in care. Magellan Complete Care is currently implementing significantly expanded data, analytic and reporting capabilities across all data sources, providers, vendors and other business partners, through the creation of a comprehensive “data lake” which will pool all data in a single source. This will provide much more timely and accurate data on EPSDT/CHCUP services, gaps in care, provider performance against program requirements, and patterns of utilization or program participation that may require improved interventions. Reporting from this data source will allow us to make current performance information available to internal staff, including customer service, outreach, quality management, and care management staff for outreach to enrollee’s or enrollee’s guardians at every available touchpoint. Data from this source will also be used to populate our provider portal and Connect portal which gives providers access to detailed information on gaps in care, utilization, testing, and other data for the enrollees under
their care. This same information will be provided through paper reports to both our providers and vendor partners with responsibility for closing EPSDT/CHCUP gaps in care. As noted previously, once the AHCA has identified its selected dental vendors, Magellan Complete Care will work with those vendors to establish mechanisms to capture and monitor that data as well.

Information on enrollee gaps-in-care, including EPSDT/CHCUP is used by quality staff, for outreach to both enrollees and providers as part our quality management activities, and as part of our expanded programs for population health and wellness management, and is made available to customer service staff (CSS) and ICCM staff as reminders to be used at all enrollee/guardian touchpoints. ICCM staff also use this information in ongoing monitoring and management of enrollees who are engaged in some level of DM/CC/CM.

EPSDT/CHCUP program requirements and monitoring and reporting of related gaps in care and treatment of identified conditions, are an integrated element of our expanded population health and wellness programs and our ICCM model. Enrollees who are identified as having additional care needs either through the EPSDT/CHCUP program or through other sources, are managed through our ICCM programs, which include DM, CC, and CM. As described in other sections of this ITN, engagement with the various levels of care management is driven by assessment of enrollee risk, complexity and need with DM being more those enrollees with chronic conditions such as asthma and diabetes, with indications of disease stability. Recognizing the differences in clinical requirements, enrollee risks, and utilization patterns for our enrollees under 21 years of age, Magellan Complete Care uses a modified stratification and segmentation model for these individuals.

Magellan Complete Care has also established a separate ICCM team that is focused exclusively on children and youth. That team includes monitoring and management of EPSDT/CHCUP requirements and services as part of its ongoing care management programs. All programs are also supported by Magellan’s National Child and Adolescent Program, which includes a comprehensive infrastructure with a solid clinical foundation to implement child and adolescent care and coordination designed to improve the life trajectory of youth, with a particular focus on those at risk. Magellan’s dedicated team of experts has developed and is enhancing child and adolescent delivery systems that provide effective preventive services, such as EPSDT/CHCUP, as well as needed acute and long-term treatment.

Magellan Complete Care also has a robust program to notify providers of their enrollee’s gaps in EPSDT/CHCUP and other care. We generate monthly Gap-in-Care Reports which are given to both primary care and primary behavioral health care providers. This information is also available to providers online through the provider portal and the Connect portal. These Gap-in-Care Reports are generated from the same multiple data sources used internally by Magellan Complete Care. Providers are encouraged to outreach to their patients to close gaps. For high volume practices, we collaborate with providers to facilitate gap closure, either through co-location of outreach and/or care management staff, or other supports as needed.

Magellan Complete Care also provides webinars and trainings for providers to engage and assist them in efforts to increase EPSDT/CHCUP compliance rates. Those trainings include: discussion of services included in EPSDT/CHCUP; EPSDT/CHCUP guidelines; proper billing and coding of visits; and, guidance on how to convert “sick visits” to “well visits”. On a quarterly basis, we send a Provider Newsletter to each contracted provider. These cover a variety of topics including EPSDT services, lead screening and immunizations.
Magellan Complete Care develops care gap reports, inclusive of EPSDT/CHCUP well visit and preventive dental gaps which are shared by our Provider Support Specialist team. We also conduct annual medical record reviews on a randomly selected sample of providers to check for the presence of required EPSDT/CHCUP visit elements. These reviews by our clinical staff are used as an additional training opportunity to work directly with providers and their staff where deficiencies are noted.

As noted elsewhere, Magellan Complete Care is proposing expansions to its existing provider incentive programs which currently include performance on selected EPSDT/CHCUP-related measures. As part of that expansion, we will also be expanding opportunities for providers to participate in these programs and monitoring and reporting to provider progress in meeting incentive goals for their enrollees. We believe this program expansion will be instrumental in driving additional improvements in program results.

CRITERIA 5: THE EXTENT TO WHICH THE RESPONDENT’S OVERALL OUTREACH...
Magellan Complete Care employs a multi-pronged strategy for engagement of non-health plan stakeholders to improve outcomes for EPSDT. As described above, we have a robust program of information sharing and outreach to all affected providers, with regular reporting of provider program results; specific and targeted trainings to increase awareness and around program requirements and expectations; and provider-specific support and outreach through our provider support staff, outreach staff, and ICCMs.

Magellan Complete Care also has a robust community engagement strategy that includes outreach for children and youth, including for EPSDT/CHCUP. As part of our Integrated Health NeighborhoodSM (IHN), we participate in numerous youth and family oriented community organizations, and provide education and outreach, including for EPSDT/CHCUP. We are also actively engaged with our CMHC and FQHC providers to develop and facilitate programs specifically targeting EPSDT/CHCUP, including wellness and clinic days, health fairs, and education outreach. We will continue to collaborate on programs with CMHCs, FQHCs and clinics, as well as with other community organizations, with sufficient concentrations of our enrollees, to expand our group visit, clinic day and health fair programs to specifically address EPSDT/CHCUP and preventive care across all regions of Florida. The discussion of Magellan Complete Care’s MyLife program below provides an example of the types of programs we have already developed, and will look to expand.

In addition, Magellan Complete Care has established partnerships with the Federation of Families of Central Florida for the development of the MyLife Program to conduct outreach and provide community support to at-risk youth. There is a long-established MyLife Program in Tallahassee, through a partnership with multiple stakeholders in that community. The MyLife Program actively engages youth through teaching, coaching and mentoring, and empowers them to use their voices to inspire and create positive change for themselves and others in their local communities.

In the Orlando Metro area, Magellan Complete Care is working collaboratively with a group of key stakeholders to address breakdowns in the delivery of care for at-risk children and youths. The group includes the following community organizations:
The goal is to provide a coordinated system of care, ensuring ease of access, crisis response, and an array of high-quality services for children, youth and families in Orange County. Magellan Complete Care is an active collaborator in this endeavor, lending expertise and guidance around principles of population health (including EPSDT), integrated care, peer support, strengthening relationships, aligning with community partners, provider incentives, addressing stigma, and targeting clinical outcomes. Magellan Complete Care is providing continued support to these efforts through the development of youth-specific materials to share with key community organizations, stakeholders and providers. Materials include resource lists detailing ways to connect to services.

As a result of these efforts, Magellan Complete Care has been invited to participate in a pilot being developed by the key stakeholders noted above, with a goal of directly transforming the system of care for youths and families in Orange County. This means individuals would benefit from integrated funding of needed services with no barriers. This, of course, would include access to EPSDT/CHCUP services for eligible individuals.

Magellan Complete Care also uses social media as a very effective tool to increase awareness and engagement of enrollees for EPSDT/CHCUP. We use multiple social media platforms to explain program features and benefits, provide information on how to access services, and answer questions for our enrollees and the community. As an example, using Twitter, we sent out a tweet in October of last year, about coverage for children's dental exams. That one tweet alone, reached more than 10,400 impressions. As part of our robust social media strategy, we plan expanded use of these platforms which we believe are very successful for reaching young parents and adolescents. We have also made a strong commitment to the use of other forms of technology as part of our broader telehealth strategy. This includes the use of smart phone reminder messages, and apps to inform enrollees of program benefits, and remind them of recommended services.

In addition, as described in the introduction of this section, Magellan Complete Care is proposing expansion of its existing community engagement programs for children and youth. We will build on the experience of our partner, Shared Health, and their extensive experience in community outreach and engagement for Medicaid populations to identify key stakeholders and venues for reaching Magellan Complete Care enrollees. Because of the unique characteristics of our enrollees, we will place particular emphasis on community organizations and agencies that are more likely to be serving our enrollees, including selected schools, family support organizations, and child welfare programs.

Magellan Complete Care is committed to expanding community understanding of EPSDT/CHCUP program features and benefits throughout the communities we serve. We continue to collaborate with new and existing community partners to develop awareness,
education and outreach programs which will increase program participation and drive outcome improvements.
Evaluation Criteria:

1. The adequacy of the respondent’s approach related to outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements.

2. The adequacy of the enrollee engagement approach and strategies that will be deployed to improve compliance with the periodicity schedule and treatment recommendations, including identification of the data sources that will be used to monitor compliance.

3. The adequacy of the respondent’s training and education approach to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the plan/subcontractors. The respondent must illustrate a commitment to ongoing training and retraining of staff/subcontractors utilizing an array of mediums to earn all points for this component.

4. The adequacy of the respondent’s monitoring approach, including all data sources that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the respondent and with subcontractors.

5. The extent to which the respondent’s overall outreach approach identifies opportunities to improve upon the level of transparency for external stakeholders.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.
SRC# 23 – Behavioral Health/Primary Care Integration (Statewide):

The respondent shall describe its proposed approach in promoting integrated behavioral health and primary care models, including:

a. Identification of integrated models in various practice settings that have documented improved patient outcomes, patient satisfaction, and cost-effectiveness.

b. Identification of opportunities for improvement across the respondent’s system of care (e.g., care management, provider network, utilization management, enrollee services) with the goal of advancing to more integrated care models.

c. Description of strategies the respondent will deploy to overcome the barriers/gaps identified to increase its capacity for providing integrated care models, including use of alternative payment models/financing strategies.

Response:

OVERVIEW – INTEGRATION FRAMEWORK FOR BEHAVIORAL HEALTH AND PRIMARY CARE INTEGRATION

Magellan Complete Care understands that individuals with serious mental illness (SMI) or substance use disorder (SUD) have higher rates of acute and chronic medical conditions, shorter life expectancies (by an average of 25 years), and a poorer quality of life than the general medical population. These individuals also have higher utilization of emergency and inpatient resources, resulting in higher costs. The demonstrated efficacy at the heart of the Magellan Complete Care SMI Specialty Plan care coordination stems from a systems-level integration within the context of an Integrated Health Neighborhood.

We promote integrated care across a continuum from minimal collaboration to partial integration to full integration of behavioral and physical health services; disease- and condition-specific expertise; and a focus on population health—according to stakeholder needs, resources, and practice patterns. We are uniquely positioned as the SMI Specialty Plan to ensure improved access, coordinated and integrated care, and improved outcomes for individuals with SMI enrolled in Florida MMA. Our primary focus today and going forward is to constantly improve our ability to recognize, diagnose, and treat conditions effectively.

According to the AHCA for Healthcare Research and Quality (AHRQ), behavioral health integration is the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered team-based care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Integrating behavioral health care into primary and specialty medical settings offers an effective and efficient way to improve access to behavioral health and substance abuse services. Additionally, mental health care delivered in an integrated setting may help to minimize stigma and discrimination; while increasing opportunities to improve overall health outcomes. Effective integration is built on a foundation of a highly capable delivery system, and requires practice
transformation support to successfully design and implement a collaborative approach. In addition, integration is also important for positively impacting disparities in health care in minority populations.”

Magellan Complete Care has found that the features of integration are dependent upon a strong delivery system – where a provider serves as the primary location of services, providing behavioral health care in the least restrictive/most convenient location, offering team-based models with team composition driven by patient needs, and implementing stepped-care, e.g., the ability to move patients up and down the care continuum. Magellan Complete Care uses the SAMHSA Four Quadrant Clinical Integration model to identify which population segments are best served by the various integration models. This construct recognizes the need for different models of care integration, collaboration, and coordination based on degree of enrollee behavioral health and physical health complexity. Medium, High, and Ultra High Risk are stratified to be served by models which integrate medical care into specialty behavioral health; while Low Risk and Preventive Risk enrollees are well served by primary medical providers with integrated behavioral health. Any enrollee can be stepped up or down the care continuum depending upon their individual condition and management needs.

Please refer to [General SRC #23, Attachment 1: IHN Overview, Flowchart, and Flyer] for details regarding our approach.

CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT THOROUGHLY DESCRIBES ITS CURRENT...

1.0 Provider Engagement and Support – Our Approach to Integrating Behavioral Health and Primary Care

Magellan Complete Care believes that ongoing provider engagement and support fosters healthcare integration at the system and service level by ensuring collaboration and communication with all providers and caregivers across the enrollee’s entire care continuum. We deeply value our provider partnerships and seek to develop meaningful relationships to support them in the care of our enrollees. We employ a high touch provider engagement model and continuous improvement to streamline processes.

Magellan Complete Care’s approach to integrating behavioral health and primary care is focused on provider support to transform a practice, including the following key components:

>Practice Facilitation: Our Provider Support Specialists, licensed clinicians, work side-by-side with our provider practices. Using the principles of practice facilitation, Provider Support Specialists leverage their clinical and public health knowledge, along with their deep understanding of the neighborhoods they serve to provide consultation, training, and technical assistance to help providers improve the quality of care and develop integrated care solutions.

>Provider Education: Through our online Magellan Learning Alliance and our Provider Support Specialists, we are committed to expanding the knowledge base of providers in the community increasing the numbers of providers who feel appropriately equipped to serve the SMI population.

>Staffing: Through our Integrated Health Neighborhood approach, we have established multi-disciplinary teams of licensed and non-licensed professionals who live in the same communities as the enrollees they serve and the providers who care for them. This model allows us to “think
locally” as we co-design our programs to serve enrollees in each region. Team members include Provider Support Specialists, Integrated Care Case Managers (ICCM), Health Guides, Recovery Support Navigators, Family Support Specialists, Housing and Employment Specialists, Community Outreach Specialists, and Provider Relations Managers. For providers who need staffing support, we are able to co-locate staff in their office or clinic to “wrap” our services around their existing programs.

>Reimbursement Models: As stated above, Magellan Complete Care is committed to working collaboratively with providers to develop provider capabilities and implement incentives and reimbursement programs, consistent with AHCA regulation, limitations and guidelines, to encourage provider participation in medical/health home programs. As an example, we use value-based purchasing arrangements targeting OB/GYNs and pediatricians by promoting a variety of innovative compensation models with our contracted provider networks. We also currently participate in the AHCA’s MPIP program, which targets quality improvements for pediatricians and OB/GYN.

>Data and Tools: We provide the tools and data providers need to advance integrated models e.g., dissemination of best practices, utilization data, medication adherence data, and establishing learning collaboratives.

1.0.a Integrating Behavioral Health and Primary Care through the Provider Partnership Model
Our provider engagement model was designed to support integration of care models. The Provider Support Specialist team provides a unique layer of support from a clinical perspective. As licensed behavioral health clinicians or registered nurses, they have years of experience and training working with the SMI population. As members of the Integrated Health Neighborhood team and located in regions throughout the state, they are dedicated to supporting our network providers with a clinical lens to more specifically support efforts to promote healthcare integration.

In 2015, Magellan Complete Care established the Provider Partnership Program led by the Provider Support team with the goal of providing medical/health home options for our enrollees in a variety of settings throughout Florida. A key strategy of the Provider Partnership Program is specifically targeted to engage providers in the practice transformation process using innovative solutions to achieve integrated care models and address the Institute for Healthcare Improvement’s Quadruple Aim of health care. It is Magellan Complete Care’s SMI-specific version of this very successful programs for primary care transformation used throughout the country.

Provider Support Specialists target providers who are patient-centered medical home (PCMH), as well as federally-qualified health centers (FQHC), and community mental health centers (CMHC) interested in developing integrated care models. We started with the Health Resources and Services Administration (HRSA) funded health home programs in Florida; CMHCs with a co-located PCP; and FQHCs that offer behavioral health services. Our Provider Support Specialists provide practice facilitation to support provider groups as they work towards or maintain their PCMH/ Integrated Health Home status or for other integrated care models.

The Provider Partnership Program is rooted in the value and market recognition of the AHCA for Healthcare Research and Quality’s (AHRQ) Practice Facilitation. The clinically trained Provider Support Specialist team has received targeted education around Practice Facilitation from the inception of the health plan. The Provider Support Specialist team has been trained on the
principles to guide their processes with providers and have developed Magellan Complete Care specific provider materials and tools to support Practice Facilitation activities. Provider Support Specialists use a range of organizational development, project management, quality improvement (QI), and practice improvement approaches and methods to build the internal capacity of a practice to help it engage in improvement activities over time and support it in reaching incremental and transformative improvement goals.

Several key activities help to drive the process, including the following:

> Identification of Providers to Participate: This is a twofold process: (1) data analysis, and (2) qualitative input from the Provider Support Specialist assigned to the provider. We look at enrollee assignment, risk category, and provider engagement to target a provider to prioritize for the program.

> Provider Engagement: The Provider Support Specialist spends time learning about the providers, their capabilities, and goals. They gather their buy-in so that the process is successful and meaningful to support long-term transformation efforts aimed at improving integration of care.

> Provider Profile: The Provider Support Specialist creates a provider profile outlining characteristics of the practice to highlight the basic elements of the practice (size, number of locations, scope of services provided, EHR used, use of data in operations, coordination/partnership with other providers and community resources).

> Practice Observation: The Provider Support Specialist conducts on-site practice observations at all practice locations. They follow and observe the general patient experience from end to end. The Provider Support Specialist identifies best practices, strengths and areas of improvement. The goal of these observations is to listen, learn, and understand how the practice is operationally functioning.

> Workflows and Practice Integration Assessment: After conducting all practice observations, the Provider Support Specialist compiles workflows for each step of the enrollee experience to thoroughly illustrate how effective the processes are functioning and supporting the organizations goals related to enrollee care and outcomes. The Provider Support Specialist also completes a practice integration assessment which focuses on: level of collaboration (SAMSHA toolkit) and readiness for change, based on motivational interviewing. The Provider Support Specialist provides a narrative summary as feedback to the practice about the overall observation. This information is then shared and presented during a meeting with the practice organization.

> Practice Plan: Once the practice has reviewed the information, the Provider Support Specialist offers the opportunity to help guide transformation activities taking on a consultant role. Based on the feedback from the workflows and assessment, a practice plan is developed to reflect the areas of opportunity, practice growth goals, and to align with addressing the Triple Aim of health care.

For more detail, please refer to [General SRC #23, Attachment 2: Magellan Complete Care Provider Partnership Program.]
1.0.b Integrating Behavioral Health and Primary Care through Screening, Brief Intervention and Referral

Screening, Brief Intervention, and Referral to Treatment, also known as “SBIRT” is implemented with any willing primary or specialty care medical practice or PCMH. In these models, primary care takes responsibility for screening their population of patients using behavioral health screening tools and refers the patient to treatment. The treatments are available to primary care include medication, outpatient therapy, telehealth therapy, and Cobalt – Magellan Health, Inc., (“Magellan”, parent of Magellan Complete Care) proprietary “app-based” computerized cognitive behavioral therapy.

SBIRT specifically facilitates the best practice of standard behavioral health screening tools and measurement based care. Standard screening tools allow a provider to measure a patient’s symptom burden and to stratify the patient’s condition into mild, moderate, and severe levels. The provider follows the patient’s response to treatment by repeating the screening tool at appropriate intervals. Just as the management of hypertension requires the measurement of blood pressures to judge responses to therapy, the management of behavioral health conditions require the measurement of disease burden and the measurement of the response to pharmacologic and/or behavioral therapy.

Magellan offers providers a technology solution designed specifically for primary care providers called Screen and Engage. This tablet-based tool is readily implemented by primary care practices and is an easy way for the provider to screen patients while they are waiting for their visit. The tool uses standardized screening instruments, automates the scoring, integrates with the provider EMR and gives the provider clinical practice guidance based on the results of the screening. The Screen and Engage tool guides the practitioner to refer the patient to therapy of all types.

Magellan’s Cobalt Computerized Cognitive Behavioral Therapy empowers PCPs and patients to begin treatment immediately using a technique well studied and proven to be effective in over 70 published papers in peer review journals. Cobalt facilitates the administration of six behavioral health screening tools targeting the most common conditions diagnosed in primary care practice (insomnia, depression, SUD/alcohol use disorder–AUD, anxiety, obsessive compulsive disorder, and panic disorder).

We have begun the implementation of this model by identifying our highest volume PCMH and FQHC practices. Our Provider Support Specialist teams are building the alliance and beginning the process of assisting the practices in workflow modifications necessary to successfully implement SBIRT in the medical practice setting.

1.0.c Integrating Behavioral Health and Primary Care through Integrated Health Homes

Magellan Complete Care maintains a unique framework to meet the needs of the population we serve. Caring for individuals living with SMI requires a specialize approach — Integrated Health Homes, to meet the enrollees where they are and feel most comfortable accessing healthcare services. The Integrated Health Home is an approach established for individuals with SMI and consolidates all of the needed specialty and primary care resources into a single site of care. For patients with SMI, the Integrated Health Home often integrates medical care into the behavioral health site where the majority of care is delivered. This is an important care delivery model for individuals with SMI who have high complexity or multiple co-morbid medical conditions.
In Florida, we have focused our initial efforts on targeting CMHC to launch the Integrated Health Home program as a natural partner and care hub for our enrollees. We recognize the national healthcare movement to adopt and support the health home programs. For example, the Joint Commission developed a certification for Behavioral Health Homes in 2014 to create structure and consistencies to formalize the programs nationally. Similarly, the Affordable Care Act (ACA) recognizes Health Homes as a key strategy to promote whole-person health and integration among provider types to improve healthcare outcomes for chronic conditions such as SMI.

Integrated Health Homes address behavioral and physical health needs as well as the social determinants of health which we know are critical factors influencing the recovery process. Integrated Health Homes were designed to reduce barriers for enrollees as well as for providers to improve the overall system of care and quality of life outcomes for enrollees. Magellan Complete Care has launched a plan to develop Integrated Health Homes statewide to improve enrollee’s access to preventative behavioral and physical health care, partner with CMHC’s to ensure quality services, and improve the overall enrollee experience by creating a healthcare access point with enrollees needs as the central focus.

Magellan Complete Care has established a robust plan which supports the implementation of the Integrated Health Home and the growth of the model using a phased approach:

> PHASE I: Focuses on targeting existing fully integrated CMHC’s throughout the state to build on their current capacity and expertise. Similar to the logic that guides the standard PCP assignment process, we assign enrollees to a “Primary Behavioral Health Provider” (PBHP) to quarterback the behavioral health needs and coordinate with the PCP and other healthcare providers to ensure an integration of all care. All of the current Integrated Health Homes have onsite primary care services within the CMHC setting; some of which are FQHC’s and/or PCMHC’s which lend an additional layer of knowledge and expectation to prioritize care coordination activities and a collaborative treatment model.

Integrated Health Homes focus on meeting the enrollees where they are; with responsibilities for the behavioral health and physical health providers are clearly outlined within the program description to ensure role clarity and accountability across the continuum. Several key activities are employed to optimize the Integrated Health Home structure and engage the enrollees in the healthcare process in a meaningful way:

> Enrollee Engagement: Integrated Health Homes are expected to think “outside the box” for creative ways to engage enrollees outside of the clinic walls in the neighborhoods they live. Creating consistent enrollee touch points in the community and home is central principle of the Integrated Health Home model to open up pathways to care when the enrollees need it most.

> Enrollee Care Coordination: Different than traditional behavioral health case management, the Integrated Health Home facilitates communication between all treatment providers, connect enrollees with annual, preventative care, work with enrollees to collaboratively develop a plan of care, and educate the enrollee and providers when needed to ensure the highest quality of care.

> Enrollee Navigation/Outreach: Enrollee’s recovery needs go beyond standard clinical services. The social determinants of health are a great example of additional factors that impact healthcare outcomes. Integrated Health Home supports system navigation activities and outreach to address those needs by walking hand in hand with enrollees to meet housing, food, educational,
economic, and community needs of enrollees. A key component of the overall Integrated Health Home implementation is technical support for the Integrated Health Home providers. Magellan Complete Care is committed to providing support and assistance to ensure success and partnership with our provider partners. Within the program description, Magellan Complete Care has set forth several resources to lead the implementation and development of the Integrated Health Home’s throughout the state:

>Embedded Care Coordinator: Acts as a liaison to the health plan and an extension of the coordination process. Our care coordinators will provide critical healthcare information, links to additional physical and behavioral health services and support from the Integrated Health Home team.

>Clinical provider-focused support via the Provider Support Specialists: Our licensed behavioral health clinicians and/or RN’s guide and support the practice transformation activities of the Integrated Health Home providers. The Provider Support Specialist team leverages the Provider Partnership Program as the method to assess, evaluate, and collaboratively support the Integrated Health Home providers to expand and refine integration activities to improve overall enrollee outcomes.

>Integrated Care Coordination Team Meetings (ICCT): These team meetings are aimed at addressing complex enrollee’s needs are facilitated by Magellan Complete Care to include all treating providers and the enrollee to foster a collaboration through a multidisciplinary forum.

>PHASE II: Outcomes and incentives are a foundational element of Integrated Health Home. As a part of Phase II, Magellan Complete Care has identified several metrics to guide an incentive program and impact broader health outcomes. The incentives will support meaningful quality outcomes and reward the provider’s efforts and innovation employed to demonstrate success. With the direction from our analytics team, we will track progress on these metrics, as well as hospitalizations (behavioral and physical health), ER visits, and other critical health outcomes to identify impacts, such as:
  >> Increase enrollee engagement
  >> Increase medication adherence
  >> Increase access to follow up services
  >> Increase connection to physical health provider
  >> Increase the delivery of community-based services.

Starting in Q1 of 2018, Magellan Complete Care plans to launch Phase II by introducing the incentives mentioned above as well as reduction in preventable events. We plan on expanding the Integrated Health Home program to additional providers throughout Florida as we refine the model, and have already met with more than 20 CMHCs throughout the state and have received support and commitment from them to move in this direction. We will continue to work hand-in-hand with the provider to identify share savings opportunities and build their earning potential as part of the Integrated Health Home structure. By focusing efforts to address the above stated performance indicators, we expect to see a reduction in facility-based services and an overall improvement in the enrollees quality of life.
1.0.d Integrating Behavioral Health and Primary Care through the Integrated Behavioral Health Program

One of Magellan Complete Care’s strengths is understanding enrollee needs and as the Specialty Plan, being creative and nimble to draw upon best practices to develop effective solutions to improve enrollee health and wellbeing. Consistent with our overarching Integrated Health Home approach and positioning the providers to be the central hub for coordination and delivery of care, we recognized the need to develop innovative health home approaches to meet the targeted needs of a smaller, sub population utilizing the highest levels of access to care and recovery complexity.

We developed the Integrated Behavioral Health Program (IBHP) to support enrollees with the most chronic, complex behavioral health needs. Through data analysis, we were able to identify the subset of enrollees who were utilizing facility-based services or emergency care for behavioral health reasons approximately every nine days. The Magellan Complete Care team turned to the nationally recognized evidence-based best practice, “Assertive Community Treatment” (ACT) for individuals living with a serious and persistent mental illness. The ACT model established over two decades ago, moves the point of care from facilities to the community to deliver 24/7 hands on support services for those with highly complex behavioral health conditions to promote community tenure, inclusion, and recovery.

Most of our enrollees in this complex segment also have co-occurring physical health conditions that compound the challenges they experience and require additional support within their continuum of care and recovery plan. IBHP expands on the ACT model to focus on overall healthcare integration within this complex care management plan. The purpose of IBHP is to help connect enrollees to community-based services through a fully integrated, team-based model. Magellan Complete Care partners with strategic providers who deliver the care, who are experts in caring for SMI enrollees and have relationships with community-based organizations to address the social determinants of health. The IBHP program supports the providers to deliver hands-on, enrollee-centric services to ensure the right care, at the right time at the right level. The IBHP providers are the leads for delivering services and impacting the outcomes set forth.

The key IBHP services include: Outpatient behavioral health services (inclusive of the services in the AHCA behavioral health handbook), Primary care services, Care coordination with oversight and support from Magellan Complete Care, Peer support services, 24/7 crisis support services.

The IBHP multidisciplinary team includes:

> Licensed behavioral health professional
> Psychiatrist
> PCP
> Peer Support Specialist
> Case Manager
> Integrated Care Coordination Team.

This community-based, high touch model is aimed at removing barriers impacting the enrollee’s ability to achieve long-term recovery, wellness, and the highest quality of life, with the following program goals:

> Increased community tenure by reducing preventable events (including: behavioral and physical health inpatient admits and ER visits)
> Increased medication adherence
Increased access to follow up care
Improved access to preventative physical health care
Use of WRAP (Wellness Recovery Action Plan)
Increased immediate access to all IBHP services.

These goals help to shape the program’s expectations and drive outcomes. The service expectations and timelines are clearly outlined within the scope of work to ensure program integrity and clarity. The model is funded through a bundled case rate structure so providers are able to deploy innovative methods to care delivery such as community navigation, crisis interventions, and real time, same day access to psychiatrists and MDs. The funding structure allows the providers to deliver enrollee centric care which often does not exist in the fee-for-service environment and helps to support “non-traditional services” that are critical for long term recovery. The resulting enrollee care plan is comprehensive and aligned with enrollee specific life goals and mutual accountability.

While enrolled in the IBHP program, the comprehensive services within the care plan are delivered to meet the enrollee’s needs and also adhere to any specific timeline requirements (i.e., 24-hour follow up after hospitalization). The service based activities are monitored through encounter submissions to ensure all enrollees are receiving the level of support they need to achieve their recovery goals. Another important element, and differentiator of IBHP is the focus on recovery. Magellan Complete Care believes that recovery is possible for all enrollee no matter the diagnosis or condition. IBHP put the enrollee’s voice and choice at the forefront of care planning and service delivery to ensure recovery goals drive the process. As part of the IBHP program, we include peer support services as a requirement and will provide resources, training, and education to provider partners to help build and grow their capacity to deliver this valuable service.

Although the program’s primary focus is on the wellbeing of the enrollee, cost of care outcomes are evaluated on two key performance metrics (1) reduction in preventable hospitalizations and (2) reduction in ER visits. Preliminary program analysis shows promising results which are listed below. Magellan Complete Care will continue to assess these as well as the additional outcomes stated above over the next six months to understand the impact of the approach. Results include the following:

Greater reduction in ER use by enrolled/engaged enrollees and increased utilization of PCP services
Statistically significant reductions in IP utilization for all enrollees engaged in Complex Case Management (CCM) at all risk levels when compared to a control group.

Technical assistance is a significant element of IBHP. On a weekly basis, the Magellan Complete Care Program Manager hosts meetings with the IBHP providers to address the clinical, operational and administrative needs to support the providers and guide the program’s success. During these weekly meetings, the entire IBHP provider team and our Care Coordination team, join a call to ensure a comprehensive view of any challenges with the central goal of reaching a collaborative resolution to support the enrollee’s care plan and program success. The executive teams of the providers and Magellan Complete Care meet quarterly to review data, outcomes, and discuss next steps to further progress the program. This level of executive level commitment, and partnership with a shared mission has allowed Magellan Complete Care to shape a
meaningful system transformation effort, break the mold of standard care, and dramatically improve the lives of the enrollees we serve.

1.1 Provider Reimbursement and Incentivizing Care
Magellan Complete Care is committed to working collaboratively with providers to develop provider capabilities and implement incentives and reimbursement programs, consistent with AHCA regulation, limitations and guidelines, to encourage provider participation in medical/health home programs. Aligning incentives is also an important part of controlling costs. We support development and implementation of incentives to increase provider accountability and improve the quality of care delivered to enrollees. Efforts to decrease costs include identifying interventions to decrease unnecessary care and to promote both preventive care and self-management techniques.

Over the last four years as the SMI Specialty Plan, we have advanced VBP. We have increased focus on investing in our capabilities to support providers in value-based offerings with the belief that value-based incentives improve quality and reduce cost. We have experience implementing VBP arrangements targeting OB/GYNs and pediatricians in the state of Florida by promoting a variety of innovative compensation models with our contracted provider networks. We support providers focusing on education and urging them to invest in and adopt new approaches to care delivery. Our Network team works with providers to set targets for applicable metrics.

We invest deeply in people and processes to ensure we have the capabilities and know-how to support additional payment models. Our alternative payment methods include: bundled payments, Centers of Excellence, provider stratification, risk adjusted capitation, and two-sided risk sharing. Magellan Complete Care also currently participates in the AHCA’s MPIP program, which targets quality improvements for pediatricians and OB/GYN. We are proposing selected expansion to that program as well as expansion of quality incentive programs for other areas to support specific quality improvement programs to close gaps in care, and incentives to enhance access with the goal of reducing preventable events.

We are proposing expansions of our quality incentive programs to include a broader number of HEDIS and EPSDT/CHCUP metrics that are specifically targeted in our annual quality improvement initiatives. These, of course, will change as annual HEDIS and EPSDT/CHCUP improvement initiatives change. Reimbursement under these programs will be similar to that for the existing MPIP program, providing enhanced reimbursement for completion of specific gap closure activities. Beyond this targeted incentive program, we are also proposing an additional shared savings incentive program for our non-capitated providers. Performance metrics and targeted outcomes will be different than those for our capitated providers, recognizing differences in reimbursement and goals we are trying to achieve. If needed and as appropriate, our Network staff may include provisions within provider agreements for incentives or increased fees to certain providers for accepting members and ensuring timely access to needed services.

CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT PROVIDES EXAMPLES OF MORE EFFECTIVE...
Effective integrated models of care involve bringing together various providers and information systems to coordinate health services, patient needs, and data to achieve treatment goals. Care coordination/case management increases efficiency and improves patient’s health outcomes and satisfaction with care. The primary goal across the entire Magellan Complete Care system of care
is to drive the integration of behavioral health and primary care throughout. However, given the complexity of our enrollees, we recognize that not all providers are able to provide all types of care needed. Our secondary goal then is to enhance the capabilities of those providers willing and able to take on more responsibility for both behavioral health and physical health needs, and to assist those who are not willing in understanding and supporting the needs of our enrollees in other care settings.

2.0 Documented Improved Patient Outcomes, Patient Satisfaction, and Cost Effectiveness with Jackson Memorial Hospital

Magellan Health Services aims to continue implementation and evaluation of the unified integrated behavioral health and primary care model that aligns with the Strategic Initiatives in SAMHSA’s Leading Change 2.0: Advancing the Behavioral Health of the Nation via co-location of primary and specialty care medical services in community mental health settings, via an Integrated Health Neighborhood including the Integrated Behavioral Health Home, Road 2 Recovery, and Integrated Health Home programs. Within the population of SMI enrollees covered by Magellan Complete Care, approximately 16 percent do not engage with the healthcare system, in any setting. The remaining 84 percent often do not access adequate primary care. In the literature, studies have suggested that as few as 20 percent of patients treated in “usual” primary care show substantial clinical improvement, and even if these patients seek care from a mental health specialist, they may still not experience improved outcomes or access. Magellan’s data analysis of member utilization patterns using authorizations, clinical assessment and claims data has echoed these findings.

As described above, Magellan Complete Care is the IBHP approach with the largest Miami safety net hospital system, Jackson Memorial Hospital. As part of this partnership, Magellan utilizes a wide variety of data sets to assess patient appropriateness for the program. The data sources used include the administrative claims for the member, utilization management data, the Florida Health Information Exchange (HIE), gaps in care which are calculated by our clinical and quality rules engine, health risk assessment data, if available, obtained from the case management and utilization management platforms, network access via the patient’s assigned provider(s) and geographic proximity to partnering facilities and community health organizations.

Lists of patients with low willingness to accept care coordination from the plan as predicted by a propensity of engagement model, and who have a high level of admission risk via our predictive model of admission risk are shared with the system. In addition, we supply the patient’s open gaps in care, with priority given to gaps which demonstrate a low level of engagement in the primary care setting. The pilot has not been in place for a sufficient length of time to enroll the required sample size to evaluate the pilot’s efficacy, yet preliminary assessments indicate that participants have increased engagement with an integrated community provider and improved utilization of primary care services in an outpatient setting, while declining utilization in the ED setting.

We have also reviewed the population in all regions and identified providers who are providing primary and preventative care services for both adults and children, and pairs this information with geospatial analysis of areas where patients appear to have barriers to engagement with integrated behavioral and primary care locations. Magellan incorporates a proprietary Socioeconomic Risk Score (SES) derived by scoring census data about the zip code where the member resides (such as income, disability rates and rising disability rates which result in withdrawal from the workforce, educational attainment, single parent households) as well as the
CDC Social vulnerability Index which ranks census tracts on poverty, transportation barriers, and crowded housing in its evaluation of network access and integrated care opportunities. Both scores are utilized in the IBHP program to identify enrollees who often have barriers to access, even in networks where coverage may be sufficient. Please see [General SRC #23, Attachment 3: Jacksonville and Miami Higher SES Burden] as examples of the SES geospatial view for the SES burden score.

Our approach to evaluating integrated behavioral and primary care programs includes measuring performance of the program on achieving the following: improvement in provision of primary care and preventative care services in the outpatient or assisted living setting for disease surveillance, a reduction in potentially preventable ER and inpatient care, evidence of improvement in gap in care closures for medical conditions such as HgbA1c tests for the surveillance of diabetes, and appropriate medication use in patients with asthma.

In addition, programs are measured on the rate of improvement of behavioral health quality measures for our vulnerable members such as: ensuring members receive bi-annual visits with a mental health professional, improve or maintain medication compliance for their mental health condition management, eliminate sub-optimal dosing of behavioral medications, and receive proper transitions of care following discharge from an inpatient setting, follow up after emergency department visits, follow through on treatment for substance abuse, and receive bi-annual visits with a mental health professional.

Additionally, programs will be measured on their ability to improve the duration of time that a member is able to remain in the community, and on their ability to identify and resolve issues which create barriers to care access such as insecure housing and limited transportation. Initial program assessments suggest that in this complex population, patients who receive care coordination actually increase access to the ED setting for a period of time following care coordination, meaning that this population may have a transitional period of accessing care in both the primary and the ED settings.

Further evaluations of barriers to access to ambulatory care settings for patients in crisis will be undertaken to ensure that patients can continue to improve their access to primary care, and reduce dependency on the ED for management of ambulatory sensitive needs. Providers will be evaluated on their performance for these metrics after controlling for patient disease burden and socioeconomic/vulnerability scores. Providers are also ranked based upon their rates of enrollee satisfaction.

2.1 Integrated Hospitalist Program
The Integrated Hospitalist Program was implemented in May, 2016. At the time, it was the first Integrated Hospitalist Program in Florida for Medicaid recipients and specifically designed to coordinate both physical and behavioral health in our enrollees who were acutely confined to a hospital. The efforts and programs designed were so effective that they have since been duplicated by other Medicaid plans in the State. Our over-arching design for this program ensured that enrollees would be under the care of a behavioral health specialist during and following the admission and that the enrollee’s care would be coordinated with our Utilization Management Nurses and Case Managers, the enrollee’s PCPs and behavioral health specialists. As a result of this coordination and integration, there was an increase in both appropriateness of care and continuity of care. Enrollees who were hospitalized under this program participated in the inpatient
HEDIS Gap closure program in which the Behavioral Health Hospitalists worked with the Magellan Complete Care Quality team to close gaps during the inpatient stay and beyond.

The program resulted in a significant increase in detection of diabetes (through HbA1c) with enrollees being coordinated with additional diabetic care, and a significant increase in post-discharge follow-up care. In many instances, our Health Guides performed home visits and additional office-based visits, in addition to the enrollee’s assigned behavioral health providers. This ensured that enrollees received appropriate follow up to avoid future readmissions. The Hospitalists receive additional remuneration for these follow up visits and, therefore, are incentivized to provide complete care and coordination with behavioral and physical health clinicians.

In addition to improved quality, coordination and continuity of care, the Integrated Health Hospitalist program has also resulted in a diminution of inappropriate admissions. This has occurred whenever the Health Hospitalists works with the ER Specialist so that the Hospitalists can examine the enrollee in the emergency department. In those cases, several inappropriate Baker Act admissions have been avoided and enrollees have been engaged with alternative levels of care including outpatient therapy.

As a result of the initial success in five hospitals, the Integrated Hospitalists Program was expanded to 22 hospitals. Barriers to the program include the fact that some hospitals and CMHC’s contact Magellan Complete Care Hospitalists on a limited basis (less than 25 percent of the admissions are referred) and tend to send only the most difficult cases. Magellan Complete Care, through Joint Operating Committees and other efforts, continue to work with facilities to improve these numbers. However, despite these limitations, the appropriate average length of stay has decreased and follow up after hospitalization within seven days had increased.

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT IDENTIFIED OPPORTUNITIES FOR IMPROVEMENT…

3.0 Opportunities to Improve an Integrated Care Model for the SMI Specialty Plan
Magellan Complete Care has embarked on a significant expansion of initiatives aimed at identifying opportunities for improvement in delivering an improved integrated care model, including steps for implementation to increase capacity for providing integrating care. System transformation through use of integrated care models is top priority for Magellan Complete Care statewide. These specific initiatives have either recently been implemented or are being expanded throughout our network:

> Expanding Integrated Health Homes at high volume CMHCs
> Expanding PCMH alliances
> Implementing an enhanced SBIRT screening technology using Cobalt and Screen and Engage
> Implementing the Collaborative Care Model with PCMHs and FQHCs.
> Implementing the Coordinated Care Model.

In addition to expanding the approaches mentioned above, we also plan to partner with state entities to strengthen system wide adoption of best practices to support integration. Those partners include the Department of Children and Families, The AHCA for Healthcare Administration, The Florida Hospital Association, Florida Association for Community Health Centers, the Florida Council for Community Mental Health, and others. Magellan Complete Care
is committed to being a thought leader and partner in the state of Florida to improve the overall healthcare delivery system for Medicaid recipients.

Subsequent steps in leading the above efforts are outlined in Criteria #1 – Integrating Behavioral Health and Primary Care through the Provider Partnership Model.

3.0.a Expanding Integrated Health Homes at High Volume CMHCs
Magellan Complete Care has been actively working in partnership with the Florida Council for Community Mental Health and their enrollees to develop a statewide Integrated Health Home Program. As part of the planning and development process the Florida Council and Magellan Complete Care hosted a listening and planning session in Orlando with more than twenty providers from across the state to discuss the project and determine next steps.

We were able to assess the varied capabilities and implementation readiness of the provider organizations that have been targeted in each region. As a follow up to this session, Magellan Complete Care put forth a letter of intent for all of the Council members interested in pursuing this opportunity to formalize the collective commitment to moving the program forward with a focus on collaboration and partnership. Community Mental Health Centers across the state, in every region, are interested in participating in the expansion of the Integrated Health Home Program. For the providers who have been identified as phase II participants, the below steps will be taken as part of the implementation process to expand the IHH approach:

> Perform “transformational analyses” for each interested provider to determine the level of effort and support required to implement Integrated Health Home capabilities
> Develop and agree to value-based payment methodologies, and define scope of services based on the results of the analyses
> Identify and agree to performance metrics and reporting requirements that meet the providers’ current capabilities

3.0.b Expanding PCMH Alliances
The Magellan Complete Care Provider Support Specialists team has fostered partnerships with 44 traditional PCMH providers in every Florida Region we serve to impact quality, enrollee and provider experience, and cost; and to close gaps in care for our enrollees. Many of our PCMH partners have achieved PCMH 3 recognition. Most are accredited with NCQA while others have pursued Accreditation Association for Ambulatory Health Care (AAAHC) accreditation. The Provider Support Specialists team established monthly working meetings to disseminate best practices for care of individuals with SMI, address quality metrics (i.e., HEDIS gaps in care), and explore opportunities for expansion of integrated care models. The Provider Support Specialists also acted as a broker to those PCMH’s to create connections between the PCMH and behavioral health providers to facilitate coordination and integration even at the most fundamental level-communication. These settings would be ideal places to begin implementing the Collaborative Care model which Medicare now pays for and which is a primary care driven model of integrated care.

3.0.c Implementing an Enhanced SBIRT Tool Using Cobalt Solutions at PCMH and FQHC Screening and Screen and Engage Technology
Magellan Complete Care proposes to implement an “enhanced Screening, Brief Intervention, and Referral to Treatment (SBIRT)” using technology tools through the Cobalt Screening and
Cognitive Behavioral Therapy Platform and the Screen and Engage SmartScreener. We propose to implement this with high volume practices including primary care, PCMHs, and FQHCs.

Cobalt Screening and Cognitive Behavioral Therapy Platform Incentives and Expansion: Magellan Complete Care is seeking a significant expansion in the use of the Cobalt platform throughout our provider network to expand access to behavioral health services discussed above through “virtual integration”. This will include a particular emphasis on integration of the screening and provider platform with our primary care providers including FQHCs, rural health clinics, and county health departments.

We will be designing incentives for providers who participate in the program and to encourage screenings using the Cobalt tools. Magellan Complete Care will also look to provide required tablets or other hardware at reduced or no expense for providers.

Please see [General SRC #23, Attachment 4: Summary of Behavioral Health Integration Using Cobalt Solutions at FQHCs] for more information.

Screen and Engage: Identification of patients with behavioral health problems has long been recognized as challenging, so the Magellan Complete Care model of integration—called “Screen and Engage”—which includes systematic screening as one element to improve care. Our screening tool is called SmartScreener, which is behavioral health screening software, that sits at the front of Screen and Engage and is described as “smart” because it uses an algorithm developed to quickly and efficiently screen individuals for potential problems. Each symptom cluster has a short and long set of questions. The latter is only presented to the user if they score positive on the short set.

For example, if behavioral health symptoms (e.g., depression) are not identified on the short version of a scale, such as the PHQ-2, then SmartScreener skips to the next set of questions, such as the GAD-2 (anxiety). The number of questions used in SmartScreener are automatically tailored to the individuals’ condition; from those with no symptoms to those with severe illness.

SmartScreener has been in use since 2012 in clinical and non-clinical settings and includes the following, well-validated measures (including the short versions):

- ISI = Insomnia Severity Index has seven questions (short version is the first three)
- PHQ9 = Patient Health Questionnaire has nine questions (short version is the first two)
- GAD7 = General Anxiety Disorder-7 has seven questions (short version is the first two)
- AUDIT = Alcohol Use Disorders Identification Test has ten questions (short version is the first one)
- DAST = Drug Abuse Screening Test has ten questions (short version is the first one)
- PEG 3 = Pain assessment has three total questions (*to be added to screen and engage soon).

The Screen and Engage software also provides a results and recommendations page called “Scorecard”, which uses a color-coded system based on scoring. The colors allow for quick review of symptoms and severity. The scorecard can be shared or printed for consultation with a provider or counselor. Patients who indicate positive for any condition(s) will be digitally sent access to our effective cognitive behavioral therapy (CBT) apps for the corresponding condition(s).
Whenever a patient scores in the severe range on any of the assessments, the software will show a red circle next to the patient record and makes a recommendation for immediate referral to a clinician. Whenever suicidal ideation is indicated (note: only if this questions is included – it can be turned on or off) on the PHQ assessment, the patient record is highlighted with a warning sign, so that medical staff are made aware promptly without having to take the time to closely review results. In addition, we incorporate clinical scales into the programs and mobile apps, and can offer the option to ask for questions that identify suicidal ideation (such as the PHQ-9). The results from these scales can alert the individual to seek additional resources, as well as alert a clinician or a Magellan care manager.

3.0.d Implementing the Collaborative Care Model with PCMH and FQHCs
Having access to the right care at the most effective time is key to initiating and sustaining recovery as well as maintaining the quality of life for patients with both medical conditions and behavioral health concerns. That is why we seek to reduce the fragmentation between behavioral health and primary care by offering timely integrated services in support of the “whole” enrollee through the Collaborative Care Model.

Collaborative Care is different from traditional case management and co-location of a behavioral health provider. It is team-based care that supports full collaboration between the care team in an integrated practice. The care team have access to coordinated systems, regular communication and collaboration, formal meetings, and blended roles/cultures. The team works together to implement and operate new workflows to understand patient goals and improve outcomes.

The Collaborative Care team includes a PCP, care manager, and psychiatric consultant. In the model, behavioral health care managers coordinate the care team and provide psychosocial treatment. Primary care providers provide evidence-based medication with recommendations from a psychiatric consultant. The psychiatric consultant and care manager complete regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected. Magellan Complete Care proposes to implement this approach with PCMHs and FQHCs to incorporate Provider Support Specialists who are behavioral health clinicians to co-manage patients with a PCP using a “huddle” or “rounding” approach.

As mentioned in 1.0.a above, Provider Support Specialists target providers who are PCMH, as well as FQHC, and CMHC interested in developing integrated care models. Our Provider Support Specialists provide practice facilitation to support provider groups as they work towards or maintain their PCMH/Integrated Health Home status or for other integrated care models. With its extensive evidence-base, Collaborative Care has demonstrated effectiveness in the following areas:

>Increased access and satisfaction: Collaborative Care improves access to care by including input from a psychiatric consultant. Because there is a short supply of psychiatrists which can lead to frustration among patients and providers, ensuring accessibility to this expertise improves both patient and provider satisfaction.

>Improved clinical outcomes: Collaborative Care improves clinical outcomes for behavioral health conditions, such as depression and anxiety, and can also improve outcomes for chronic conditions like diabetes and heart disease.
Reduced healthcare costs: Collaborative Care shows substantial reductions for health care utilization and costs.

We can offer an end-to-end solution that organizes the delivery system while providing the people, operational support, and technology required to support successful implementation and operationalization of the Collaborative Care Model. We also offer scalability to systems through its effective implementation processes and technology solutions. Our Collaborative Care solution begins with an assessment phase that evaluates infrastructure, staffing, and analytics capabilities. The assessment results drive a customized program that effectively integrates with the system. Upon the assessment completion and program design, we support Collaborative Care implementation.

The implementation phase includes building the care team; deploying provider communication; training clinical staff on the model, technology, and coding; offering workflow support; and facilitating connections between providers and care managers. Finally, we support ongoing operations to ensure that the program is successful over time. Ongoing operations includes leveraging a practice coach to support quality improvement and cost reduction through reporting, sharing best practices, program expansion, and supporting value-based contracting arrangements that drive better patient outcomes.

The Collaborative Care solution is population-based and analytics driven. Our approach organizes data for rapid review through a population health registry driven by predictive analytics and reviewed monthly within a multi-disciplinary team. There are two ways to identify patients to participate in Collaborative Care:

- Magellan Healthcare’s proprietary SmartScreener tool is used to quickly and efficiently screen and engage individuals with behavioral health symptoms as measured by clinical scales. The tool is color-coded system for triage, empowers providers with access to real time screening results, and allows for ease of use in clinics. We leverage Smart Screener results to support measurement-based care and treating to target by allowing the care team to set patient goals and track patient progress over time. Patients are organized and sorted based on progress so that the care team can conduct rapid case reviews and prioritize patients based on need.

- Predictive modeling allows for patients to be easily identified and enrolled in the program. With a full claims dataset, we will run our predictive algorithms to identify patients who qualify and may benefit from Collaborative Care. Once patients are identified, we will work with the practices to integrate the results into their workflow in order to ensure follow-up with the appropriate patients.

The Collaborative Care Model is the only model with a clear evidence base (more than 80 randomized control trials) supporting its effectiveness in meeting the Triple Aim – better access to care, better health outcomes, and cost savings.

3.0.e Implementing the Coordinated Care Model
Coordinated care, the most basic model of integration, integrates care across practice environments by connecting them to a fully integrated behavioral-medical care coordination team. For high volume inpatient acute care facilities, a health guide is assigned to the facility and ensures that there is coordination between the hospital discharge planners, patients, families and outpatient providers. Magellan Health Guides are cross-trained in both behavioral and medical care coordination and are able to facilitate care planning across the continuum. Outpatient
providers with complex enrollees, such as the Sickle Cell Clinic at Broward General Hospital, are aligned with a Magellan ICCM, and outpatient providers with lower panel size can access an integrated care coordination by referring a patient to the team at any time.

Coordinated Care is more intensive, and adds a psychiatrist into the medical treatment team as well as an ongoing system of practice collaboration and patient clinical case review between the primary care and psychiatry providers. Coordinated care, the most basic model of integration, integrates care across practice environments by connecting them to a fully integrated behavioral-medical care coordination team. In this model we support all network PCPs through education regarding screening for behavioral health conditions, resources within the Integrated Health Neighborhood/System of Care, and referral to Care Management/Case Managers and Health Guides.

**Evaluation Criteria:**

1. The extent with which the respondent thoroughly describes its current approach to and readiness for promoting/incentivizing, and removing barriers to, integrating behavioral health and primary care throughout its system of care.

2. The extent to which the respondent provides examples of more effective integrated models within its provider network that have documented improved patient outcomes, patient satisfaction, and cost-effectiveness. The respondent must also describe the data sources.

3. The extent to which the respondent identified opportunities for improvement in delivering an improved integrated care model and subsequent steps the respondent will implement across its systems to increase capacity for providing integrated care.

**Score:** This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 24 – Transportation (Statewide):

The respondent shall describe its experience and approach for coverage of non-emergency transportation services by providing the following:

a. A description of the software capabilities utilized to facilitate ease in scheduling and tracking of enrollee pickup adherence;

b. Strategies for determining the most appropriate mode of transportation; and

c. Providing data on the following performance metrics for calendar year 2016:

   (1) Percentage of trips where the enrollee arrived to their scheduled appointment on-time;
   (2) Percentage of missed trip requests (failed to pick up the enrollee);
   (3) Percentage of hospital discharge requests fulfilled within three (3) hours of the request;
   (4) Percentage of urgent care requests fulfilled within three (3) hours of the request; and
   (5) Number of transportation related complaints and grievances per 1,000 enrollees.

d. A description of how the respondent uses the performance metric data above to identify areas in need of improvement and implements successful strategies that improve the provision of service.

Response:

OVERVIEW

As the managed Medicaid specialty plan for the comprehensive care of enrollees with serious mental illness (SMI) since 2014, Magellan Complete Care has covered medically necessary Medicaid non-emergency transportation (NET) services for Medicaid eligible recipients who have no other means of transportation available to Medicaid covered services. In addition, Medicaid will pay for medically necessary emergency ground or air ambulance transportation for a Medicaid eligible recipient requiring emergency transportation services. In order to assist enrollees who experience challenges with transportation, we offer NET services through our contract with transportation subcontractor, Veyo, who ensures transportation is not a barrier to Medicaid covered services and quality health care.

Our approach to transportation is based on a strong oversight process to ensure Veyo is providing the appropriate services in accordance with the Medicaid contract between Magellan Complete Care and the Florida Agency for Health Care Administration (AHCA), including the corresponding Medicaid Transportation Coverage, Limitations, and Reimbursement Handbook. To ensure ongoing compliance with applicable the contract and regulatory requirements, Magellan Complete Care maintains oversight authority of its vendor/subcontractor through its Vendor Oversight Committee to ensure our enrollees are provided with needed transportation services.

Enrollees with SMI face a unique set of challenges related to accessing and coordinating their care. Mental illness may also make it harder for people to adhere to a therapeutic regimen, keep follow-up appointments, and navigate the health care system. Magellan Complete Care
recognizes that timely and appropriate access to transportation services is often more important for enrollees with SMI due to challenges they may experience in managing their illness, which may also present unique challenges for transportation providers. Transportation services, including urgent and emergent transportation, are important elements of serving this population because many enrollees have difficulty arranging transportation for needed care. Magellan Complete Care ensures that the use of transportation services is provided when it is appropriate. Magellan Complete Care understands the importance of transportation services to achieve improved outcomes for SMI enrollees. A recent study by the University of South Florida examined the strengths and weaknesses of Florida managed care plans in meeting the needs of SMI enrollees. The study cited Magellan Complete Care, as follows: “Participants in the SMI specialty plan focus groups identified a number of ways that the plan has been helpful in ensuring their access to services by matching their needs with appropriate services. Transportation to scheduled services, both medical and behavioral, was one strength identified by many participants. Comments were that transportation service was on time and available when needed after appointments.”

Our commitment to provide appropriate transportation for our enrollees led us to seek opportunities for improvement with the transportation market. Through our regular monitoring of critical performance metrics, we were able to identify a trend in areas of enrollee and performance concerns. As a result, we made a vendor change from LogistiCare to Veyo. The addition of Veyo as our transportation vendor, effective June 2017, has further enhanced the transportation benefit and remains a key element in our SMI enrollee care management model.

Magellan Complete Care is aligned with Veyo’s mission as a revolutionary company that is redefining healthcare logistics. Veyo is a technology-centered non-emergency medical transportation (NEMT) broker that is committed to eliminating transportation issues as a reason for missing or delaying medical care in America. Veyo’s commitment to Florida, includes the following:

> Working to develop Florida business for 1.5 years
> Understands AHCA and has built strong relationships with AHCA
> Active associate member of the Florida Association of Health Plans (FAHP)
> Prominent role in shaping the newly signed into law Transportation Network Company (TNC) regulations in Florida

Magellan Complete Care expects to deploy Veyo’s Independent Driver-Provider (IDP) Model in 2018, to increase service:

> Dispatch to driver acceptance time is 28 seconds
> Average 10-minute response time from IDP driver acceptance to pick up
> Overall grievance rate is less than 0.09 percent and less than 0.03 percent for the IDP fleet
> Overall on-time performance rate for the entire fleet is 97.79 percent and 99.47 percent for the IDP fleet

The Veyo difference includes the following features:

> Built on technology that includes predictive analytics and GPS tracking
> Vertically integrated with a full service broker that is transparent and offers cost savings
> Includes a virtual fleet with Rideshare+ and commercial providers
Scalable in all Florida regions and all transportation modes.

Magellan Complete Care has collaborated with Veyo to develop processes that guide and manage Veyo's day-to-day operations and workflows. We direct this process and improve performance opportunities in real time. Magellan Complete Care has communicated the vendor change and transportation access to our enrollees. As a result of our collaborative engagement with Veyo, we continue to expand our commitment to serve the transportation needs of our enrollees.

Veyo has had a positive effect on our enrollees that exceeds the effectiveness of transportation service process and methodology. The following example illustrates that positive outcome.

~~Sam’s Story: Finding Shelter during Hurricane Irma (name changed protect privacy)~~
A 54-year-old, 500 pound male enrollee, Sam, currently resides in a mobile home in Homestead, Florida. During Hurricane Irma in September 2017, Sam’s mobile home was considered to be in an evacuation zone. Sam needed to go to a shelter; however, he had no family or social supports and required transportation assistance to get to a shelter. He called the Magellan Complete Care Coordination Health Guide (CCHG) who provided him with information on hurricane preparedness and Veyo’s contact numbers with a list of area shelters. Veyo transported the enrollee to the first shelter only to discover it was full.

Sam contacted the CCHG again who included the Manager of Clinical Care Services to help Sam find a shelter. The Manager called Veyo and made a reservation for Sam to be taken to Felix Variela Senior High School. The CCHG called Sam and instructed him to be ready for Veyo to pick him up. While Veyo was on the way to pick up the enrollee, the Manager learned on the local news that Felix Variela was already filled to capacity. The Manager immediately called Veyo and changed the transport location to North Miami Beach Senior High School. The CCHG and Sam were updated on this change. Again, Sam arrived at North Miami Beach Senior High School to find it was full.

The Manager spoke with the Veyo driver and asked him to allow for more time as we searched for another location. Because schools were closed and the 311 line was inundated, it was difficult to get confirmation of which shelters were full or open. The CCHG continued to communicate with Sam, reassuring him and helping him to remain calm and to be assured that we were working to get him to a shelter. The Manager updated Magellan Complete Care senior leadership on the progress of shelter access and spoke directly with Veyo leadership to advocate for a safe transport.

The Manager reviewed the area shelter list again, discussed Sam’s current location with the driver, and monitored the news and identified another shelter option: Highland Oaks Middle School. The Veyo driver agreed to transport Sam to Highland Oaks Middle School. Sam stayed at the shelter until it was safe for him to return to his home. The CCHG assisted Sam in learning if his home was intact, and it was. The CCHG assisted Sam in obtaining transport back home through Veyo. Sam was able to safely move back to his home. The CCHG was in constant communication with Sam who reported he was back at his home safely and reported again that “nothing happened” to his home. Sam reported that he was doing well but was exhausted from all of the “hurricane movement”. Sam has taken and is taking all of his medications and was very relieved and thankful that the CCHG assisted him through the hurricane crisis. [General SRC #24, Attachment 1: Covered Services Transportation Policy and Procedure] provides more detail.
CRITERIA 1: THE ADEQUACY OF THE RESPONDENT’S SOFTWARE CAPABILITIES TO FACILITATE...

1.0 Ease in Scheduling Transportation and Tracking of Enrollee Pick-up Adherence

Veyo offers significantly enhanced software and technology capabilities to facilitate scheduling transportation, and tracking of enrollee pick up contract adherence. Veyo provides a convenient, expanded set of capabilities including data analysis that allows them to scale up and down to meet changes in demand within minutes, enhancing on-time access. Veyo’s technology and operational capabilities, along with the comprehensive and very strong contract language negotiated by Magellan Complete Care, provides significant capabilities to monitor and manage enrollee use of transportation services, and the performance of Veyo in meeting those needs. Veyo supports improved performance through real-time tracking and analytics, enrollee insight, and fraud prevention. In addition, Veyo’s technology platform includes portals for call center, online booking site, health plan data portal (to monitor vendor performance and usage statistics), and enrollee application, with plans to leverage this technology in the near future.

The Veyo technology platform was specifically designed for health care transportation services, and incorporates predictive analytics and GPS tracking, allowing the company to continually monitor and optimize transportation services usage and performance. It supports real-time trip statistics, comprehensive analytic, supply and demand forecasting, and fraud, waste, and abuse monitoring, and reporting. Veyo’s enrollee management platform is especially robust, focused on meeting enrollee needs while simultaneously limiting inappropriate use of transportation services.

The platform tracks and reports:

> Contact information, captured within Veyo’s Enrollee Profile, a passenger/trip database for each enrollee transported
> Account information
> Eligibility
> Trip history
> Special instructions
> Utilization rates
> Transportation modes
> Plan details
> Public transit
> Mileage reimbursement.

Using Veyo’s proprietary tracking and monitoring systems, Magellan Complete Care can also monitor, manage, and report trip information, minimizing risks of inappropriate utilization or abuse. Veyo captures detailed trip information, including:

> Date, time, and location of pick-up and/or drop-off
> Trip duration (time and mileage)
> Total passengers
> Enrollee identifiers
> Modes
> Enrollee eligibility and plan parameters
> Car and driver identifier
> Claim number (if applicable)
Using the Veyo portal, Magellan Complete Care monitors all trips in real-time reviews trip data (including trips in progress).

Veyo’s call center and online portal support includes the following components:
> Multi-level IVR system
> 24/7/365 access
> Real-time information
> Customizable call queues and protocols
> Call center surveys and automated after-call IVR
> On-hold messaging
> Customizable language capabilities
> Service reminders and proactive IVR management of no-shows.

Veyo’s online portal supports enrollee/benefit management, virtual fleet training and credentialing, optimal dispatch, trip clustering, FWA monitoring, lowest cost/most appropriate mode optimization, low density routing and scheduling, and public transit/mileage reimbursement.

Veyo maintains an enrollee profile for each enrollee and tracks that information on the portal. Any time an enrollee calls into the call center, the profile is updated to reflect any changes to information and/or critical needs. In addition to standard information, such as name and contact number(s), Veyo tracks special requests and makes every attempt to satisfy particular needs for each enrollee. For example, interpreters for Spanish-speaking or hearing-impaired enrollees are noted on the Enrollee Profile. Veyo’s data is, in fact, so robust, that Magellan Complete Care will be incorporating that data into its own master enrollee data files.

1.0.a Monitoring Scheduling and Pick-up Adherence
Magellan Complete Care actively monitors and oversees Veyo activities and performance on regular and ongoing bases through the Quality Improvement Committee (QIC) and the Vendor Delegation Oversight Committee (VDOC). Rigorous vendor management processes are overseen by the Magellan Complete Care Compliance Department and the Chief Compliance Officer, with direct reporting to our Board. The Magellan Complete Care dynamic, active monitoring process responds to immediate oversight focus and the development of collaborative mitigation and workflow integration strategies.

Because Veyo is our new transportation provider, Magellan Complete Care and Veyo have daily touchpoint calls that address the day-to-day transportation resolution and coordination needs of our enrollees. The calls also address integrated and independent workflow refinements to improve the response to the unique transportation challenges of enrollees living with SMI.

Veyo is overseen by the same NCQA-based delegated services policies and procedures that govern all delegated services. These policies and procedures include activities from pre-delegation, contracting, routine monitoring and reporting, auditing, noncompliance, and Corrective Action Plans (CAP) up to and including termination and transition of a subcontractor relationship.

Magellan Complete Care uses enrollee utilization and enrollee satisfaction to develop and improve programs and practices and to address issues if they arise. We also operate under specific service level agreements, reporting and oversight, and vendor audit requirements which are described later in this section and are included in the statement of work.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

It is precisely because of our regular monitoring and reporting of transportation services, that Magellan Complete Care was motivated to seek out and contract with a new transportation vendor. Veyo provides us and our enrollees with services and capabilities not supported by our previous vendor, such as enhanced reporting and tracking. Through the terms negotiated in our contract, we are also provided with detail that allows us to verify that transportation has been provided for Medicaid-eligible services and to monitor potential fraud, waste, and abuse in transportation services.

Our contract with Veyo includes performance guarantees and additional funding aligned with exceeding defined service parameters in the contract. The contract allows us to levy monetary sanctions for non-performance against negotiated standards. The details of monitoring, reporting, and performance guarantees for our new contract are discussed later in this section. Magellan Complete Care also monitors and oversees the performance of our transportation vendor through our vendor management and oversight processes as detailed in the [General SRC #24, Attachment 2: Vendor FDR/Delegate/Subcontractor Routine Monitoring Procedure].

The Magellan Complete Care contract with Veyo includes regular reporting by Veyo, regularly scheduled meetings and reviews, and vendor audits as described in the contract. In addition, Veyo’s contract with Magellan Complete Care includes provisions regarding an annual delegation oversight audit, semi-annual desk-top claims delegation audit, and, other audits and reports as required to monitor performance.

If, during any oversight activity, Veyo does not perform in accordance with the provisions of its contract, thereby placing the health plan at risk for non-compliance with its contract with AHCA, the Compliance Officer will be notified. The Compliance Officer will work with Delegated Vendor Management to issue and demand immediate mitigation of the problem and issue a corrective action plan. The Compliance Department, in collaboration with Delegated Vendor Management, will track the corrective action plan to its completion. Transportation has been identified as a high risk service and is included in the Compliance Program’s risk assessment and work plan activities.

As part of the work plan activities, the Compliance Department monitors Veyo’s performance relative to the contract and issues impacting enrollees as identified through complaints and grievances. At any time, the Compliance Officer can call for a tracer audit on individual enrollee complaints or grievances to ascertain the breadth and seriousness of the issue. Magellan Complete Care has established extensive reporting and monitoring requirements for Veyo, as described in the Statement of Work, including reporting on numerous enrollee service metrics as well as network capacity, availability, and performance of various administrative functions.

Enrollee complaints are also reviewed by our vendor management and QI staff. Veyo is required to document and send notification of all enrollee grievances on the day of receipt. Veyo must report on all complaints resolved as part of its monthly reporting, and complaints are tracked and trended to identify any performance issues or opportunities for improvement. Magellan Complete Care and Veyo have developed a workflow to fully integrate the complaint tracking and resolution between the technology platforms allowing for a seamless resolution, coordination, tracking, and reporting of all complaints.

For more information about complaint tracking and resolution, please refer to [General SRC #24, Attachment 3: Complaints and Grievances], which includes the Magellan Complaints and
Grievances Processing Desktop Procedure and the Magellan Complete Care Process Flow to Resolve Enrollee Complaints.

If we detect consistent patterns of inappropriate utilization or enrollee difficulties in accessing the appropriate type of transportation, the issues are further reviewed to determine required corrective actions. This may include outreach to Veyo to address specific issues or issuance of a CAP. Magellan Complete Care Health Guides may also reach out and work directly with the enrollee if the enrollee is using transportation services inappropriately or having issues accessing this benefit. Veyo Transportation Services also supports the unique requirements of enrollees with special needs.

CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES STRATEGIES FOR DETERMINING...

Magellan Complete Care regards transportation services as an important element of our integrated care delivery model. We continually monitor performance of our transportation provider to ensure Veyo is meeting the needs of our enrollees. Magellan Complete Care ensures transportation services that meet the needs of its enrollees including use of multi-load vehicles, public transportation, wheelchair vehicles, stretcher vehicles, private volunteer transport, over-the-road bus service, ambulance, or, where applicable, commercial air carrier transport. The primary strategy we employ for determining the appropriate mode of transportation equipped to meet the enrollee’s physical and behavioral care needs, includes an active discussion between Veyo and the enrollee/caregiver or advocate.

The advocate for the enrollee, in most instances a caregiver, calls Veyo for transportation needs. They ask the enrollee/caregiver if the enrollee has any special needs. As part of the registration process, Veyo screens each enrollee for special transportation needs. The mode of transportation is set up to accommodate the special needs, which are captured within Veyo's Enrollee Profile. For future trips, the special needs are referenced and updated as needed. If the mode of transportation requires a pre-authorization, then Veyo engages Magellan Complete Care to obtain the pre-authorization.

Transportation Coordinators are responsible for screening and processing all transportation requests received for the Physical & Behavioral Health subdivision of the Magellan Complete Care of Florida UM/Health Services Department. The following process will apply for all requests for transportation services received from Veyo.

All requests are entered by the Veyo team using their portal which allows our staff to review and validate that the following criteria are met:

Prior authorization is required for the following:
> Mileage Approval
>> Any one-way trip that is over 30 miles
> Service Day Count
>> A trip that is on the 10th service day within a 30-day period
>>> Authorization number is valid for all future service days for enrollee until the end of month
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

>Same-Location Approval
>>Trips to the same location 3 or more times per week. The third trip that week will need prior authorization
>>>If transportation is for dialysis, the same authorization number is valid for 6 months
>>>For other trip purposes, the authorization number is valid for 3 months
>>>If the first or second trip is cancelled, future trips are re-evaluated

>Mobility Need Approval
>>Any transportation for bariatric wheelchair and bariatric stretcher trips
>>>Authorization number is valid for 3 months
>Advanced Life Support (ALS) and Basic Life Support (BLS):
>>For any pick up locations other than hospitals, i.e. enrollee’s home

Prior authorization is not required for hospital discharges unless the enrollee is out of state. If an enrollee has personal property that can be carried by the passenger and/or driver, and can be stowed safely in the vehicle, it will be transported with the passenger at no additional charge. The driver will provide transportation of the following items, as applicable, within the capabilities of the vehicle e.g., wheelchairs, child seats, stretchers, secured oxygen, personal assistive devices, and/or intravenous devices.

The transportation provider will assist the enrollee upon boarding the vehicle, if necessary or requested, to the seating portion of the vehicle. This assistance includes, but is not limited to opening the vehicle door, fastening the seat belt or wheelchair securing devices, storage of mobility assistive devices, and closing the vehicle door. In the door-through-door paratransit service category, the driver will open and close doors to buildings, except in situations in which assistance in opening and/or closing building doors would not be safe for passengers remaining in the vehicle. The driver will provide assisted access in a dignified manner.

At a minimum, Magellan Complete Care ensures the following non-emergency transportation services are provided to meet the need of its enrollees:

>Ambulatory transportation
>Long haul ambulatory transportation
>Wheelchair transportation
>Stretcher transportation
>Multi-load transportation
>Mass transit
>Over-the-road bus
>Over-the-road trains
>Private volunteer transportation
>Commercial air carrier transportation.

Magellan Complete Care’s Health Services Team and Customer Service staff will work with Veyo to control the cost of providing transportation services outside Magellan Complete Care’s service area. Magellan Complete Care also reviews Veyo’s monthly reports to monitor the appropriateness of transportation usage by type of transportation. This review includes monthly quality management reporting. Veyo is contractually required to provide additional ad hoc reporting as needed to support Magellan Complete Care monitoring and management of transportation services.
Maria's Story for Non-emergency Medical Transportation (name changed to protect privacy)~Maria is a middle-aged female with a behavioral and medical history of schizophrenia and left leg amputation due to diabetes. She was referred to case management after another ER admission for uncontrolled blood glucose. Maria was assigned an Integrated Care Case Manager (ICCM) as well as a Health Guide based on her Health Risk Assessment results. As part of the ICCM's initial assessment, her behavioral and physical health providers communicated that Maria frequently did not show up for appointments and her providers were concerned about her lack of follow-up treatment after frequent ER visits.

The Health Guide arranged a Care Coordination Team meeting with Maria and her sister. The team discovered that anxiety and her intellectual disability were barriers for Maria to use a transportation provider. In addition, she did not understand that transportation providers could accommodate her wheelchair.

The team discussed Veyo’s ability to capture enrollee specific profile information that directs the assignment of transportation needs, e.g., Maria could be assigned to the same transportation driver each time, if possible, to be more responsive to her anxiety. With Maria’s input, a care coordination goal was established to improve her ability to attend appointments independently. In addition, the Health Guide arranged to ride with Maria to and from her next several scheduled appointments. As a result, when Maria had a cold and cough, instead of calling 911 to go the hospital; she called her Health Guide who arranged transportation to the doctor's office.

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT’S APPROACH INCLUDES AN ASSESSMENT...
Magellan Complete Care has partnered with Veyo to work with enrollees to use the most efficient means of transportation, and to encourage the use of alternative means of transportation when appropriate. Our approach to assessing whether an enrollee has any other means of transportation begins with an active discussion between Veyo and the enrollee/caregiver or advocate.

Enrollee information is captured within the enrollee profile for future reference (confirmation with enrollee for future transportation requests), including whether or not they have other means of transportation. This profile feature is a significant differentiator with Veyo, given their foundation in data centric IT. Veyo reviews all appropriate transportation alternatives with the enrollee, and works with us to obtain prior authorization when specific parameters are deemed appropriate for clinical review. In addition, Veyo works with us to identify any unique enrollee situations where quality of care may be compromised within and outside the provision of transportation. For future trips, transportation alternatives are referenced and updated as needed.

If a Magellan Complete Care healthcare provider (facility) offers transportation or an enrollee's family is eligible to provide transportation, Veyo's Customer Service Representatives follow the appropriate procedure and refers the enrollee to Magellan Complete Care’s Enrollee Services for coordination of transportation for the appointment(s). Veyo is responsible for providing bus passes in those areas where public transportation is conveniently available, as requested by Magellan Complete Care Case Management staff. Assistance may include providing Magellan Complete Care Peer Specialists or Health Guides to accompany the enrollee while they get used to
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navigating the transportation system. This approach has proven very successful in other
programs Magellan Complete Care operates across the country.
The Mileage Reimbursement Program is a cost-effective means for Veyo to ensure that eligible
Medicaid participants receive transportation to and from their medical appointments. The program
ensures that transportation is provided and that the individual providing the service meets
minimum standards for performance. The contract may provide mileage reimbursement for
transportation provided by a private individual for an enrollee. If the enrollee is traveling to and
from an eligible medical appointment, private transportation may be the most cost-effective means
of providing transportation.

Of particular importance is our process regarding standing orders for transportation. In the case
where an enrollee has a standing order and does not appear for pickup, the driver immediately
alerts Veyo’s Customer Service team and a Customer Service Representative makes a follow-up
call to the enrollee to ensure that the enrollee does not miss their appointment or treatment.
Frequently, the enrollee has already reached the appointment using other means of
transportation. At that point, we evaluate the frequency and reliability of the alternate
transportation and may remove the standing order and instruct the enrollee to set up
transportation with Veyo on an as-needed basis. This added contact point reduces frustration for
drivers who arrive, only to find that the enrollee is not there. It also assists the enrollee in setting
up the transportation arrangement that best suits his/her needs.

Magellan Complete Care is responsible for the cost of transporting an enrollee from a non-
participating facility or hospital to a participating facility or hospital if the reason for the transport
is solely for our convenience. Magellan Complete Care’s Health Services Team and Customer
Service staff work with Veyo to control the cost of providing transportation services outside
Magellan Complete Care’s service area.

CRITERIA 4. THE ADEQUACY OF THE RESPONDENT’S PERFORMANCE RELATED TO…
Effective transportation is critical to support enrollee access to all elements with the enrollee’s
continuum of care and support. In June 2017, Magellan Complete Care transitioned from
LogistiCare to Veyo as a result of an extensive Request for Proposal (RFP) review. As a result of
the RFP process, it was clear that Veyo’s innovative approach and technology platform would
significantly improve all aspects of transportation services to better serve our enrollees.

One of Veyo’s key attributes is their ability to capture and report key performance metrics as
referenced within the ITN. We report below the metrics for Veyo, with notations. One key notation
is the reference to reflect hospital discharge requests within three hours. Magellan Complete
Care’s requirement in Veyo’s Statement of Work is to fulfill these requests within two hours of
hospital discharge, which is reflected in the reported metric.

As described above, Magellan Complete Care’s desire to improve performance and further
enhance transportation services and capabilities prompted us to seek and select our current
vendor, Veyo. In addition to a jointly prepared and integrated transition plan, we established daily
internal calls as well as daily calls with Veyo to address any transition issues. Veyo and Magellan
Complete Care have worked in collaboration with AHCA, to address those issues and deliver
significantly enhanced results.
Our data trend lines continue to increase and Veyo’s data on specific performance metrics are provided below:

a. Percentage of trips where the enrollee arrived to their scheduled appointment on time: 95.77%

b. Percentage of missed trip requests (failed to pick up enrollee): 0.41% (tracked by actual provider logs) – Metric includes all missed trips via provider logs

c. Percentage of hospital discharge requests fulfilled within three (3) hours of the request: 95.69% – While AHCA’s standard is within three (3) hours, Magellan Complete Care’s standard is within two (2) hours of the request, which is reflected in the reported metric.

d. Percentage of urgent requests fulfilled within three (3) hours of the request: 98.3%

e. Number of transportation-related complaints and grievances per 1,000 enrollees: 7.48 complaints per 1,000 enrollees

We continue to monitor these and other data points on an ongoing basis and otherwise work closely with Veyo to identify trends and to improve transportation management services. Our staff facilitates internal meetings and joint meetings between Veyo and Magellan Complete Care. The meetings include focus on review of grievances, performance metrics, operational efficiencies, integration of new technology, and any opportunity to enhance or further support enrollee transportation needs. These regular discussions allow us to ensure that issues are properly addressed in a timely fashion. When enrollee behavior patterns are noted, Veyo will place the enrollee on a monitor list. Veyo monitors the trips by calling both the enrollee and the transportation provider the night before a scheduled trip, calling the transportation provider one hour before pick-up, monitoring the ride throughout the day, and finally, following up by a call to the enrollee the next day to ensure satisfaction.

Magellan Complete Care’s Vendor Oversight Committee monitors the activities of its transportation vendor against contractual requirements.

CRITERIA 5: THE EXTENT TO WHICH THE RESPONDENT USES PERFORMANCE METRIC DATA TO IDENTIFY...

It is a direct result of the regular monitoring and reporting of performance metrics by our previous transportation vendor that Magellan Complete Care was motivated to seek out, select, and implement a new transportation solution for our enrollees. Our enrollees have complex needs that a standard transportation program is not prepared to accommodate. Due to the uniqueness of our enrollees, including behavioral issues such as anxiety, we changed transportation vendors to Veyo to offer a transportation solution to provide the required support; while ensuring the appropriate use of transportation services.

We continue to monitor the performance metric data of the transition to Veyo and ongoing operations. We have worked with Veyo and AHCA to identify areas in need of improvement. As a result, we have implemented successful strategies to address operational and performance issues and to improve the provision of transportation services for our enrollees.
We currently have daily calls with Veyo to address any issues. We discuss implementation problems, ongoing transportation related operational improvements, and specific enrollee quality of care opportunities. Based on our experience as the SMI Specialty Plan, there are areas that require constant monitoring from a management perspective based on the needs of the SMI population.

5.1 Successful Strategies to Improve Service Provision
Magellan Complete Care initiated an intensive process to identify any transportation-related opportunities to improve the enrollee experience. The enrollee journey touchpoints related to transportation were identified. Each department was charged with tracking key aspects of enrollee service to ensure a smooth transition of transportation vendors and opportunities to improve this service. We worked closely with our enrollees and providers to ensure that critical and general trips were accommodated. We worked closely with AHCA in conveying Magellan Complete Care transportation interventions, and we provided AHCA with a summary that was used to improve the overall performance of our transportation service. Please refer to [General SRC #24, Attachment 4: Transportation Interventions] to review Magellan Complete Care’s for lessons learned submitted to AHCA.

A summary of the key interventions to improve enrollee transportation services includes:

> Internal, daily stand-up calls across multiple departments to identify and address interventions
> Magellan Complete Care and Veyo, daily stand-up calls across multiple departments to address interventions
> Daily status calls with AHCA focusing on critical services
> SWAT team approach to allow for real time contact and resolution
> Daily interface with our Care Management and Provider Support teams to coordinate transportation needs at the enrollee level
> Our Care Management team directly engaged enrollees proactively to coordinate transportation needs and retrospectively to ensure care was provided and engage with any mitigation if necessary
> Tracking and real time resolution of enrollee and provider complaints by our care management team for continuity of care
> Magellan Complete Care call center reached out directly to enrollees to address any missed trips or real time support for any late pick-up times and coordinated with providers and Veyo
> Magellan Complete Care call center reached out to directly to enrollees that were no longer eligible, to inform them that they need to coordinate transportation services with their current plan
> Deployed our clinical Provider Support Specialist team on a daily basis to conduct outreach to providers scheduling transportation for critical trips such as dialysis and chemotherapy
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> Developed a robust field-based resolution process by which the local Provider Support Specialists and Health Services teams can report issues back to the Veyo team in real time for immediate resolution
> Supplemented our after call services with transportation subject matter experts to assist with any transportation interventions

> Magellan Complete Care incorporated an enrollee risk assessment process to prioritize enrollee engagement, ultra high priority, priority and general outreach, which allowed for Dialysis and Chemotherapy services to be monitored real time

> Incorporated multiple reporting mechanisms to track performance and identify areas in need of intervention

> Veyo conducted ongoing education and training with their transportation provider base, both general and specific to identified concerns

> Veyo added call center agents to ensure call stats are within targets

> Improved workflow of the hospital discharge transportation needs and IVR options

> Veyo incorporated preferred transportation providers to streamline transportation needs for the ultra-high priority transportation needs.

As a result of focusing on these areas, we highlight strategies to improve the provision of services in the following section.

5.1.a Enrollee Service Interruption
To proactively respond to possible enrollee service interruptions, Magellan Complete Care began internal, daily morning stand-up calls in June of 2017 to review Veyo daily trip reports from the previous day and to review any concerning trip information for the current day to plan interventions with enrollees, providers, and Veyo.

At AHCA’s request, Magellan Complete Care and Veyo began attending daily status review calls with AHCA to review trip data from the prior day, including a focus on critical services such as dialysis and chemotherapy, as well as reviewing missed trips and complaints coming through AHCA. We leveraged trip information and data received by Veyo to assign outreach to our clinical, field-based, Provider Support Specialists who were charged with daily, on-site provider outreach. Our Provider Support Specialist team developed a process to track and monitor provider-based issues including: morning outreach to confirm appointments and time, afternoon follow up to ensure the enrollees made their appointments in a timely manner, and training and technical assistance whenever an issue was identified, to improve the provider and enrollee experience. This outreach activity is tracked and shared internally to ensure coordination among teams. This practice continues today and has afforded an additional mechanism to ensure enrollee safety, access, and satisfaction.

5.1.b Missed Trips
The Magellan Complete Care Health Services Director reviews Veyo daily trip reports (including weekends and holidays) that currently do not have drivers assigned to pick enrollees up as scheduled. “Missed trips” encompass (1) unaccommodated (resolved with few exceptions), (2)
accommodated no shows (tracking and rapid resolution, including Veyo education of its providers), (3) late pick-ups, and (4) all operational elements, e.g., hospital education to call Veyo for enrollee transportation needs.

Our Care Management staff review the daily report of unconfirmed trips and assigns a Care Manager to reach out to enrollees to address issues. Staff also conduct ongoing follow up for unresolved trips. The unassigned drivers (unaccommodated trips) metric has dropped to practically zero as a result of the coordination between Veyo and Magellan Complete Care. The collaborative and data-centric Veyo resources allowed for a successful and rapid response to all implementation issues, including Veyo’s engagement with a new provider network for Florida. This is an example of success as a result of the daily calls and rapid deployment of resolution tactics.

The Health Services team also receives and resolves enrollee and provider complaints of missed trips and/or late pickups. They also contact Veyo to ensure that they send a driver for that current trip and to ensure that future trips are booked with Veyo as indicated. All complaints are recorded in the Resolve Vendor Management System and also forwarded to Veyo for integration into their complaint resolution tracking system.

Magellan Complete Care continues to have daily internal multi-department calls to address specific enrollee transportation needs, including unaccommodated trips, scheduled critical trips, re-authorization of standing orders, and unique enrollee care needs (transportation and enrollee case management). The daily trips reports from Veyo listing all enrollee trips allows us to conduct internal reviews for assessments and ongoing quality of care improvement.

5.1.c Transportation Issue Resolution on Weekends
To respond effectively to transportation issues we implemented the following initiatives:
> For unconfirmed trips of a non-critical nature (i.e., enrollees with scheduled transportation and an unconfirmed pick up), the Provider Support Specialist calls Veyo and confirms that the enrollee will be picked up for the appointment.
> The Manager of Customer Care is on-call for transportation resolutions on Saturday and Sunday. We provide outreach to enrollees with non-critical missed trips (enrollees not picked up).
> Direct follow-up to Veyo and enrollee, for enrollees with a late pick up to appointment.
> Direct outreach for enrollees who are no longer eligible with Magellan Complete Care. If the appointment is considered critical or urgent, the case is escalated to the Care Coordination team and Veyo team as “Urgent”.

5.1.d Provider Support During the Transition to Veyo
The Provider Support Specialist team used Veyo daily trip reports to prioritize and drive outreach. We leveraged an internal tracking system to document outreach, outcomes, and coordination between Magellan Complete Care’s Health Services team and the Veyo team. The Provider Support Specialist team employed a combination of onsite visits and phone calls to support providers during the transition phase. Provider outreach priority was based on urgency of trip type. The team conducted outreach twice daily (morning and afternoon) to critical providers (chemo and dialysis) to confirm, support, and manage critical trips.

We conducted daily outreach to providers for all confirmed trips. The goal of the calls was to address any issues, provide education, and connect the provider to Veyo to ensure a smooth transition. The Provider Support Specialist team held daily coordination meetings with Magellan
Complete Care’s Health Services team to coordinate transportation needs for high risk enrollees who were experiencing transportation issues to prevent and avoid disruption in services or access to care. The team had direct contact with the Veyo team to trouble shoot issues real time, develop alternatives, and streamline trips to accommodate enrollees’ needs. Since go live, the Provider Support Specialist team has been actively reaching out to more than 175 providers ongoing to confirm and coordinate critical and scheduled trips. On average, the Provider Support Specialist team is making 100 provider contacts per day, statewide to support providers with the Veyo transition.

5.1.e Prioritizing Critical (Dialysis and Chemotherapy) Trips
Veyo joined us to review any unaccommodated trip bookings and address real-time transportation issues. We added 11 transportation providers to the Veyo network to accommodate higher-than-forecasted trip volume post-launch. We also added incremental call center agents to accommodate higher than forecasted call volume post-launch. In partnership, Veyo communicated to transportation providers that they would be paid for invalid trips due to bad data recorded during the launch period, to ensure that providers remained in the Veyo network and enrollees were transported appropriately. As a result, we improved the hospital discharge workflow.

With Magellan Complete Care approval, Veyo lifted prior authorization requirements so that trips would proceed immediately to fulfillment. In addition, Veyo worked with transportation providers to retrain them on their contractual obligations and to address reported issues. As a result, night-before trip reminders were implemented to all enrollees who have trips scheduled for the following day.

It is important to note that, as previously described, our contract with Veyo, provides us with significantly improved access to transportation-related data which allows us to regularly monitor and audit transportation utilization, usage trends, and appropriateness of services.

This, along with our new contract performance requirements, allows Magellan Complete Care to manage transportation services more efficiently, ensure compliance with contract and AHCA requirements, and monitor enrollee satisfaction. We are committed to continuing to combine ongoing performance reporting, monitoring with vendor management oversight, and collaborative program management to enhance our transportation services and access outcomes for enrollees.

**Evaluation Criteria:**

1. **The adequacy of the respondent’s software capabilities to facilitate ease in scheduling transportation and tracking of enrollee pickup adherence;**

2. **The extent to which the respondent describes strategies for determining the appropriate mode of transportation equipped to meet the enrollee’s individual needs.**

3. **The extent to which the respondent’s approach includes an assessment of whether the enrollee has any other means of transportation, including a description of the process that will be utilized to make this assessment.**

4. **The adequacy of the respondent’s performance related to:***
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(a) Percentage of trips where the enrollee arrived to their scheduled appointment on-time;
(b) Percentage of missed trip requests;
(c) Percentage of hospital discharge requests fulfilled within three (3) hours of the request;
(d) Percentage of urgent care requests fulfilled within three (3) hours of the request; and
(e) Number of transportation related complaints and grievances per 1,000 enrollees.

5. The extent to which the respondent uses performance metric data to identify areas in need of improvement and implements successful strategies to improve the provision of services.

Score: This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

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SRC# 25 – Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

Deshea is 25 years old. She was auto-assigned to your plan and enrolled effective January 1, 2019. Deshea’s enrollment information did not include a telephone number and listed a local area homeless shelter as her last place of residence. She left the shelter on December 27, 2018, and the shelter does not know her current whereabouts.

The respondent shall describe the process it will use to attempt to contact Deshea by March 29, 2019.

Response:

OVERVIEW: LOCATING DESHEA
Magellan Complete Care’s ultimate goal is to help Deshea live a vibrant, healthy life as independently as possible. The critical first step is making contact with Deshea to identify and support her in meeting her needs. Our enrollees are often difficult to contact and engage due to incorrect or missing information, and unstable housing, as is the case with Deshea. Magellan Complete Care employs hands-on and innovative approaches to contact our difficult to find enrollees. We work diligently to find Deshea because we know recovery is possible.

Magellan Complete Care has deep experience working with individuals in Deshea’s situation. Our homeless rate is 150 out of every 10,000 enrollees – a homeless rate that is eight times greater than the Florida or national rates of homelessness (17.7 per 10,000 and 18 per 10,000 individuals respectively, as cited by the National Alliance to End Homelessness. According to the National Alliance on Mental Illness’s (NAMI) information, we know that an estimated 26 percent of homeless adults staying in shelters live with Serious Mental Illness (SMI).

We facilitate our Magellan Complete Care outreach and engagement model by deploying teams dedicated to each region of the State with first-hand knowledge of community and neighborhoods, including neighborhood strengths, resources, and service gaps. We hire multilingual staff with diverse cultural and social backgrounds who live in the same communities as our enrollees. The beauty of our neighborhood based model is that it naturally bridges language and cultural barriers regardless of region. Our teams are accountable and responsible for a group of members and providers; this allows flexibility as they work collaboratively to facilitate the best possible service options for members. The unique Integrated Health Neighborhood (IHN) model allows us to “think locally” as we customize member outreach programs in each region to meet members where they are. One size does not fit all even within a region, county, or city. We augment our IHN “lived experience” with data and analytic insights to drive our outreach efforts.

CRITERIA 1. THE ADEQUACY OF THE RESPONDENT’S APPROACH IN ADDRESSING THE FOLLOWING
1.(a) IDENTIFICATION OF STRATEGIES FOR IDENTIFYING NEW ENROLLEES; AND
Magellan Complete Care strategies for identifying new enrollees like Deshea include AHCA’s X12-834 Enrollment File.
Magellan Complete Care receives Deshea on the X12-834 daily enrollment file with an effective date of January 1st, 2019. The enrollment file contains an address that appears to be valid, but no phone number. Magellan Complete Care loads AHCA’s enrollment file daily into CAPS, our eligibility system. The enrollment file feeds downstream to a variety of systems including TruCare, our care management system and viewable by our Health Services team. Our sophisticated technology infrastructure allows our teams to quickly access and leverage information to identify new members. Enrollees who reside in homeless shelters, such as Deshea, are identified appropriately and quickly to ensure timely engagement and assistance by the care coordination team.

Once Deshea is loaded into CAPS an automated process kicks off, issuing her a Magellan Complete Care Welcome Kit including the Member Handbook, Provider Directory, ID card and Primary Care Physician (PCP) assignment. This process ensures that new enrollee materials are sent within five days of receipt of AHCA’s X12-834 enrollment file.

Case Manager selection and assignment, including protocols to ensure new enrollees are assigned to a Case Manager, occur immediately based on available data. All new enrollees are prioritized for outreach via a welcome call. In Deshea’s case, we do not have a phone number and her address is a homeless shelter. She is assigned to an Integrated Care Case Manager (ICCM) who oversees the process to find and engage Deshea with the support of the ICCM’s IHN team.

On a rare occasion, Magellan Complete Care may identify an assigned enrollee who was not listed on AHCA’s enrollment file (e.g. from the 820 capitation file, enrollee help line call, or when a new enrollee tries to fill a prescription). We work directly with our Contract Manager at AHCA to quickly resolve these issues to ensure the enrollee’s needs are met.

As discussed throughout this response, Magellan Complete Care utilizes a variety of methods to identify new enrollees to complete the health risk assessment (HRA) and connect them to needed services, including:

- Enrollee Help Line calls or e-mails
- Authorizations or referrals
- CareLine (24/7 nurse line) calls
- Florida Health Information Exchange Event Notification System (ENS)
- Claims, including pharmacy claims
- Direct referrals from a family member or provider
- Transportation vendor information (from our subcontractor, Veyo) or other subcontractor
- Member portal self-service tools

1.(b): DESCRIPTION OF THE SOURCES OF DATA/INFORMATION THAT WILL BE UTILIZED TO IDENTIFY ENROLLEES WITH SPECIAL HEALTH CARE NEEDS OR CIRCUMSTANCES.

Magellan Complete Care uses a variety of strategies and data sources to identify Deshea’s special health care needs or circumstances including:

- Agency Enrollment Files: Magellan Complete Care receives “special needs indicators” on AHCA’s daily X12-834 enrollment file. In addition, we receive “special conditions indicator” for Deshea on AHCA’s daily panel roster file. These indicators prompt early identification of enrollees with high risk physical or behavioral health conditions. Both the enrollment file and panel roster file data feed downstream to a variety of systems including our care management system, TruCare, and is viewable by our Health Services team. Our sophisticated technology
infrastructure is nimble and flexible so that our teams can quickly access and leverage information to assist Deshea with her needs once we engage with her. Enrollees such as Deshea who are homeless are identified appropriately and quickly to ensure timely engagement and assistance by the care coordination/case management (CC/CM) team.

> Health Risk Assessment (HRA): In Deshea’s case, we were initially not able to find her to complete the HRA. However, enrollees are able to complete the HRA online. If she completes it online, we use that information to identify her needs. If not, as soon as we locate her, we attempt to complete the HRA to determine her immediate and long-term behavioral health, physical health, and social needs.

> Authorizations or referrals: The Magellan Complete Care Health Services team will identify Deshea’s special needs through authorization or referral requests for care and services. When an enrollee is identified, a referral is made to an ICCM by the UM professional through TruCare or warm transfer depending on the enrollee’s needs.

> Provider Electronic Health Record (EHR): For high volume practices, we maintain agreements when possible to access our enrollees’ information, including special needs, directly in the providers EHR.

> Enrollee Help Line: The Magellan Complete Care Enrollee Services Team may identify a special need or circumstance during an enrollee call, or call from a family member or provider regarding an enrollee. Our call center platform Total Member Record (TMR), alerts the Customer Service Specialist (CSS) that Deshea has not completed the HRA and the CSS warm transfers her to an ICCM to complete the assessment, with Deshea’s consent, after attempting to capture updated contact information.

> CareLine (24/7 nurse line): Our CareLine nurses will identify Deshea’s special needs if Deshea calls into the CareLine. When an enrollee is identified, a referral is made to an ICCM by the CareLine through TruCare or warm transfer during weekdays or the CareLine nurse will complete it after hours or on weekends after capturing updated contact information.

> Emergency Room/Inpatient Admission: Magellan Complete Care receives real-time notifications via the Florida Health Information Exchange Event Notification System (ENS). This information is used directly by Health Services to identify special needs and circumstances.

> Direct referrals from the enrollee, family, or provider: Deshea, her family, or her provider can refer her to Magellan Complete Care for enrollment in our CC/CM programs at any time based on her needs.

> Claims history: Magellan Complete Care uses available historical or current claims data including pharmacy to identify Deshea’s special needs or circumstances.

> Lab results: LabCorp sends lab results weekly. Through our risk stratification/predictive modeling processes, this data combined with claims and other available data is used to identify Deshea’s special needs.
CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES ITS PROCESS FOR CONTACTING ENROLLEES, INCLUDING THE DATA SOURCES

CRITERIA #3: A DESCRIPTION OF HOW NETWORK PROVIDERS AND COMMUNITY PARTNERS WILL BE ENGAGED IN THE IDENTIFICATION PROCESS

The sections below address both Criteria 2 and 3, as our process for identifying and contacting enrollees, and the associated date sources, incorporate the use of network providers and community partners.

Magellan Complete Care has vast experience finding and engaging enrollees like Deshea, who are homeless, using a variety of traditional and innovative approaches. We use these engagement approaches not only for the purpose of completing the initial screening and/or HRA, but also for ongoing care coordination and/or health and wellness outreach. Informed by our experience in Florida and other states, our “no-stone-unturned” approach starts with traditional methods but also features innovative strategies for engaging members. We continue to focus on opportunities to improve our approaches and efforts including solicitation of direct feedback from enrollees, caregivers, providers, Enrollee Advisory Groups, community partners, and peers.

All attempts to reach Deshea are noted in our TruCare system. When we identify updated contact information, the information is entered into TruCare in the “alternate contact information” screen. The information is then sent to enrollee services for input into the enrollee’s eligibility record in CAPS, stored in the “alternate contact information” screen and then fed downstream to other integrated systems. Once we find and engage Deshea, if she does not have a personal phone, we assist with obtaining a Smart Phone through SafeLink.

As part of ongoing improvement activities, we are expanding our abilities via the development of an enrollee master data store, which captures and tracks enrollee contact information from multiple sources. Magellan Complete Care has developed and validated a sophisticated algorithm to determine the most viable enrollee contact information to ensure ongoing enrollee engagement. The recommended contact algorithm incorporates data integrity validations (such as valid area codes), known data preferences (hospital information as compared to enrollment information), and timing considerations. All contact information is retained and is used to update the algorithm on an ongoing basis.

Our approach to contacting Deshea by March 29th, 2019 include a variety of methods to include:

> "Desktop Search" for Updated Contact Information

We use a variety of methods and data sources to search for updated contact information for Deshea including:

>> Returned Mail: Returned mail is processed weekly by a Customer Service Specialist upon receipt of the Returned Mail Report from Webb-Mason, our print vendor. We then follow our Returned Mail process to attempt to obtain an updated address. If we receive a forwarding address on the returned mail from the homeless shelter, we will send a Community Health Worker (CHW) or Health Guide to that address to attempt to find Deshea. We automatically resend the Welcome Packet and ID card to the new address.

>> Claims: We use information from submitted claims to try to track down enrollees either through an updated address or outreach to the provider who submitted the claim. Since pharmacy claims
are submitted at the point of sale, these are often the first claims we receive when Deshea fills a prescription. This information can be used to seek updated contact information from the pharmacy and may lead us to the current neighborhood where Deshea resides.

>>Veyo: If Deshea uses the Magellan Complete Care transportation service, we get updated contact/address information from our vendor, Veyo.

>>SafeLink: SafeLink supplies Tracfones for our enrollees. Based on the monthly enrollment file, SafeLink provides phone numbers for any Magellan Complete Care enrollee who is enrolled in the Tracfone program. Magellan Complete Care's SafeLink Phone Program provides enrollees with a free Smartphone, one GB of data, 350 minutes of calling, and unlimited texting on a monthly basis. Magellan Complete Care is working with SafeLink to address the need for a mailing address in order for enrollees who are homeless to receive a SafeLink phone. We are able to assign an address for them through a mail service program within specified drop off centers.

>> Publicly Available Information: Magellan Complete Care uses a sophisticated database-matching people search tool, which leverages web and social media-available public information. We also use publicly available incarceration data in an attempt to find our enrollees.

>Enrollee Services or CareLine

Magellan Complete Care’s system creates a flag in Total Member Record (TMR) and TruCare alerts staff when we have been unable to reach an enrollee.

>>If Deshea calls our Enrollee Services Help Line, our Customer Service Specialist (CSS) does everything possible to assist Deshea and obtain current contact information. In addition, when a hard-to-locate enrollee calls our Help Line, our CSS attempts to connect Deshea to an ICCM so that an HRA can be completed.

>>Deshea may also send an e-mail to Enrollee Services. The CSS will respond and request updated contact information and refer Deshea to an ICCM.

>>Deshea may access our enrollee self-service tools on our secure member portal and update her profile and/or complete the HRA. A Health Guide or ICCM will use this information to immediately outreach to Deshea either telephonically or in person.

>> If Deshea calls our CareLine, the nurse will assist her with her immediate needs and attempt to collect updated contact information. On weekdays, the CareLine nurse will ask to warm transfer Deshea to an ICCM for completion of the HRA, or after hours, the CareLine nurse will complete it and send the referral for follow-up to the ICCM via a queue in TruCare.

> “Feet on the Street”

We facilitate our Magellan Complete Care outreach and engagement model by deploying teams dedicated to each region of the State with first-hand knowledge of community and neighborhoods they serve. We hire multilingual staff with diverse cultural and social backgrounds who live in the communities where our enrollees live. Our IHN staff receive intensive training on methods and strategies for finding and engaging our members. By being embedded in the neighborhoods we serve, our community partners and providers work with us to facilitate connections with our enrollees. We work within the local public health system and informal neighborhood networks and become immersed in the knowledge of common gathering places of our enrollees who are homeless. We work hand-in-hand with our network providers and community partners to find and engage Deshea.
2.1 Partnership with Providers
We work in partnership with our network providers to find and engage our enrollees. Outpatient Providers: Magellan Complete Care uses available claims or prior authorization data to identify providers or facilities where Deshea may have accessed care. We contact those providers in an attempt to get updated contact information for Deshea. This includes a wide range of providers, including clinics, dialysis centers, pharmacies, Veyo, Coastal Care (home health and DME subcontractor), and other subcontractors.

We maintain agreements, when possible, to access our enrollees' information directly in the provider’s HER. If Deshea has an upcoming appointment scheduled, our CHW or Health Guide will meet her at the appointment and attempt to complete the HRA. For high volume providers, we offer to co-locate a CHW or care coordination staff in the practice to work as part of the provider’s team.

In some cases, our providers are contracted to provide care coordination services and to find and engage our enrollees (e.g. CMHCs, FQHCs, or Integrated Health Homes). They can be highly effective since these providers are neighborhood based, and they are often familiar with family members or common gathering places for individuals who are homeless.

Emergency Room or Hospital Admission: Hospitals are often a safety net for individuals who are homeless, especially when they lack access to care or need basic things, such as food and shelter. Lack of stable housing limits an individual’s ability to engage in healthy behaviors, and health and wellness activities. The Health Guides maintain close communication with the inpatient facility Social Work Teams, who know about the Magellan Complete Care Transitions Program and available benefits and services. The Social Work Team at the facility will provide Deshea with the contact information for the Health Guide and alert the Health Guide that she has been admitted. Magellan Complete Care also receives real-time notifications via the Florida Health Information Exchange Event Notification System (ENS). Once notification is received from an inpatient facility, the Health Guide will visit the enrollee as soon as possible or within 24 hours to offer support.

2.2 Partnership with Community Organizations and Informal Neighborhood Networks
As part of our Integrated Health Neighborhood, we leave no stone unturned in our efforts to find and engage our members. We count on our strong connections with community partners, including local agencies, community organizations, and informal social networks to reach our members. Examples include: local housing agencies and housing member associations, libraries, homeless shelters, food pantries, soup kitchens, community centers, and cultural/ethnic-specific community centers, and faith-based locations, such as churches. We extend our neighborhood based teams with trusted community partners to help find and engage our members, for example, Community Health Workers or Peer Support Specialists who often have existing relationships and contacts in the local community to assist in locating members.

Magellan Complete Care has established and maintained a high performing team of Community Outreach Specialists (COS), who members of the IHN Team, since the inception of our SMI Specialty Plan. These master's-level trained professionals are located in each active Magellan Complete Care Region with specialized backgrounds in social work, public health, and community organization. Our COS team has established over 4,000 community relationships, all maintained in a routinely-updated and convenient-to-access online Community Resource Guide, to provide comprehensive support to Magellan enrollees in their local neighborhoods. This allows us the
ability to address social determinants of health and leverage non-traditional services for those who we support and serve.

In collaboration with our community partners, strategies to find and engage Deshea include:

> Last Known Address: Deshea’s last known address, as indicated on the eligibility file we received, was a homeless shelter in Tampa. A Magellan Complete Care CHW or Health Guide contacts or visit the homeless shelter. Deshea may be back to find food, shelter, safety, and/or security. If she hasn’t returned, the shelter may know where she is. We leave the Welcome Packet along with our business card for Deshea in case she returns.

> Other Gathering Places: The team counts on our knowledge of the communities we serve and our community partners to identify common gathering places for individuals who are homeless in the neighborhood. Our CHW or Health Guide visits surrounding libraries, other homeless shelters, food pantries, soup kitchens, community centers, and cultural/ethnic-specific centers.

> Integra, our Subcontractor Specializing in Locating Enrollees: Magellan Complete Care contracts with Integra to extend our reach in finding our highest risk members and connect them to appropriate clinical and social services. Integra’s customized people-finding approach engages our enrollees through personalized face-to-face interaction, driving increased participation in clinical and quality outcome initiatives, including CC/CM. Integra provides “hands-on” community-based services to locate and build relationships with our hardest-to-find, hardest-to-engage enrollees. Integra sends their employees out into the community to locate and meet with enrollees nearly anywhere, including quite literally, in alleyways and under bridges. Integra’s success in locating and connecting with enrollees like Deshea, is largely due to the fact that its field teams are recruited from the communities where they work; representing the diverse cultures and languages of our enrollees.

Integra works on behalf of Magellan Complete Care until the enrollee is located, agrees to engage, and is ready to accept services and supports. Integra is able to help Magellan Complete Care engage Deshea either in person or by telephone, or a combination of both. Integra builds the relationship with Deshea until she is ready to engage with our Care Coordination Team for further assessment.

CONCLUSION – SUCCESSFUL ENGAGEMENT WITH DESHEA
Magellan Complete Care uses innovative opportunities, approaches, a variety of data sources, and extensive effort to identify, locate, and engage with Deshea. All of this, exercised in the first 90 days of her enrollment with Magellan Complete Care, has paid off. We are able to locate her at another nearby homeless shelter in Tampa. When we successfully connect with Deshea, we work to establish a supportive relationship. Our team focuses on meeting Deshea’s most immediate needs, for example assistance with securing shelter, food, and services to meet her basic needs. We complete the HRA, if possible. The Magellan Complete Care assessment includes social determinants of health. Depending on her behavioral/physical and social needs, we connect her to the most appropriate Care Coordination Team member. In Deshea’s case, we discover SMI and substance use concerns and we connect her to a Peer Support Specialist to help manage those issues. Through our experience, it is important for each enrollee who is homeless to have a consistent point of contact to navigate the healthcare system and build a trusting relationship to encourage continuing engagement. The Peer Support Specialist works closely with Deshea and her ICCM to help her manage her complex health care needs.
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We provide Deshea with a SafeLink Smartphone to communicate with her on an on-going basis, along with the number for our 24/7 toll-free enrollee services line. This provides access to our CareLine nurses and crisis line. With her consent, Deshea provides a broader list of her contacts, such as neighbors, relatives, friends, and/or religious counselors who can help us stay connected to her in the future.

After assisting Deshea with her most immediate needs, the team coordinates available housing options for her with a Magellan Complete Care Housing Director and COS who help her to complete the necessary applications. The team helps to schedule appointments for her PCP and behavioral health provider, ensures pharmacy needs are resolved, and sets up transportation to appointments and the pharmacy. The team works with Deshea and her providers to ensure any other needed referrals and supports are facilitated, including referrals to peer support services, community agencies, Targeted Case Management (TCM) and case management.

Deshea is well positioned to continue her “member journey” through recovery, and continue coordination with the supports in her neighborhood to reach her improved health and housing goals, while reinforcing safety and stability in her life. Engaging and serving enrollees like Deshea changes lives and creates a momentum within the community for continued success, all reflecting Magellan Complete Care’s vision and objectives.

Evaluation Criteria:

1. The adequacy of the respondent’s approach in addressing the following:
   
   (a) Identification of strategies for identifying new enrollees; and
   
   (b) Description of the sources of data/information that will be utilized to identify enrollees with special health care needs or circumstances.

2. The extent to which the respondent describes its process for contacting enrollees, including the data sources.

3. A description of how network providers and community partners will be engaged in the identification process.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.
F. OVERSIGHT AND ACCOUNTABILITY

SRC# 26 – Subcontractor Oversight (Statewide):

The respondent shall list any proposed subcontractors to which it will delegate the management of: provision of covered services, utilization management, provider networks or paying providers. The respondent shall describe how it will oversee and monitor the performance of subcontractors in general, as well as any specific oversight planned for certain subcontractors, including any corresponding service level agreements. The respondent shall include in its response the schedule and type of monitoring and how findings are reported, remediated, and used for process improvements.

Response:

OVERVIEW
Based upon our current Statewide Medicaid Managed Care Contract (the Contract) with AHCA, Magellan Complete Care understands well and takes very seriously our responsibility for all work performed under the Contract. No subcontract that Magellan Complete Care enters into with respect to performance under the Contract shall, in any way, relieve us of this responsibility. But, we may, with the prior written approval of AHCA, enter into subcontracts for the performance of work required under this Contract (see Attachment II, Section VIII, Administration and Management, sub-section B., Subcontracts). We appreciate the opportunity to subcontract with third parties for certain and select services covered by our Contract and approach any such subcontracting with deliberate planning, ongoing monitoring and diligent oversight.

These types of arrangements afford Magellan Complete Care some flexibility in the structure and operation of our business as we strive to serve and support our enrollees in the most effective and efficient manner. Delegation to certain subcontractors further affords us the opportunity to utilize the specialized experience and expertise of third parties as we continuously endeavor to improve upon our enrollees’ experience in accessing services and care they need.

We retain and safeguard our accountability for the quality and compliance of our subcontractors’ performance from various perspectives, including legal and regulatory, but also in principle and purpose, based on the mission of Magellan Complete Care to serve the SMI population. So we consider it essential to administer our subcontracted relationships and services through robust management, monitoring and oversight of these third parties.

Our comprehensive and consistent approach in this regard not only meets our obligations to AHCA and assures compliance with other legal and regulatory requirements, but also mitigates risk to our organization and AHCA, enables effectiveness in business operations, and can increase financial efficiencies – all while assuring that our SMI Members’ get integrated behavioral and physical services of high quality with us as their advocate and champion.

Magellan Complete Care already has the organizational structure, policies and procedures, as well as experienced resources, to enable effective oversight over subcontractors to which it delegates the management of: provision of covered services, utilization management, provider networks or paying providers, as described more fully below.
CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT PROVIDES A LIST OF SUBCONTRACTORS IT PROPOSES TO USE UNDER THE SMMC PROGRAM FOR THE DELEGATION OF WORK AS DESCRIBED ABOVE.

Magellan Complete Care, as the current Specialty Care Plan for the SMI population, already contracts with and delegates to several third parties for the provision of certain covered services, utilization management, provider networks and/or paying providers. We propose to use these same subcontractors, listed below, under the SMMC Program moving forward.

Listed in alphabetical order, these subcontractors, with a brief description of the services they respectively provide (and the functions delegated to each), include the following:

> Coastal Care Services, Inc. – DME/HME (provider services, credentialing/re-credentialing, reporting, quality management program, provider contracting, provider directory, access and availability)

> DentaQuest of Florida, Inc. - dental benefit administration (utilization management, customer service, claims processing, provider services, credentialing/re-credentialing, reporting, quality management, provider contracting, provider directory, access and availability)

> Engaging Solutions – member outreach via live call and in-person contact (welcome call, health risk assessments, provider appointment scheduling)

> Florida Eye Corporation, Inc. – vision benefit administration (claims processing, provider services, credentialing/re-credentialing, reporting, quality management, provider contracting, provider directory, access and availability)

> Global Interpreting – language interpreting
> Integra Service Connect, LLC – member engagement and care coordination (community-based services)
> Pacific Interpreters – language interpreting

> PNS Management – podiatry, dermatology, and orthopedic services (network management, network development, credentialing intake, provider services, claims management, and claims adjudication)
> Premier Eye Care of Florida, LLC – vision benefit administration (claims processing, provider services, credentialing/re-credentialing, reporting, quality management, provider contracting, provider directory, access and availability)
> Sinfonia Rx – medication therapy management services (data analysis, patient outreach, provider notification)
> Sivantos d/b/a Hear USA – hearing benefit administration (claims processing, provider services, credentialing/re-credentialing, reporting, quality management, provider contracting, provider directory, access and availability) and

> Veyo, LLC – non-emergent transportation (claims processing, provider services, credentialing/re-credentialing, reporting, quality management, provider contracting, provider directory, access and availability)
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Each of these subcontractors has been approved by AHCA, is well versed in the obligations that Magellan Complete Care has directly to AHCA, is performing the services that Magellan Complete Care has delegated to it in good standing, and more particularly, is in compliance with the requirements included in the Contract between Magellan Complete Care and AHCA. Assuming that Magellan Complete Care enters into a new agreement equivalent to the current Statewide Medicaid Contract with AHCA, our plan would be to again seek required written approval to delegate the described services to these subcontractors.

Criteria 2: THE ADEQUACY OF THE RESPONDENT'S OVERSIGHT STRUCTURE...
Magellan Complete Care has a formalized and fully-staffed approach to conducting robust and ongoing subcontractor management and oversight. This approach incorporates multi-disciplinary and multi-level engagement, including continuous participation by our executive team.

2.1 Management/Staff Accountabilities
The management and oversight of Magellan Complete Care subcontractors is primarily the responsibility of the Delegated Vendor Management team, led by Magellan Complete Care Sr. Director, Vendor Management, who reports directly to the Vice President, Network Development, as shown, in [General SRC #26, Attachment 1: Organizational Chart – Delegated Vendor Management].

Delegated Vendor Management has extensive experience in not only subcontractor management and oversight, but also contractual compliance, and accreditation, with much of this experience in the healthcare industry. There is also expertise and experience on the team leveraged every day in operations, administration, training, and auditing, as well as extensive knowledge and understanding of all aspects of contract requirements and implementation. The team’s command of program governance assures both proactive monitoring and continuous oversight, as well as effective and efficient resolution of subcontractor issues when stricter scrutiny and remediation is necessary. Execution of complex vendor management oversight processes and implementation plans, performance-driven strategies, strategic partner continuous improvement activities, regulatory compliance, auditing and reporting, are all competencies in Delegated Vendor Management. Magellan Complete Care’s subcontractor management and oversight is thus in very capable and effective hands.

Delegated Vendor Management is accountable for the operation of our subcontractor management and oversight, which includes:

>Execution of written agreements with each delegated subcontractor that specifies the activities to be delegated and those to be retained by Magellan Complete Care, including data reporting standards;

>Evaluation of the third party’s ability to fulfill delegated responsibilities through fulsome review of its programs, policies, procedures, and service delivery, including use and handling of protected health information and other applicable HIPAA privacy and security concerns prior to delegation;

>Maintenance of ongoing performance monitoring via review of submitted data reports and diligent attention to corrective action that must be taken, in a timely manner, to address any identified opportunities for improvement;
>Completion of an annual formal performance review, to include renewed approval of all applicable delegation, such as the subcontractor’s QI program;

>Imposing sanctions or revoking delegation of any function or activity if the subcontractor’s performance does not meet established standards; and

>Ensuring ongoing compliance with applicable Statewide Medicaid Contract and other regulatory requirements.

Magellan Complete Care’s Delegated Vendor Management is supported in its subcontractor management and oversight accountabilities by the corporate (Magellan Complete Care’s parent, Magellan Health, Inc.) Vendor Management Office, as well as Quality and National Delegation Oversight. All functional departments of Magellan Complete Care participate in subcontractor oversight in one aspect or another as well, as further described in later sections of this response.

As part of its continuous improvement initiatives, Magellan Health, Inc. established a Vendor Risk Management Program, operated by the Vendor Management Office (VMO) in Strategic Sourcing, to assure an even more holistic, formalized, and effective construct for selecting, monitoring, and overseeing vendors and subcontractors across the enterprise, including Magellan Complete Care. [General SRC #26, Attachment 2: Organizational Chart – Strategic Sourcing and Vendor Management].

Since its inception, the VMO, headed by a leader seasoned in supplier chain, quality, diversity and procurement, has modeled the Vendor Risk Management Program to include a number of best practices that effectively address subcontractor risk, for example:

>Creation and renovation of standardized processes for mitigating subcontractor risk;

>Enhanced validation of potential subcontractors with additionally rigorous due-diligence during a pre-award phase;

>Increased monitoring (by frequency and type) of subcontractor risk during the post-award phase;

>Adopting a “portfolio” view of all vendors/subcontractors that evaluates and manages the collective risk of third parties across the entire organization, to include identification and application of lessons learned; and

>Use of automated reporting tools to strengthen management, communication, reporting, and monitoring/oversight.

This VMO operates in support of various business at Magellan, including Magellan Complete Care and our Delegated Vendor Management team, to assure additional support to the integrity of our subcontractor management and oversight. For example, through the assistance of the VMO, Delegated Vendor Management can validate that potential third parties are viable, legitimate businesses and confirm that the third party has the financial stability and organizational resources to provide the required services.
Quality and Delegation Oversight, another area providing support and assistance to Magellan Complete Care Delegated Vendor Management, is led by the Senior Director, Quality and National Delegation Oversight. This leader has acquired over 25 years of experience in clinical (including as a licensed counselor), operations, account management/customer relations, vendor management, and quality, lending itself to the provision of multi-faceted perspective when developing healthcare management strategies. This leader is a member of the Magellan Health, Inc. corporate Quality Improvement department [General SRC #26, Attachment 3: Organizational Chart – Quality Improvement], but serves as an independent subject matter expert for all Magellan entities, including Magellan Complete Care, regarding requirements for and determinations of delegation. In that capacity, she plays a strategic role leading and consulting on quality improvement initiatives to enhance efficiency and value in behavioral health, physical health, specialty, and pharmacy operations.

As it pertains more specifically to Magellan Complete Care’s subcontractor oversight initiatives, this leader advises on and promotes consistency in the structure, tools, practices and expectations for delegated subcontractor management. Under her leadership, an enterprise-wide program to monitor and manage performance and compliance of delegated vendors was developed and implemented in 2013, satisfying all requirements for NCQA, URAC, Medicaid and Medicare. Indeed, Magellan Complete Care, as well as greater Magellan, has had complete (100 percent) success in audits of our delegation oversight.

2.2 Committee and Executive Team Oversight
As part of the Magellan Complete Care Quality Committee structure, the Senior Director of Delegated Vendor Management, along with Magellan Complete Care’s Chief Operating Officer (COO), jointly chair our Delegated Vendor Oversight Committee. This Committee is responsible for assessing and overseeing the quality of performance of delegated services provided by subcontractors to ensure the safety and well-being of our Enrollees, as well as to assure that applicable regulatory performance requirements and accreditation standards are met. It serves as an additional layer of and forum for subcontractor management and oversight at a multi-disciplinary leadership level and performs a number of necessary functions related to delegated subcontractor management and oversight, including most notably:

> Oversight of coordination and reporting of delegated vendor oversight performed by the Magellan Complete Care quality/clinical/operations/network personnel working with the vendor

> Assurance that pre-delegation reviews are completed for delegated vendors prior to provision of services; conduct ongoing monitoring of performance and annual vendor oversight reviews

> Verification that standard contract compliance tools are used for subcontractor evaluation

> Strategic review and evaluation of vendors, to include, for example:
>> The vendor has effective organizational structure and operational processes to perform the care/services
>> Scope of services
>> Vendor policies and procedures
>> Staffing resources
The ability to meet contractual, state and federal regulations, such as those related to protected health information privacy and security, as well as fraud/waste/abuse detection and prevention
>>Information systems and reporting capabilities
>>Quality management/improvement program and quality controls
>>Evidence the can meet performance guarantees

This Committee meets at least quarterly. In addition to the Senior Director of Delegated Vendor Management and the COO, other members of Magellan Complete Care’s leadership team participate as standing members of the Delegated Vendor Oversight Committee, including our Compliance Officer, Vice President of Health Services, Vice President of Network, Quality Director, Director of Operations, and Director of Investigations. At the corporate Magellan level, the Senior Director, Quality and National Delegation Oversight is also a member of this Committee and provides strategic and consultative input on the quality of subcontractor performance as more fully described above.

In addition, the Magellan Complete Care Compliance Committee routinely receives updates from Delegated Vendor Management regarding subcontractor management and oversight and evaluates subcontractor performance to assure adherence to applicable regulatory and contractual requirements. This serves as another local governance control to assure that our obligations to AHCA and commitments to our SMI enrollees are met. This Committee meets at least quarterly and is chaired by our Compliance Officer. Reflecting that our Compliance Program is embedded in our business operations at the senior level, additional standing members of the Compliance Committee include the Magellan Complete Care Chief Executive Officer, Chief Financial Officer, COO, Medical Director, Vice President of Health Services, and Quality Director, as well as the Senior Directors of Delegated Vendor Management and the Special Investigations Unit, among others. There is also national Magellan Compliance and SIU leadership who participate as active members of the Compliance Committee to assure consistency and enhance effectiveness in the Committee’s compliance-related business, including subcontractor oversight.

Also, Magellan Complete Care’s COO conducts Joint Operations Committee meetings on at least a monthly basis. Subcontractor performance is a topic of discussion, particularly if a subcontractor is not meeting key performance indicators or quality standards. This meeting is attended by leaders in Delegated Vendor Management, Compliance, Quality, Operations, and other critical departments/functional areas.

Magellan Health, Inc. maintains and operates a National Delegated Vendor Oversight Group in which Magellan Complete Care actively participates. This centralized workgroup is comprised of representatives of delegated subcontractors as well as internal stakeholders throughout the enterprise, including Magellan Complete Care Delegated Vendor Management, our COO and Compliance Officer, and the corporate Vendor Management Office and Strategic Sourcing, among other leadership. It is tasked with ensuring communication, consistency, and compliant oversight processes for all delegated vendors and subcontractors. As a working operational body, the focus of this group is ensuring delegation and oversight processes are being followed, supporting identification and communication of risk, applying consistency in approach, and providing strategic consultation. This group also provides a vehicle for communicating vendor and subcontractor management issues and concerns across business units which may share the same vendors and thus, Magellan Complete Care’s participation allows for our team to benefit by working with business peers across the enterprise to assess and address any shared issues and concerns.
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2.3 Governing Oversight Policy and Framework
The Magellan Health, Inc. Delegate and Subcontractor Contracting and Oversight Policy (see [General SRC #26, Attachment 4]) governs Magellan Complete Care’s framework for and approach to monitor delegates and subcontractors for initial and ongoing compliance, including appropriate documentation of our monitoring and oversight activities. The Policy addresses activities from pre-delegation, contracting, routine monitoring through annual auditing and termination of a subcontractor relationship. This framework and approach takes account of our understanding that we are ultimately accountable for our obligations to AHCA; thus we assure that subcontractors meet all contract and regulatory as well as quality requirements through comprehensive monitoring and oversight to ensure performance by adhering to standards that address in overarching terms:

> Determining whether to delegate/subcontract a function;
> Determining whether a service is delegated/subcontracted;
> Pre-delegation /due diligence;
> Contracting;
> Delegation agreement;
> Subcontractor addendum;
> Non-performance issues;
> Reporting to Vendor Oversight Committee/Quality Committee/National Delegate Oversight Group; and
> Audits.

Written, detailed procedures that support this Policy are maintained on a Delegated Vendor Oversight site, easily accessible to Delegated Vendor Management as well as business areas with a need to know and adhere to these procedures. The procedures cover a host of topics including, by way of relevant example: determination of a delegate; routine monitoring; subcontractor risk driven audit stratification and audits; Code of Conduct and compliance assessment, and subcontractor termination.

Consistent with this Policy and related procedures, Magellan Complete Care’s Delegated Vendor Management maintains robust management, monitoring, and oversight of each subcontractor, reviewing reports/data monthly, quarterly and annually, as deemed applicable. Data/reports reviewed may include, but are not limited to the following: access and availability reports; telephone call center statistics; credentialing and re-credentialing process and files; utilization management data and analyses addressing potential under or over utilization; claims processing/payment data; complaints and grievances; adverse incident reports and quality of care concerns; enrollee satisfaction; fraud, waste, and abuse/compliance program materials; staff training; patient safety activities; encounter compliance reports; and other performance measures as they correlate to the services provided by the subcontractor.

Magellan Complete Care has an extensive internal “network” of experience, expertise, and resources to assure effective, efficient, and compliant subcontractor management and oversight, through the entire subcontract lifecycle. Having an integrated approach like this promotes consistency, professionalism, and rigor that strengthen decision-making and subcontractor oversight.
As we look for ways to enhance this oversight structure, we have selected and will incorporate appropriate software applications and tools for automating this oversight function. Indeed, Magellan already uses Cobblestone (offered by a woman-owned company) to author, track changes to, and publish subcontractor agreements via a centralized repository. The company has also purchased and will be implementing by the end of 2017 a Governance, Risk, and Compliance tool, Compliance 360, to further enable monitoring and oversight (as well as provide improvements to other functions in the company, such as the Magellan Complete Care Compliance Program).

More detailed information regarding how Magellan Complete Care addresses subcontractor management and oversight is outlined in later criteria of this response.

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT USES AND MONITORS...
In addition to a host of other terms included in our subcontractor agreements, Magellan Complete Care’s subcontractors are contractually obligated to comply with the terms and conditions of our current Statewide Medicaid Managed Care Contract with AHCA (the Contract). Our subcontractors are contractually obligated to provide covered services to our Enrollees not only in accordance with the Contract, but also the applicable Florida Medicaid Coverage and Limitations Handbook, applicable statutory and regulatory requirements, as well as our internal standards of operation. Each subcontractor agreement includes additional specifics – service level standards - as applicable to the services to be provided by that subcontractor. It is all of these terms, by reference and particular mention, against which a subcontractor is monitored and evaluated on a routine basis, including prior to implementation.

Prior to entering into a delegated arrangement, Delegated Vendor Management, in partnership with appropriate Magellan Complete Care subject matter experts in various departments and functional areas, conducts a rigorous pre-delegation review to assess the intended subcontractor’s ability to perform the services for which they are being contracted, to include, for example:

1. Compliance with accreditation and contractual requirements;
2. Determining potential business conflicts and exclusion status;
3. IT Security Assessment (if/as applicable); and
4. Existence of policies, procedures, and an established quality monitoring program/processes.

Delegated Vendor Management uses an internally-developed and very detailed audit tool to accomplish this review. This audit tool has been utilized in many such reviews with many subcontractors since the inception of our business, both at the pre-delegation/contracting stage, as well as for a full annual review, to which all of our subcontractors listed in Criterion 1 are subject. The tool may be used for a targeted audit as well. A targeted audit is focused on specific areas of the subcontractor’s scope of services such as claims, credentialing, enrollee services, or utilization management. Targeted areas are usually delegated functions, but may be structural areas such as compliance, or privacy/security, based on risk identified through routine monitoring.

This audit tool is first completed by the subcontractor and submitted to Magellan Complete Care along with additional information/attachments requested in the tool. For a full audit at the pre-delegation and annual stages, the review is comprehensive, covering areas such as organizational structure and appropriate licensure (depending on the functions to be
subcontracted), core operations, quality assurance/improvement, compliance, privacy and security, program integrity, and communications/enrollee materials, through detailed indicators for each. In addition, a pre-delegation on-site review is conducted as well, tailored to the nature and scope of services to be delegated as well as any considerations that require, in Magellan Complete Care’s discretion, evaluation at the proposed subcontractor’s location.

Pre-delegation activity also includes validation of adherence to AHCA requirements via a dedicated tab of indicators related exclusively to these requirements in the Audit Tool. Additional review of specific functions, such as Utilization Management, are reviewed in detail as well, dependent on the specific functions to be delegated, again through topic-specific tabs in the Audit Tool.

Once the pre-delegation audit is complete Delegated Vendor Management submits the results and recommendations to the Magellan Complete Care Quality Improvement Committee. The Quality Committee then conducts its own review and determination regarding whether Magellan Complete Care will move forward. If that decision is in the affirmative, additional steps are taken to bring the subcontractor into Magellan Complete Care’s business operations, including but not limited to notification of the subcontractor to AHCA for approval.

On annual basis, each of Magellan Complete Care’s subcontractors listed in Criterion 1 is reviewed according to the same process and with the use of the same Audit Tool as described above to assure ongoing compliance as well as continuity of performance. Results of these audits are shared with and evaluated by Delegated Vendor Management, as well as subject matter experts for each delegated function or service and the Delegated Vendor Oversight Committee. Delegated Vendor Management follows up with the subcontractor regarding any findings from the audit until such findings have been effectively addressed or resolved.

In addition, each of the subcontractor agreements that Magellan Complete Care enters into, outlining relevant legal terms and obligations, as well as specific performance standards that apply to the particular subcontractor, also includes a Delegation Agreement incorporated into it. Sometimes referred to as a Subcontractor Addendum, this document is intended to further assist in the monitoring of critical subcontracted functions through the codification of our systematic process to assess compliance and performance. Delegated Vendor Management assures that this Delegation Agreement/Subcontractor Addendum is included in the contracting process for each subcontractor.

This very detailed written document must be agreed to by the subcontractor for the subcontractor’s arrangement to proceed. It includes provisions addressing, among other things:

1. A description of all delegated functions
2. Identified responsibilities of both parties
3. Identified scope of delegated services provided to Enrollees on behalf of Magellan Complete Care by the delegate, as well as any services that are not delegated
4. An explicit statement indicating that the subcontractor shall follow all applicable State and Federal laws and regulations, as well as all terms and conditions of the contract between Magellan Complete Care and the subcontractor
5. An explicit statement indicating that the subcontractor will follow all applicable Magellan Complete Care policies and procedures, as required, and as applicable, will be in compliance with
accréditing entities’ standards, such as the National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC)

6. An explicit statement indicating that the subcontractor has mechanisms in place to monitor patient safety

7. A statement addressing whether Magellan allows sub-delegation by the subcontractor to occur and a description of the permission process

8. The reporting process by the subcontractor to Magellan Complete Care, which in no case will be less than semiannually, but given how robust our management and oversight is, usually more frequently

9. Arrangements for the use and disclosure of protected health information by the delegate (evidenced in a separate Business Associate Agreement document), including an agreement to comply with all applicable HIPAA requirements and with any restrictions or conditions with regard to PHI set by AHCA

10. A process for evaluating the delegate’s performance including (i) review of periodic performance data (ii) the right of Magellan Complete Care to conduct audits of the subcontractor if quality of care or performance measures are not met (iii) development of a Corrective Action Plan (CAP) within thirty (30) days of the audit or identification of opportunities and (iv) periodic follow-up reports based on established CAP timeframes

11. Notification to Magellan Complete Care (or its corporate parent, Magellan Health, Inc., as they case may be) if there are any material changes in the delegates’ performance within 30 days

12. A description of remedies, including revocation of the delegation in whole or in part, if the subcontractor does not fulfill its obligations.

This Delegation Agreement has served us well as an effective control to use and monitor against in assuring our subcontractors perform in compliance with their and our obligations to AHCA and to our enrollees.

Magellan Complete Care retains responsibility for the quality of services delivered to our enrollees and customer organizations through our delegated vendors. As previously mentioned, each subcontractor contract includes specific performance standards and requirements. To ensure quality and that the terms and conditions of contractual obligations are adhered to, Magellan Complete also monitors delegate performance on an ongoing basis. Examples of monitoring methods include: data review, joint partnership meetings, Compliance reviews, and Sanction and Exclusion Monitoring.

More specifically, upon implementation of a new subcontractor and on an annual basis thereafter, Delegated Vendor Management creates a monitoring plan for each delegated subcontractor. The plan takes account of service level standards and may be adjusted as needed throughout the year. This plan takes into consideration risk factors such as scope or impact of the subcontractor’s services, tenure of the subcontractor’s relationship with Magellan Complete Care, performance history, as well as accreditation and AHCA contractual commitments.
Pursuant to this monitoring plan and based on the services the subcontractor provides, a subcontractor submit standard reports at the frequency determined by contract and by agreement with Delegated Vendor Management and a designated business leader-liaison for the subcontractor. This Vendor Performance Analysis Report was developed by Delegated Vendor Management and is used consistently to monitor our subcontractors. Most typically for those subcontractors used by Magellan Complete Care that frequency is established as monthly (although not all performance indicators may be reportable with that frequency as some are better trended on a quarterly basis, for example). These reports are submitted by the subcontractor in a standard format developed by Magellan Complete Care and include performance against service level agreements as well as general utilization and other quality indicators.

Results of the data review are evaluated by Delegated Vendor Management in partnership with business department/functional area subject matter experts. Findings are summarized and reported routinely by Delegated Vendor Management to our Delegated Vendor Oversight Committee. Where performance issues are identified or any Corrective Action Plans (CAP) are indicated, Delegated Vendor Management also reports the issues to our Compliance Officer and Compliance Committee.

While generally included in the performance data reviews done on a monthly basis as part of Delegated Vendor Management’s monitoring plan for a subcontractor, complaints received from enrollees or providers regarding the services provided by the subcontractor are tracked and trended. Any findings are reviewed within Magellan complete Care’s Delegated Vendor Oversight, Quality Improvement, and Compliance Committees

Delegated Vendor Management and relevant business stakeholders also meet with the subcontractor on a regular basis consistent with the monitoring plan. These joint partnership meetings are intended as a vehicle for two-way communication as well as avenues for quality monitoring and improvement. Standard agenda items include: results of data review, operational changes and issues, implementations, audits, and as applicable, corrective actions (needed or in progress). We conduct these meetings at least every other month and most typically, on a monthly basis.

In addition, and borne out of lessons Magellan Complete Care has learned over the course of the last few years in operation as we have managed and overseen a number of subcontractors, we are enhancing our contracting approach with them. More specifically, we are now embedding performance guarantees in our subcontractor agreements as new subcontractors are added to our operations (subject, of course, to approval from AHCA).

Our first instance of doing so occurred when Magellan Complete Care transitioned its delegation of non-emergent transportation earlier in 2017. As AHCA knows, we took the same approach with our previous transportation subcontractor that we have used with other subcontractors as described above. That is, we embedded performance standards and other delegation, monitoring, and oversight protocols in the agreement with that subcontractor, and exercised routine, even frequent, reviews of its performance. But, based on performance that we considered to be below our expectations on behalf of our enrollees, we ultimately terminated our relationship with that subcontractor, and transitioned to Veyo.

After conducting our due diligence, we took the opportunity, in identifying Veyo as a third party that would perform more effectively, to enhance our remedies to assure that effective (and
Compliant) performance. A detailed exhibit to our Administrative Services Agreement with Veyo outlines not only all of the relevant performance standards to which this subcontractor must adhere, but also ties each such performance standard to a corresponding penalty (by day, per report, quarterly, etc. as applicable to the standard). Indeed, as the Agreement provides in relevant part, “The performance standards and associated penalties set forth...provide for the right of Magellan to impose monetary penalties if the performance standard is not met independently of any regulatory fine or penalty or other claim for which Delegate is responsible.” (Section IV, Standards of Performance). The agreement with Veyo also includes positive financial incentives for Veyo to meet or even exceed its obligations. Our intention is to strongly consider financial penalties and incentives tied to performance in our subcontractor agreements as part of our continuously improving approach to subcontractor management and monitoring moving forward.

CRITERIA 4: THE ADEQUACY OF THE RESPONDENT’S APPROACH TO MONITORING THE QUALITY...
Prior to entering into a delegated subcontractor arrangement, we audit the intended subcontractor for, among other things, the existence of policies and procedures, an established quality program, compliance with applicable regulatory requirements including performance standards, and the ability to consistently and reliably provide the services to be covered by the proposed arrangement. We use our internally developed Audit Tool referenced above to enable this review and then we conduct the same or similar audit annually thereafter.

Findings and recommendations are presented by Delegated Vendor Management to the Magellan Complete Care Delegated Vendor Oversight Committee and ultimately the Quality Improvement Committee (QIC) for these pre-delegation and annual reviews for evaluation, approval and follow-up, if any. Any actions needed to correct deficiencies are identified and monitored through to completion by Delegated Vendor Management in partnership with relevant Magellan Complete Care business subject matter experts, including, for example, Quality Improvement staff.

We also leverage the formal delegation agreement, as well as the contract, with each subcontractor to develop a monitoring plan that outlines the overarching framework of monitoring subcontracted activities and functions on a routine basis using a systematic process and reporting to assess compliance. To that end, routine reporting measurements are established with each delegated subcontractor.

These measurements, or key performance indicators (KPIs), are included in a Vendor Performance Analysis Report developed by Delegated Vendor Management. This Report begins as a standard template tool in Excel, and includes those measures that are applied to all subcontractors in monitoring performance, such as those related to HIPAA privacy, for example. It is then adapted as necessary to reflect the specific functions that have been delegated to the subcontractor.

Each subcontractor must complete and submit its performance metrics for all KPIs included in this Report and any supporting documentation to Magellan Complete Care Delegated Vendor Management on a monthly basis. Once Delegated Vendor Management receives the Report, it forwards select components of it to subject matter expert (SME) leaders within Magellan Complete Care for their respective review and evaluation for adherence to applicable standards in a Vendor Scorecard. So, for example, enrollee and provider services metrics go to our
Customer Services leader, utilization management metrics got our Health Services leader, and so forth.

Then, in turn, the SME for each set of function-related KPIs must review the performance data included in the Vendor Scorecard. Following that review, the SME must attest to that subcontractor’s compliance as reflected by the relevant indicators and metrics, or alternatively, identify any issue of noncompliance with a recommendation for follow-up. All of that SME activity is documented and tracked by Delegated Vendor Management.

In addition to this SME-driven monitoring and oversight, Delegated Vendor Management takes the lead for a number of performance monitoring activities, including the following:

- Service Operations Oversight - Business Owner/Vendor Management; ongoing
- Performance Monitoring through Vendor Management Analysis and SME Approval; Monthly, Quarterly Annually
- Encounter Reconciliation Monitoring; Monthly
- Claims Issue Monitoring; Weekly
- Joint Operations Meetings with Delegates; Monthly
- FWA and HIPAA Monitoring; Monthly
- Eligibility File Accuracy Monitoring; Monthly
- Monitor Subcontractor Eligibility - Ongoing Sanction and Licensure Monitoring; Monthly
- Monitor Subcontractor Eligibility - Background Screening and Sanction Monitoring; Annual
- Complaint Monitoring through Delegate Reporting and QI Analysis and Trending; Ongoing
- Claims Adjudication Audit; Semi-annual
- AHCA Subcontractor Reporting; As Required
- Pre-delegation Oversight Audit; As Required
- Annual Delegation Oversight Audits; Annual.

Certain KPIs are required to be reported on a quarterly or annual basis, but in general, the subcontractor must submit the Report on a monthly basis. We believe that the discipline that must be maintained in order to monitor and report on performance – self monitoring and reporting by the subcontractor and oversight monitoring and attestation by Magellan Complete Care SMEs – is supported by this regularity. In addition, this level and frequency of reporting allows Magellan Complete Care to identify any concerns about subcontractor performance, should they arise, as proactively as possible.

If the subcontractor is in compliance with all applicable performance standards following review by all SMEs, no further action is needed or taken. If, however, there is some identification of noncompliance by any one or more of the business SMEs, or Delegated Vendor Management identifies an issue or concern itself, then Delegated Vendor Management assumes responsibility for further follow-up with the subcontractor. See [General SRC #26, Attachment 5: Vendor Performance Reporting Process Flow].

In addition, Delegated Vendor Management conducts joint operations meetings with designated representatives of each subcontractor on a monthly or quarterly basis, depending on the nature and extent of delegated functions as well as the overall performance of the subcontractor. Additional participation from Magellan Complete Care is determined in advance of these meetings based on the agenda of critical topics for discussion, but typically includes leadership from each area of business operations at the health plan. A formal written agenda routinely includes topics that include performance reviews of each delegated function, program changes, encounter
submission accuracy, and progress on a corrective action plan if one is in place. The meeting is also an opportunity for Delegated Vendor Management and/or Magellan Complete Care SMEs to ask questions or seek clarification regarding the subcontractor’s monthly performance address concern save concerning the subcontractor’s monthly performance reports. Minutes are maintained for these meetings.

This monitoring construct is carried out rigorously, but also dynamically and adaptively to address opportunities for improvement and development of collaborative mitigation and workflow integration strategies. A clear and recent example is our diligent, dynamic, and ongoing monitoring and oversight of transportation services, As a result of ongoing monitoring of our prior subcontractor for these services, we identified areas for improvement and were ultimately Complete Care was compelled to seek out and contract with a new transportation vendor.

Our latest subcontractor arrangement with Veyo provides us and our enrollees with services and capabilities not supported by our previous vendor such as enhanced reporting and tracking. Through the terms we included in our contract with this subcontractor, we are also provided with additional detail that allows us to verify, among other things, that transportation has been provided to our enrollees and monitor potential fraud, waste and abuse in transportation services.

Even beyond that, when more monitoring and oversight appeared to be necessary through the early months of implementation than our more routine approach, we introduced more. For example, Magellan Complete Care and Veyo have used daily touchpoint calls that address day-to-day transportation resolution/coordination needs of our enrollees. We have also identified and are working together workflow refinements to successfully respond to the unique transportation demands of our SMI enrollees. None of this enhancement to service delivery and operations would have transpired without our effective subcontractor monitoring.

Furthermore it is through our application of lessons we learned during the transition from our previous transportation subcontractor to Veyo and higher touch implementation of our delegation to Veyo that we have had the opportunity to enhance not only our already-robust monitoring activities, but also interventions and contract compliance actions, as further referenced below.

CRITERIA 5: THE ADEQUACY OF THE RESPONDENT’S PROCESSES FOR ADDRESSING PERFORMANCE...

In the event that an issue of inadequate performance or noncompliance with any requirement or standard to which a subcontractor is subject has been identified, Delegated Vendor Management springs into action by following up with that subcontractor in accordance with our well established protocols (see again [General SRC #26, Attachment 4: Delegate and Subcontractor Oversight Policy], and [General SRC #26, Attachment 6: Non-compliant Performance Process Flow]).

In general, if during any oversight activity the subcontractor does not perform in accordance to its contract thereby placing the health plan at risk for non-compliance with its contract with AHCA, our Compliance Officer will be notified by Delegated Vendor Management. The Compliance Officer will then work with Delegated Vendor Management to issue notification to the subcontractor, demand immediate mitigation of the issue, and issue corrective action, tracking corrective action to its completion. Following through the example of our transportation subcontractor, transportation was identified as a high risk service and included in the Compliance Program’s risk assessment and work plan activities this year.
Magellan Complete Care uses early warning indicators as part of our overall subcontractor management, monitoring and oversight to detect and address subcontractor performance deficiencies as proactively as possible. These “triggers” include:

>Significant changes in the subcontractor’s leadership or personnel, around which the subcontractor must make notification to Magellan Complete Care as required under the terms of its contract with us;

>Trends in enrollee concerns, complaints, and grievances regarding unavailable or inadequate services, identified based on routine monitoring of standard reports by Quality Improvement and Customer Service;

>Trends in provider complaints regarding delays or lapses in payment, received anecdotally or otherwise;

>The subcontractor consistently fails to meet specific service-level requirements, especially those related to timely and adequate provision of services to Magellan Complete Care enrollees, based on routine monitoring and oversight of subcontractor performance by Vendor Management, Delegation Oversight, Compliance and other key areas of operations;

>The subcontractor’s financial statements, which are reviewed on at least an annual basis by Strategic Sourcing and more frequently as necessary by Magellan Complete Care Finance, fall below acceptable industry standards;

>The subcontractor experiences an incident of disruption in internal operations of a significant magnitude;

>The subcontractor fails one of our Compliance or Vendor Management audits or reviews, also performed routinely, in evaluating, by way of example only, provider payment timeliness; and/or

>Magellan Complete Care experiences significant and adverse changes in the subcontractor’s responsiveness to any of the triggers listed above or another issue of material concern to Magellan Complete Care and/or AHCA.

In the example of our transportation subcontractor, our Compliance Department, along with our Delegated Vendor Management and Quality Improvement teams, is monitoring Veyo’s performance and issues impacting enrollees as identified through complaints and grievances, as part of its work plan activities. The subcontractor must report on all complaints resolved as part of its monthly reporting and complaints are tracked and trended to identify any performance issues or any opportunities for improvement. Magellan Complete Care and Veyo developed a workflow to fully integrate the complaint tracking and resolution between the technology platforms allowing for a seamless resolution, coordination, and tracking/reporting of all complaints.

At any time, the Compliance Officer can call for a tracer audit on individual enrollee complaints/grievances to ascertain the breadth and seriousness of the issue. As previously mentioned, Magellan Complete Care has established extensive reporting and monitoring requirements for Veyo and this includes reporting on numerous enrollee service metrics. This enhanced and higher touch approach, only one aspect of our process for addressing performance
issues is working effectively for both Magellan Complete Care and Veyo as well as the intended beneficiaries of effective and efficient service delivery – our enrollees.

So, when a subcontractor’s performance does not meet expectations or the entity is non-compliant with requirements, Delegated Vendor Management, after notifying Compliance and with that team’s support, communicates the issues identified by Magellan Complete Care to the delegated subcontractor. The subcontractor is given a reasonable amount of time to assess the issue of which it is notified and then respond in writing to Delegated Vendor Management. That response could be, for example, to submit a corrected Vendor Performance Analysis Report if a metric was originally reported in error. Another example might be that the subcontractor provides an explanation of why the issue of noncompliance occurred and what steps are being taken within what timeframes to effectively address the issue.

Once Delegated Vendor Management receives a written response from the subcontractor, this team conducts a review with Compliance and in some cases, they will make a determination that on its face, the subcontractor’s response is acceptable. In some cases, the business SME who identified the issue in the first place will be consulted and collectively, these stakeholders will make a determination together regarding whether the response is acceptable.

If the issue appears to be resolved/corrected at this point in our process, then the Delegated Vendor Management team continues to monitor it through ongoing performance reporting to ensure that what was identified as the root cause was indeed responsible for the issue and that whatever steps were taken to achieve the resolution/correction were effective. If the issue appears random or simple error and is effectively and efficiently resolved, Delegated Vendor Management may well consider the issue closed. In that case, performance monitoring would continue as usual, but the issue may not be a target for more focused monitoring. But, depending on the nature and severity of the issue, this monitoring may be more frequent and/or include additional metrics; to assure effective subcontractor management and oversight, our Delegated Vendor Management team is given wide latitude and discretion by business leadership in this regard.

In the event that a subcontractor’s response to Magellan Complete Care’s identification of an issue is not considered to be acceptable, Delegated Vendor Management, perhaps in consultation with the Compliance Officer and business SME, will develop appropriate next steps to further address the matter with the subcontractor. Again, Delegated Vendor Management is given wide discretion to develop a follow-up plan with the subcontractor and a timeline for effective resolution. In addition to increased monitoring by frequency and/or additional measures, that could also include the requirement that a subcontractor submit to a formal written Corrective Action Plan (CAP).

In general, a CAP is utilized if the performance issue appears to be part of a trend or does not appear to be one which can be easily and/or quickly resolved. The decision to impose a CAP upon a subcontractor is not made lightly, but Magellan Complete Care does consider it to be an effective approach when needed to assure performance improvement by a subcontractor. It is undertaken deliberately and thoughtfully. Magellan Complete Care makes every effort to work with our subcontractors, giving these third parties technical assistance and providing not just monitoring and oversight, but also partnership, whenever and wherever possible. So, the CAP may be developed by Magellan Complete Care or the subcontractor unilaterally or developed together by Delegated Vendor Management working with a designated contact at the subcontractor.
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The CAP must include concrete steps likely to be effective in resolving the issue as well as clear timelines for completion and it must be approved by Magellan Complete Care before it is considered to be acceptable. Depending on the nature and severity of the issue, this CAP will be reviewed and approved by Delegated Vendor Management, a business SME(s), the Compliance Officer, and our Vendor Oversight Committee, to assure multi-disciplinary participation, and thus, more effective results, in the process.

This approach is demonstrated by the identification and resolution of an issue we had with our dental benefits administrator, DentaQuest. Based on routine monitoring by Delegated Vendor Management in partnership with Compliance, Magellan Complete Care placed DentaQuest on a corrective action plan for encounter acceptance submission rates falling well below the AHCA contractual rate of 95 percent in late 2014/early 2015. This was specifically due to an excessive number of dental encounter denials related to Medicaid provider enrollments and Provider Master List (PML) data issues.

Once notified of the need for a corrective action plan, DentaQuest cooperated fully and actively by developing a detailed plan of action, making programmatic changes to its 837D processing, conducting outreach to providers to correct registration issues, and removing non-compliant providers from its network. Magellan provided technical assistance to help propose solutions to resolve extract issues and brokered encounter meetings with AHCA’s fiscal agent.

Magellan Complete Care and DentaQuest held bi-weekly meetings for months to review remediation efforts and data results and to collaborate on solutions. All the while, we were conducting routine as well as targeted monitoring on a frequent basis. Over the course of five months (March-July 2016), for example, significant reductions in provider registration and PML dental encounter denials were evident. DentaQuest was released from the corrective action plan and Delegated Vendor Management continued to closely monitor DentaQuest’s encounter acceptance rates until it was clear that the remediation was effective.

In the case of a significant performance issue, such one that could impact the safety of Magellan Complete Care Enrollees, Delegated Vendor Management works with Health Services, Legal, Compliance and Quality Improvement to conduct a thorough and very intensive evaluation of the vendor’s performance and compliance as soon as possible. These audits, which may include an on-site visit, as well as documentation review, are contemplated by our subcontractor agreements and thus the subcontractor agrees to them upon execution of its contract with our company. The results of the audit are shared with the subcontractor and as with other approaches taken to address subcontractor deficiencies in performance and/or compliance, Delegated Vendor Management works closely with the subcontractor to resolve findings as timely and effectively as possible.

If a subcontractor refused to cooperate, or did not follow through on an effective and timely basis to correct performance issues, Delegated Vendor Management and relevant SMEs review and make recommendations regarding the performance issues with key stakeholders who support Magellan Complete Care’s business, including but not limited to the Legal and Compliance teams. From this multi-disciplinary evaluation, Magellan Complete Care leadership determines the appropriate course of action, which could ultimately include termination and replacement of the subcontractor.
Despite our partnering approach with our subcontractors, if a subcontractor will not work with us to correct performance or non-compliance, or has not effectively corrected these issues after being given ample opportunity to do so, Magellan Complete Care has to consider termination of the subcontractor. If it comes to it, Magellan Complete Care will transition away from an existing subcontractor relationship, moving to a new arrangement in such a way as to mitigate risk to enrollees’ services or AHCA commitments, using a previously-developed, well considered contingency plan and other appropriate implementation activities.

The decision to terminate a subcontractor relationship at Magellan Complete Care is ultimately made by our Chief Executive Officer (CEO). But in the case of nonperformance or noncompliance, a recommendation will likely be initiated from Delegated Vendor Management and/or the Delegated Vendor Oversight Committee as a whole after reviewing all the relevant information and circumstances. Alternative methods to continue to provide the delegated subcontractor’s services are also reviewed with the CEO and other business leaders pursuant to a contingency plan; these alternatives may include but not be limited to identifying a new vendor through a formal Request for Proposal (RFP) process, limited request for bid from already known vendor options, or bringing the services in house to a Magellan operation.

If a decision is made to terminate the subcontractor, established protocols are in place to make proper and timely notifications to the third party, AHCA, and as/when appropriate, enrollees and providers. Delegated Vendor Management works with the business owner(s) of the functions that are covered by the delegated subcontractor to apply whatever contingency plan is currently in place and develop a transition project plan with additional details for the transition. The project will be led by Delegated Vendor Management and may be co-managed by another business owner or project management resource based on stakeholder agreement and complexity. In all cases, Delegated Vendor Management will ensure any oversight requirements related to the transition to a new arrangement are applied according to the Delegate and Subcontractor Contracting and Oversight Policy referenced throughout this response.

CRITERION 6: MAGELLAN COMPLETE CARE’S MONITORING ACTIVITIES TO ENSURE THE FINANCIAL...

To address potential risk to our business, AHCA, and our SMI Enrollees, we take very seriously our responsibility to be appropriately assured of the financial “health” of our subcontractors, particularly those which provide services directly to Enrollees, or to which utilization management authority, and/or payments to providers have been delegated. Accordingly, we utilize a complement of monitoring activities and standards to routinely assess the financial stability of these third parties as part of our overall subcontractor management and oversight approach.

6.1 Financial Review
At the time of our pre-delegation assessment and on at least an annual basis post-delegation/contract, we require the subcontractor to submit financial statements, including audited annual statements as available. Magellan’s Vendor Management Office will conduct the initial review as part of pre-delegation due diligence, as well as annual reviews. If more frequent reviews become necessary, as in a case where there are concerns regarding a subcontractor’s financial solvency or stability, Magellan Complete Care Finance will conduct these reviews.

In any case, these financial reviews will be conducted using standard objective metrics - such as Moody’s or Standard and Poor’s for public companies, a Z-score calculation for private
companies, and various financial ratios built off of a Form 990 for nonprofit organizations - to evaluate potential and actual subcontractors as a key step in the process. Other financial documentation and information will be collected and evaluated as necessary. There are many areas of a subcontractor’s balance sheet that may be important to review, but we pay special attention to a subcontractor’s cash position.

In the event that a financial review described here results in concerns, we may require the subcontractor to submit to additional follow-up, to include but not necessarily be limited to financial reviews of greater frequency. Once the Vendor Management Office’s GRC Third-party Risk module, Compliance 360, is implemented (by year-end 2017), the information collected pursuant to these financial reviews will be stored in that module, enabling automated scheduling of and reporting on these reviews.

6.2 Capability and Experience
As part of our pre-delegation assessment, we consider whether the subcontractor has experience with business of a similar size, scope, and complexity, as well as whether the third party has worked in the state of Florida previously. Without some prior and demonstrated capability and experience in this regard – while not a complete prohibition from Magellan Complete Care contracting with the subcontractor - these are circumstances that we consider as greater potential risk of performance issues.

6.3 Historical Performance
Separate but related, Magellan Complete Care draws on any historical relationship and performance that a potential/actual subcontractor has had with Magellan Health, Inc. affiliates. At the time of procurement and pre-delegation, Delegated Vendor Management partners with the Vendor Management Office to solicit information from other lines of business at the company regarding how well (or not) things went with the third party under consideration.

In addition, this type of information collection and sharing does not stop once Magellan Complete Care contracts with the delegated subcontractor. Holistic subcontractor performance assessment is not a one-time thing for Magellan Complete Care, as should be evident in the earlier sections of our response here – it can only be valuable if is on-going. To the extent that we can buttress our own monitoring and oversight activities with intelligence regarding how a subcontractor is doing across the Magellan enterprise, even better. For delegated subcontractors of the type we have identified here, and accounting for heightened risk by virtue of what has been/will be delegated to each of them, comparison reviews of this type are done annually under the leadership of Delegated Vendor Management, in partnership with our executive leadership team. Any concerns that may be raised by this type of intelligence gathering is assessed further by Delegated Vendor Management in consultation with the relevant subject matter; then, issues or concerns are communicated to the Delegated Vendor Oversight and Compliance Committees for further consideration and follow-up.

6.4 Invoice Integrity
Each subcontractor’s written contract describes in sufficient detail how and when, and in what form and with what detail, the subcontractor is to request payment or reimbursement from Magellan Complete Care for services rendered. These contractual terms serve as clearly communicated controls to assure consistent, timely and effective process as well as to properly protect company assets. We consider it to be essential to then verify compliance with the process to be followed by the subcontractor as well as integrity (completeness, accuracy, supporting
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information and documentation) of the subcontractor’s remittance for payment. Thus, Magellan Complete Care’s Finance team closely scrutinizes subcontractor invoices on a monthly basis. Any apparent deviation by the subcontractor in adhering to the process it is required to adhere to and/or irregularity in an invoice is referred by finance to Delegated Vendor Management for further follow-up. To the extent that any finding could be potential, fraud, waste, and abuse, the finding is also referred to our Special Investigation unit for review and possible investigation.

6.5 Early Warning Triggers
As outlined in Criteria 5 above, Magellan Complete Care uses early warning indicators to proactively identify and address deficient or substandard performance by a subcontractor. These triggers would similarly apply to ensuring financial stability of a subcontractor as our observation and experience has been that where a subcontractor is not meeting its performance obligations, it may be due, in whole or in part to financial challenges.

These triggers are replicated for convenient reference and include:

> Significant changes in the subcontractor’s leadership or personnel, around which the subcontractor must make notification to Magellan Complete Care as required under the terms of its contract with us;

> Trends in enrollee concerns, complaints, and grievances regarding unavailable or inadequate services, identified based on routine monitoring of standard reports by Quality Improvement and Customer Service;

> Trends in provider complaints regarding delays or lapses in payment, received anecdotally or otherwise;

> The subcontractor consistently fails to meet specific service-level requirements, especially those related to timely and adequate provision of services to Magellan Complete Care enrollees, based on routine monitoring and oversight of subcontractor performance by Vendor Management, Delegation Oversight, Compliance and other key areas of operations;

> The subcontractor’s financial statements, which are reviewed on at least an annual basis by Strategic Sourcing and more frequently as necessary by Magellan Complete Care Finance, fall below acceptable industry standards;

> The subcontractor experiences an incident of disruption in internal operations of a significant magnitude;

> The subcontractor fails one of our Compliance or Vendor Management audits or reviews, also performed routinely, in evaluating, by way of example only, provider payment timeliness; and/or

> Magellan Complete Care experiences significant and adverse changes in the subcontractor’s responsiveness to any of the triggers listed above or another issue of material concern to Magellan Complete Care and/or AHCA.

In the event that Magellan Complete Care considers it to be necessary, a pre-established and fulsomely-developed contingency plan for the subcontractor may be instituted in the event that significant concerns are presented regarding the subcontractor’s financial or operational stability.
and a transition to another solution is necessary. Otherwise, increased monitoring and oversight in the context of our applicable processes above is carried out to the nature, degree, and frequency as Magellan Complete Care considers to be necessary and appropriate.

**Evaluation Criteria:**

1. The extent to which the respondent provides a list of subcontractors it proposes to use under the SMMC Program for the delegation of work as described above.

2. The adequacy of the respondent’s oversight structure, including the extent of executive level staff participation.

3. The extent to which the respondent uses and monitors for service level agreements consistent with the SMMC Program Scope of Services.

4. The adequacy of the respondent’s approach to monitoring the quality of work performed by subcontractors, including the frequency and type of monitoring.

5. The adequacy of the respondent’s processes for addressing performance issues, including the triggers for increased monitoring activities, interventions and Contract compliance action.

6. The extent to which the respondent provides monitoring activities it will use to ensure the financial stability of the subcontractor, including the required financial reporting frequency for subcontractors.

**Score:** This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.
The respondent shall submit a sample contingency plan it would enact in the event a subcontractor to which the plan has delegated authority to manage utilization and pay providers on behalf of the plan, files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources.

Response:

OVERVIEW

Magellan Complete Care exercises robust subcontractor management, including ongoing updates to effective contingency plans in the event that a subcontractor that provides or supports critical services files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources. This is particularly essential for third parties to whom we have delegated authority to manage utilization and/or pay providers. In maintaining these contingency plans, Magellan Complete Care’s targeted focus is on continuity of care for our enrollees as well as timely and appropriate payment to providers. We also strive to minimize the operational impact on our business as well as adverse consequences to AHCA.

Magellan Complete Care’s Delegated Vendor Management team maintains a robust contingency plan for each delegated subcontractor. Each plan includes a comprehensive outline of change-specific steps and activities that must be completed to ensure a smooth transition from one subcontractor to another if necessary. These contingency plans include certain subcontractor-specific aspects depending on, for example, the nature and scope of services provided by the third party. There are common elements to these plans as well, including but not limited to: our approach to communications with various stakeholders, especially our enrollees and providers; notification of and cooperation with AHCA and/or other regulatory agencies regarding this type of situation; assurances that providers will be paid as appropriate; and safeguards for program integrity.

Each Magellan Complete Care contingency plan is subject to ongoing evaluation and updating by Delegated Vendor Management on at least a semiannual basis, as well as discussion and monitoring at least annually by Magellan Complete Care’s Delegation Vendor Oversight and Network Oversight Committees, both of which are part of our Quality Improvement Committee structure. A sample plan – the current contingency plan for our dental benefits administrator, DentaQuest – can be found in [General SRC #27, Attachment 1: Sample Vendor Contingency Plan].

More information regarding the development and implementation of these plans, as well as their structure and content, is outlined below.

CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT HAS OUTLINED...

We know that an effective contingency plan enables our organization to respond as proactively as possible when a subcontractor’s financial or operational “health” reaches an unacceptable level of risk. Delegated Vendor Management leads our efforts in this planning and transition to another subcontractor if we need to implement a contingency plan, involving various other critical departments. Any need to implement a contingency plan is overseen by a steering group made...
up of leaders tasked with ensuring appropriate and effective governance, including the Magellan Complete Care CEO, COO, and Compliance Officer.

Before any subcontractor contingency plan would need to be implemented, we exercise as much proactive subcontractor management as possible. We develop these plans in a considered and informed manner, and we use a number of controls to enable their effectiveness, including:

> Due diligence conducted prior to contract signing with each subcontractor to identify potential risk areas, as well as verification that the subcontractor has adequate financial resources to perform the contract and is qualified and eligible to contract with Magellan Complete Care under applicable legal and regulatory requirements

> Ongoing use of risk management and monitoring/oversight plans, to include regular review and updating as appropriate

> Inclusion of contract language in our written agreements with subcontractors that clearly identifies the notification expectations from the subcontractor, as well as the transition process, responsibilities, and timelines

> Development of robust contingency plans and strategy(ies), reviewed and periodically updated to support readiness to handle this scenario, however unlikely

> Using a contingency plan as the foundation, creation and execution of more detailed project plans at the time that a contingency plan would need to be exercised, addressing in more tactical and real-time terms activities included in the contingency plan and other tasks that can only be known at the time the contingency presents itself

> Assessment on an ongoing and periodic basis of the market to identify alternate subcontractors, and associated costs and transition timelines for each of these potential alternatives

Magellan Complete Care maintains a proactive and iterative approach to managing subcontractor performance, which includes but is not limited to comprehensive pre-delegation and annual auditing; routine and multi-disciplinary review of reports regarding compliance with AHCA and Magellan Complete Care requirements, service level standards, and other key indicators for all delegated functions; joint operations meetings with each subcontractor to discuss topics of interest or concern; use of corrective action plans when deficiencies are identified; and leadership oversight through our Quality Improvement Committee structure. In the context of this subcontractor management, Magellan uses the following data sources to trigger consideration of implementing the contingency plan:

> Significant changes in the subcontractor’s leadership or personnel, around which the subcontractor must make notification to Magellan Complete Care as required under the terms of its contract with us

> Material trends in enrollee concerns, complaints, and grievances regarding unavailable or inadequate services, identified based on routine monitoring of standard reports by Quality Improvement and Customer Service
Trends in provider complaints regarding delays or lapses in payment, received anecdotally or otherwise

The subcontractor consistently fails to meet specific service-level requirements, especially those related to timely and adequate provision of services to Magellan Complete Care enrollees, based on routine monitoring and oversight of subcontractor performance by Vendor Management, Delegation Oversight, Compliance and other key areas of operations

The subcontractor’s financial statements, which are reviewed on at least an annual basis by Strategic Sourcing and more frequently as necessary by Magellan Complete Care Finance, fall below acceptable industry standards

The subcontractor experiences an incident of disruption in internal operations of a significant magnitude

The subcontractor fails one of our Compliance or Vendor Management audits or reviews, also performed routinely to evaluate issues such as provider payment timeliness, for example

Magellan Complete Care experiences significant and adverse changes in the subcontractor’s responsiveness to any of the other triggers listed above or identifies another issue of material concern to us and/or AHCA

Our vendor risk and performance management tools are extremely helpful in monitoring for these triggers. As a particularly noteworthy example, Compliance 360, commercially available from SAI Global, is a governance, risk, and compliance (GRC) application used to manage third-party risk, among other functions. This tool serves as our central repository of subcontractor and vendor information and enables ongoing monitoring and oversight through system-configured workflows. Subcontractor contingency plans are formatted and stored electronically to allow ongoing assessment and monitoring to facilitate reference, review and follow up. With Compliance 360, we have the capability to run reports regarding a subcontractor that we may subject to closer scrutiny, such as in a circumstance where we have imposed a corrective action plan.

In the event that any one of these triggers becomes evident through our ongoing monitoring and oversight of our subcontractors, the Delegated Vendor Management team would immediately convene key business stakeholders, including the Magellan Complete Care CEO and COO, as well as our Compliance Officer and legal counsel; a decision would be reached regarding whether the risk has reached a level such that we need to explore or actually pursue other services alternatives and the timeframe within which that should occur. Once a decision is made to implement a contingency plan, Magellan Complete Care moves forward as quickly as possible.

In the event that any of these triggers becomes evident, or if a subcontractor were to file for bankruptcy without any prior indication or warning, our executive leadership team and the Delegation Vendor Oversight Committee would be convened on an emergent basis to make the decision to implement our contingency plan as quickly as possible.

Unfortunately, not all subcontractor risks can be avoided. However, we know that they can potentially and proactively be anticipated and effectively addressed with the right plans in place, so that adequate transition can be established in the unlikely event that a subcontractor failure of the type described occurs.
CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT OUTLINES A COMMUNICATIONS...

Once Magellan Complete Care determines that a subcontractor contingency plan must be implemented, one of the most essential and highest-priority aspects of this implementation is timely and informative communications to various stakeholders. Our contingency plans reflect the need to communicate the transition away from that subcontractor to another, as well as the overall framework, timing, and accountabilities for these communications. See [General SRC #27, Attachment 1: Sample Vendor Contingency Plan] as an example in our contingency plan for the Magellan Complete Care dental benefits administrator, DentaQuest.

Some of the communications, as well as their content, timing and delivery method(s), associated with our contingency plans are dependent on the circumstances of the contingency as well as the delegated functions the subcontractor performs on behalf of Magellan Complete Care. But in all cases, our Contract Manager notifies AHCA within 24 hours as required, and any other regulatory body as necessary, such as the Department of Children and Families or Medicaid Program Integrity, based on other applicable requirements and/or an assessment of those entities with a need to be informed.

Our notification to AHCA includes submission of a required subcontractor change/termination form, a subcontractor checklist, and any other written documents prescribed by AHCA; whenever possible – depending on the actual contingency that has triggered our plan to make a change in subcontractors – Magellan Complete Care will give AHCA 90 days’ written notice of this transition.

In addition, the Magellan Complete Care Contract Manager ensures throughout the process of implementing our contingency plan that AHCA has the information it needs to be satisfied that the transition is being implemented effectively. This includes, for example, enrollee and provider announcements, process workflows, eligibility transfer testing results, claims and encounters testing results, and transition/implementation staffing plans. Written documents are supplemented by verbal communications with AHCA representatives on topics and with frequency as determined by AHCA once we have notified AHCA of the planned transition.

Additional communication initiatives are referenced in the contingency plan and addressed in a more detailed communications plan developed and implemented by a multi-disciplinary workgroup led by Delegated Vendor Management and our Contract Manager in partnership with Compliance, Operations, Healthcare Marketing, Creative Services, and other areas as necessary. Delegated Vendor Management ensures the creation and implementation of the communication plan as part of its efforts to ensure a smooth transition under the contingency plan. Healthcare Marketing, with guidance from the other members of the group as well as assistance from Creative Services, creates content and documents, and implements fulfillment, delivery and publishing. Compliance ensures that our regulatory and internal requirements are met and our Contract Manager secures AHCA approvals.

This communication plan, supporting the contingency plan and incorporated into an overall project plan for the subcontractor transition, includes the following: all communications to be issued internally as well as externally, the target audiences for each one, key messages for each stakeholder group, and timing and method(s) of delivery for every communication. The communication plan, as well as actual communications, are reviewed and/or approved by key leaders on the Magellan Complete Care leadership team, including our CEO and COO, to ensure effectiveness, alignment, and transparency in our transition initiatives.
For communications with our enrollees, our priority is to notify them of the change from one subcontractor to another with enough lead time to avoid any potential disruption in their services. Therefore, our communication plans include as many forms of messaging as possible to reach Magellan Complete Care enrollees, including but not necessarily limited to a letter to all enrollees, an update to the Enrollee Handbook, new postings to our website, and articles in enrollee newsletters. Earlier in 2017, Magellan Complete Care transitioned to a new transportation subcontractor, Veyo (that we thought would serve our enrollees more effectively and efficiently – not because of any financial challenges experienced by our previous subcontractor). See [General SRC #27, Attachment 2: Total Care Bulletin], which was sent to our enrollees and includes an article about Veyo as an example of our communication approach. We also institute IVR and on-hold messages for use in our call center notifying a caller of the subcontractor change.

These enrollee communications are supplemented with internal communications created for and distributed to staff in those areas that have the greatest likelihood of direct enrollee contact, including Customer Service and Health Services. Frequently Asked Questions (FAQs) and scripts are typically used, particularly to address inbound calls with questions from our enrollees. An example in the context of our transportation subcontractor is a set of FAQs included in [General SRC #27, Attachment 3: Non-emergency Medical Transportation Announcement]. Training of Magellan Complete Care staff is conducted as necessary so that our teams are well prepared to address questions and requests for clarification.

We also conduct an enrollee impact assessment of our claims history to identify those enrollees who used the services of the subcontractor in the past. In some cases, particularly where quite a few of our enrollees have previously accessed the services of the outgoing subcontractor, we employ an outreach call campaign, carried out by Health Guides and Case Managers in Health Services and Representatives in Customer Service. Outreach is prioritized to target our highest-utilizing enrollees to notify them of the transition. If necessary, we make in-person home visits to enrollees most vulnerable to any potential interruption or disruption in service.

We take a similar approach with our providers; our communication plans include as many forms of messaging as possible to our network providers to further ensure smooth transition. That includes our issuance of a letter to the network, sent via U.S. mail and/or email blast, an update to the Provider Handbook, flyers distributed by Provider Support Specialists and Provider Relations staff during on-site office visits, provider newsletter articles, and website updates.

Since our Customer Services call center takes calls from both enrollees and providers, the FAQs and scripting we provide to our Representatives, as well as the IVR and on-hold messages, also supports requests for information and clarification from our network providers. Depending on the services delegated to the outgoing as well as incoming subcontractors, we also conduct training sessions in Town Hall and/or other provider-targeted meetings. Network providers, particularly those with open authorizations and/or claims, may also receive calls from Magellan Complete Care Network staff.

Our detailed communications plan is updated on a routine basis, and progress is monitored and discussed at frequent intervals by the communications workgroup described above.
CRITERIA 3: THE EXTENT TO WHICH THE CONTINGENCY PLAN INCLUDES STRATEGIES...

In the event a decision is reached to implement a transition away from a subcontractor experiencing financial challenges – or even significant operational issues regardless of their cause – our most current contingency plan serves as the foundation for our strategic approach to such an event accompanied by additional, more specific process steps as applicable for the particular situation. Where there may be open authorizations and/or pending claims associated with the outgoing subcontractor, a review of these authorizations is conducted for providers by Utilization Management, usually within 24-72 hours of the decision to implement a contingency plan. Data relied upon in conducting this review is typically the most recent open authorization in-network/out-of-network report from the subcontractor (assuming provider networking has been delegated by Magellan Complete Care), encounter data for the previous 12 months filed by the subcontractor with us, and/or another report we request as part of the transition. See, for example, the DentaQuest contingency plan found in [General SRC #27, Attachment 1: Sample Vendor Contingency Plan].

This review of authorizations will yield specific enrollee and provider situations that can only be addressed once known. But our priority is to ensure that providers with these open authorizations get paid timely and appropriately, thus reducing the risk that service to our enrollees might be interrupted. We consider the most effective resolution for many of these situations is to enter into a single case agreement with as many providers who have open authorizations as possible. Utilization Management will share the results of its open authorization review with the Magellan Complete Care Network team; that team will contact each provider and attempt to enter into such an agreement. Each single case agreement outlines the short terms arrangements between Magellan Complete Care and the provider regarding payment for services, among other matters.

To the extent that a provider is not willing to enter into a single case agreement or has a very limited number of open authorizations to be addressed, or the financial challenges experienced by our subcontractor do not allow us time to pursue that type of agreement with providers at the time that the contingency plan is implemented, we have a model pending claims process that will serve to ensure payment of providers just as effectively. This model was borne out of a situation in which one of our subcontractors, Univita (arranging for home care and durable medical equipment), ceased business operations precipitously. That experience, while challenging, allowed us to test our preparedness for expedited action, as well as to develop and apply lessons learned based on that experience.

More specifically, we developed a pending claims process for the Univita transition that serves as our model today because of its effectiveness and endorsement from AHCA. Under our Standard Contract with AHCA, no subcontract that Magellan Complete Care enters into with respect to performance under the Contract relieves us of any responsibility of the performance of duties under it. We recognize that Magellan Complete Care is accountable for all services provided to our enrollees and accompanying provider payments on valid claims, subject to certain conditions being satisfied by the provider (and with AHCA’s approval).

More specifically, our process contemplates that pending claims are paid under prescribed timeframes and guidelines that include:

>Submitted claims are for dates of service within a prescribed prior period
Claims for dates of service on or before a “trigger date” related to the date of the subcontractor's termination or suspension of operations must be submitted before a clearly identified due date, giving providers a reasonable and adequate period of time to make this submission. Submitted claims must include any prior authorization approvals or other documentation of approval for services rendered. Submitted claims must include clinical records, staff notes, or any other evidence of service delivery relevant to the claims. Any other relevant communications between the provider and the subcontractor regarding the submitted claims is included with the submission. Claims must be accompanied by an attestation signed by the Provider’s CEO, COO, or CFO with language that to the best of this official’s knowledge, information, and belief, the claims information and related documentation submitted is true, accurate, and complete (or words to that effect).

Of course this approach may need to be adjusted based on the specific circumstances associated with a given contingency of the type outlined here. But our single case agreement approach, this pending claims payment process, and/or whatever alternative would be used based on the specific circumstances is transparently communicated to providers as a critical component of our communications plan described in Criteria 2.

CRITERIA 4: THE EXTENT TO WHICH THE CONTINGENCY PLAN INCLUDES STRATEGIES TO PREVENT PROVIDER FRAUD AND ABUSE…
As the Magellan Complete Care sample subcontractor contingency plan found in [General SRC #27, Attachment 1: Sample Vendor Contingency Plan], indicates, efforts to ensure program integrity through the transition away from a subcontractor that files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources are included in these plans. More specifically, Magellan Complete Care’s Manager of the Special Investigations Unit (SIU) is a key member of the work group convened at the time that the contingency plan is initiated, and the team begins to assess the risk of potential FWA immediately.

Magellan Complete Care appreciates that in the event one of our subcontractors cannot or does not continue operations due to financial challenges, the health plan, our enrollees, and AHCA can be vulnerable to not only interruption/disruption of services, but also fraud, waste and abuse. These vulnerabilities prompt our SIU to assess program integrity risk from providers as well as the subcontractor to determine highest potential risk areas. Those risks, if any, are given prioritized focus and attention for review by our SIU team.

This prioritized focus and attention will most typically take several forms. First, the SIU will take the lead in coordinating and implementing additional control mechanisms on an expedited basis with various internal departments such as Health Services, Claims, Finance, and Operations to prevent FWA “leakage” during the transition. That might include, for example, retrospective review of all invoices from the subcontractor submitted in the last 90 days and audit of authorizations approved by the subcontractor during this same period. It might also include similarly stringent review by Magellan Complete Care of all provider authorization requests on a prospective basis...
during the period of transition from the legacy subcontractor to a new one. We might also require that provider claims be submitted directly to us, with adjudication based on increased pre- and/or post monitoring through edit or algorithm to identify potential red flags, duplicate claims, or inappropriate payments.

In any case, our SIU team would conduct an expedited review of any FWA allegations stemming from or related to the subcontractor’s financial challenge and the subsequent need for a vendor transition. Also, the contracts with our subcontractors, as shown in our sample DentaQuest contingency plan, require the subcontractor to maintain an anti-fraud plan and to report potential instances of provider (and enrollee) fraud to Magellan Complete Care. These obligations would remain in effect until the effective date of termination of the subcontractor’s agreement with our organization. Our SIU team would make inquiries of the outgoing subcontractor as to any such instances of which the subcontractor is aware and if any, follow up on that information as appropriate. In addition, the Magellan Complete Care SIU team would actively participate in an effective but accelerated pre-delegation assessment of the newly selected subcontractor to ensure this entity has adequate and programmatic controls and oversight in place to prevent, detect, and address fraud, waste and abuse.

This work would continue as long as necessary, but at least through any claims run-out period or any period requested by AHCA, whichever is longer. The SIU would, as a member of the established, multi-disciplinary contingency plan workgroup, provide updates to the greater group about any noteworthy findings on the pre-determined frequency and schedule. In the event that, for example, excessive fraud would be uncovered or proximate patient harm would be identified, the SIU would escalate the appropriate communications and work with other stakeholders to promptly address the findings.

**Evaluation Criteria:**

1. The extent to which the respondent has outlined the data sources it would use to trigger the respondent to put the contingency plan into play in advance of the subcontractor filing for bankruptcy or otherwise becoming unable to continue operations due to lack of financial resources.

2. The extent to which the respondent outlines a communications strategy in the contingency plan.

3. The extent to which the contingency plan includes strategies for ensuring providers get paid for situations where there were open authorizations.

4. The extent to which the contingency plan includes strategies to prevent provider fraud and abuse in situations where a subcontractor files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources.

**Score:** This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.
SRC# 28 – System Modification Protocol (Statewide):

The respondent shall describe, in detail the following change control IT processes:

a. How the respondent will initiate and coordinate internal modifications for any of its core systems (including, but not limited to, encounter submission, EDI/Clearinghouse, and financial reporting) or any potential subcontractor's core systems,

b. How the respondent will accommodate Agency-directed IT modifications; and

c. How the respondent will identify, track, communicate, and resolve IT production issues that affect internal or external stakeholders.

For each of the descriptions, the respondent shall also include the expected timeframes for making modifications, the prioritization process employed, the communication processes used for planned or unplanned changes, as well as status updates provided to employees, Agency staff, and providers. The descriptions shall also address testing procedures, production control procedures, and any applicable claims/encounter reprocessing for historical or retroactive system changes.

Response:

OVERVIEW

Magellan Complete Care follows an Agile approach to development that is centered in Design Thinking. This time-boxed, iterative, and user-focused approach to development and delivery enables us to build solutions incrementally from the start of the project, while maintaining the flexibility to make course corrections or changes quickly and efficiently. This continuous delivery approach also enables Magellan Complete Care to maximize internal and client resources while delivering a meaningful and useful product. Our approach is applied to all changes, including but not limited to: encounter submissions, claims processing, EDI/Clearinghouse, financial reporting, eligibility, fee schedule updates, new service codes, and reporting templates.

Magellan Complete Care leverages a robust, tried-and-true suite of information technology systems that are customized to meet the unique needs of our current SMI (Serious Mental Illness) Specialty Plan. Magellan Complete Care’s information technology department services and maintains these systems, employing the developers and analysts. This commitment gives us the advantage of quick action when there is a need for special configuration to address a customer requirement, as well as complete control of the change management process.

CRITERIA 1: THE ADEQUACY OF THE RESPONDENT’S IT PROCESSES …

When we receive any request to make system changes, whether the request originates from our customers or from internal stakeholders, we are very deliberate about our approach. We consider the pros and cons of making changes across our organization. We obtain feedback about the prospective changes from a broad stakeholder group, including our subcontractors, and then we develop a thoughtful communication and implementation plan. Prior to implementing the plan we seek AHCA approval as appropriate for the change. Upon completing the system modification,
we run parallel systems to validate the change and its impact on the system before making the permanent system changes.

Magellan Complete Care currently regularly receives system enhancement requests and/or system modification requests from AHCA. We address AHCA enhancement and modification requests appropriately, according to the nature of these requests. For example, we distribute fee schedule updates, new service codes or reporting template changes to the appropriate department leads and/or subcontractors for execution. These departments may include but are not limited to IT, Claims, Network Configuration and Health Services.

Our IT team then meets with the operational area to gather business requirements for the AHCA configuration change request. We evaluate the time required for development of the system change and review the upcoming configuration cycle to provide an estimated time of delivery. When a particular change request has the potential to affect Magellan Complete Care’s subcontractors and vendors, our Vendor Management team is included so that they notify the vendor of the request. The vendor then executes the request and reports back to the Vendor Management team that the request was successfully executed.

1.1 Change Management Process
Magellan Complete Care applies the same change management process to all IT system changes, regardless of the type of change. Encounter submission, EDI/Clearinghouse, financial reporting, and all other core system changes, such as eligibility and claims processing, follow the same work process. All system changes are managed according to our Software Hardware Data Change Management Policy [General SRC #28, Attachment 1: Software Hardware Data Change Management].

To identify and prioritize new system change requirements, a Magellan Complete Care employee creates a New Project Request (NPR) and then obtains leadership approval before routing it to IT. For emergency change requests, the employee contacts the IT Support Center, where one of our team members creates a Help Desk request ticket. When an NPR or ticket is activated and resources are assigned, the IT systems analyst works with the users to gather and refine the functional requirements associated with the requested change.

Once an issue requiring a change is identified, the impacted department head(s) give approval for the change before it is sent to AHCA. Examples of departments that can identify the need for a change include:

> Compliance Department (monitors AHCA communications outlining changes in enrollee benefits, changes to AHCA reports, changes to file layouts, corrective action plans, etc.)

> Quality Improvement (QI) Department (monitors changes to AHCA required performance metrics, NCQA, and HEDIS specifications)

> Network Department (monitors systemic claims or EDI issues)

> Finance Department (monitors changes to file layouts, payment or related financial systems)

Our Chief Operating Officer (COO) submits a summary of the proposed system change, when appropriate, to AHCA for approval and communicates the business need to our cross-functional departments. Magellan Complete Care then deploys a standardized implementation methodology
for our changes leveraging the cross-functional work teams and Subject Matter Experts (SMEs) in key areas. When appropriate, larger system changes are led by a Project Manager, who is charged with developing a work plan that supports the system change, testing, and deployment of all required information system functionality.

An IT project team then transforms the functional requirements into a technical design. A System Change Document (SCD) describes each component. If the development and testing processes subsequently demonstrate a need for additional changes, we evaluate the impact of each change, submit the proposed change for project management or Steering Committee approval, and update the change in new versions of the Business Requirements, Functional Requirements, SCDs, and testing plans, documenting the software development life cycle.

1.2 Magellan Complete Care’s Software Development Life Cycle and Version Controls
Each solution is created in a development environment, then promoted to a staging environment for testing. After testing and approval, the solution is promoted to the production environment for use. This process ensures that each environment affected by the solution is properly updated as changes are made. All of our development, maintenance, upgrades, repairs, etc., follow procedures outlined in Magellan Complete Care’s Software/Hardware/Data Change Management Policy [General SRC #28, Attachment 1: Software Hardware Data Change Management].

When working on a project, our programmers check out our source code from the secure development environment. Changes to the actual source code can only be made once a version of the source code has been copied from the secure development environment to the programmer’s personal development environment via an approved promotion request.

Changes to source code in the secure development environment are not possible and can only be made to the copy of the source code that has been placed within the programmer’s personal development environment.

As we create/modify programs, we use the "check-in"/"check-out" functions to maintain version control. This approach ensures that we:

> Coordinate changes across multiple projects
> Allow only authorized personnel to make changes
> Maintain an audit trail that identifies who has touched the code
> Obtain proper approvals before we promote changes to another environment

Once development is complete, programmers perform program and unit testing. After satisfactory testing, both the program source and objects are promoted to a secure testing environment. In this environment, our Systems Analyst performs more in-depth system integration testing before turning the project over to the business owners for user acceptance testing. In an iterative process, if any defects are found, the source code and objects are rejected from the secure testing environment and moved back into the programmer’s development environment for correction. Once errors are corrected, the source code and objects are moved back into the secure testing environment.

Once the Testing Phase is completed, changes are moved to a staging environment for implementation. Communication updates and training resources are distributed to affected users.
by way of our centralized notification process, and the required approvals from IT management and the change management process are recorded.

At the assigned time, authorized individuals move any source code or technical changes to the production environment. The project team validates the changes and then notifies the affected departments that the changes are ready for use.

Magellan’s web-based change management application, GetIT, serves as our repository of documentation for software changes and upgrades. This software enables IT personnel to communicate change activity to a central location, allows change information to be stored in a database, and provides real-time access to the current agenda and schedule of changes as well as past and future submitted changes.

1.3 Regulatory Compliance

Magellan Complete Care, as a public company, is required to comply with all aspects of the Sarbanes-Oxley Act of 2002 (SOX). This means that system changes must be documented and project requests are reviewed and approved. External auditors have verified Magellan Complete Care’s compliance since the inception of the requirements.

All changes to Magellan Complete Care systems are performed according to the rules set in our Software Hardware Data Change Management Policy. The purpose of the policy is to ensure that updates made to applications, systems, direct accessed data, and hardware are:

>Documented in a clear, concise manner
>Managed to prevent system/performance conflicts
>Scheduled to minimize impact on normal business operations
>Approved and communicated effectively to all IT departments and the user community
>Implemented to support efficient and stable updates in the future

1.4 Implementation of System Changes

Customer communication for system changes is managed by Magellan Complete Care. Typically, we apply changes to the system at off-peak hours, such as overnight on weekends when the potential of service disruption is the lowest. All affected entities are given multiple email notifications about the upcoming change and are informed that the referenced system will be unavailable for a specific period of time.

CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT’S IT PROCESSES...

As an incumbent providing services to AHCA, we have historically made changes and configurations to the system within 90 days. If a requested change is expected to require more than 90 days, Magellan Complete Care works with AHCA to determine a mutually agreeable delivery date. We understand that requests originating from AHCA may initiate from the Centers for Medicare and Medicaid Services (CMS), state-level legislative priorities, and other sources, and we know that these changes must be made in a timely manner.

Magellan Complete Care’s IT team is responsible for initiating change management to systems affecting AHCA. Those requests are considered top priority and are addressed immediately. Our IT Department employs the developers and analysts who service and maintain our internal systems, providing the advantage of quick action when there is a need for special configuration
to address AHCA’s requirements. Our Agile approach to development is time-boxed, iterative, and user-focused, allowing delivery of solutions incrementally.

All AHCA-directed modifications that require system modifications are communicated by Magellan Complete Care’s Account Manager. A request is submitted for a system modification, and this request is then tracked within Magellan Complete Care’s JIRA project tracking software. A case is submitted in the JIRA system for each request modification, and these modifications are tracked through updates to the JIRA case to complete resolution. All system modification requests are reviewed with the business leads to support documentation of requirements, testing scenarios, and timeframes for completion. After the system modification is configured, our IT QA testing team conducts testing in the system development and testing environments, and user acceptance testing (UAT) is completed with the business leads for the request. Only modifications approved through this system change process are moved to production, after successful completion of user acceptance testing. The system changes are then incorporated into updates to staff training and process flows, if the change requires a change in process. Confirmation of completion of the change is communicated back to the Magellan Complete Care Account Manager, Compliance Officer, and business leads for the request.

Magellan Complete Care’s Chief Operating Officer (COO) is the business lead for the monitoring, oversight, and implementation of needed system changes. The COO works closely with the Compliance Officer to ensure contract compliance according to the requirements of our contract including notification of AHCA, Magellan Complete Care staff, providers, enrollees, partners and other stakeholders as necessary. Our COO submits all communications to AHCA according to contract requirements before dissemination to providers and enrollees.

**CRITERIA 3: THE ADEQUACY OF THE RESPONDENT’S PROCESSES DOCUMENTED…**

Our data center is staffed 24 hours a day, 7 days a week. Magellan Complete Care staff members monitor the systems constantly to maintain uptime and performance. System capacity is forecasted regularly to ensure that adequate system resources are available to support current and future business. In the unlikely event of downtime, staff can contact our Information Technology Support Center (ITSC) 24 hours a day, and providers can contact Magellan Complete Care’s Provider Service Line for downtime procedures and estimated outage durations.

****Trade secret as defined in Section 812.081, Florida Statutes. The information on this page is also “confidential” and exempt from disclosure pursuant to Section 119.071(3)(a), Florida Statutes.****
hardware or system connectivity. The ITSC also supports Change Management and delivers email notifications for Outage Notifications, Global Outages and IT Advisories.

All IT-related requests, problems or issues are tracked within Magellan Complete Care’s GetIT system. The ITSC maintains the GetIT system but allows access for any IT staff supporting the Magellan Complete Care users. When the ITSC receives an issue, a GetIT event (ticket) is created with the employee demographics. If the issue cannot be resolved during first call, the ITSC assigns the ticket to the appropriate IT staff. Issues affecting a group of employees are considered “Global” and are routed using an escalation process. If the issue results in system downtime, we institute our outage management procedures. General issues are assigned via GetIT. A member of the assignment group resolves the issue or further assigns the ticket if necessary. Reports are taken weekly to manage tickets that have not been resolved within required time limits.

For emergency requests, the user contacts the ITSC, where a Support Center employee creates an incident in GetIT. When an NPR or incident is activated and resources are assigned, the IT systems analyst works with the users to gather and refine the functional requirements. The project team transforms the functional requirements into a technical design. A System Change Document (SCD) describes each component.

*****Trade secret as defined in Section 812.081, Florida Statutes. The information on this page is also “confidential” and exempt from disclosure pursuant to Section 119.071(3)(a), Florida Statutes.*****

Production server or system downtime are relayed to the ITSC and tracked in our IT service 3.1 Priority Criteria/Target Response Escalation/ Notification/ Additional Notification
Magellan Complete Care’s approach to categorizing and assigning priorities to defects and enhancements incorporates AHCA’s categories and prioritization priorities, which reference and include the definitions of urgent, high, medium, and low priorities.

3.1.a P1/Urgent
1. Used when a production system, database, service or application is entirely down
2. No one who uses this system, database or service can work at all
3. Network connectivity of an entire site is out, site power outage
4. For some mission critical SLAs for clients and/or state issues

Process: Immediate

P1 Notification list and group impacted will be paged and e-mailed upon assignment; Requestor will be e-mailed.

1. Escalation: every 15 minutes (until acknowledged)
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

2. The manager of the group impacted will be paged if no response from technician
3. If another level of escalation is in place, such as director, that page will go if manager does not respond. With each successive escalation the group and their management will be paged again.

> The P1 notification will be automatically notified with each "Status Update" entered. This needs to happen on hourly or otherwise notated intervals
> The business is sent updates on the same basis

3.1.b P2/High
1. A group of users (five or more, whole departments or site) is somehow unable to work but the overall system is operating
2. Site is experiencing slowness or general access issues (maybe raised if needed)
3. Application is experiencing slowness across multiple sites (maybe raised if needed)
4. For some single users for mission critical SLAs for clients and/or state issues

Process: Within one hour
1. Group impacted will be paged and e-mailed upon assignment and the Requestor will be e-mailed

Within four hours escalation
1. Technician’s manager will be paged if no response from technician
2. If another level of escalation is in place such as director that page will go if manager does not respond.
With each successive escalation the group and their management will be paged again.

3.1.c P3/Medium
1. Fewer than five colleagues are entirely unable to perform one of the major functions of the job
2. No workaround is in place or available
3. Getting a “Dr. Watson” error when opening an application

Process: Within one business day

The appropriate support group and requestor will be e-mailed upon assignment

Within three business days’ e-mailed escalation:
1. To the support group
2. Support group’s manager if no response from technician
3. If another level of known application support may be raised if needed
4. Escalation is in place such as director is emailed if manager does not respond
With each successive escalation the group and their management will be paged again

3.1.d P4/Low
1. A single user experiences a problem that may hamper, but not entirely stop productivity
2. Minor hardware issues
3. Password issues (e-mail, application, network, etc.)

Process: ranges between 30 minutes to five business days

The appropriate support group and requestor will be e-mailed upon assignment.
3.1.e P5/Projects
1. User request for additional system features and/or functionality. Example: minor group (up to 10) moves, adds, and changes; ordering or loading new software for individuals
2. User request for significant technical resources. Example: major group moves, adds and changes; group (off the self) software rollout
3. For software enhancements or upgrades work will begin as appropriate based upon development team’s assessment of the request
4. Projects and major group (11+) moves, additions, and changes will be project coordinated and committed based on available resources, but will require at least 15 business days advance notice

CRITERIA 4: THE ADEQUACY OF THE RESPONDENT’S COMMUNICATION PROCESS…
Magellan Complete Care has a strong communication process in place, both internally and externally, for when system issues and/or updates are identified, planned in advance or when there are issues with the functioning of the system. Planned updates to Magellan Complete Care’s or vendors’ systems are announced in advance so that the appropriate stakeholders (enrollees, providers, or AHCA) are notified in advance and can plan accordingly. These announcements are made via email and as announcements on Magellan Complete Care’s enrollee and provider websites. AHCA is informed directly and in advance of all changes by Magellan Complete Care’s Account Manager regarding upcoming changes or planned downtime. Most of the planned system updates are scheduled at off hours so its impact to the end-user is minimal.

When unexpected system functionality is disrupted, we initiate our Business Continuity Plan. This plan details procedures, in a step-by-step manner, for activation of recovery teams, immediate response, review and assessment, communications to staff and AHCA, relocation to a recovery site if needed, a detailed recovery process, and the resumption of business functions. Key Magellan Complete Care staff are notified of the issue causing the disruption, the systems impacted, back-up processes and the approximate length of time the system is expected to be disrupted. These types of disruptions are reported by the Magellan Complete Care Account Manager to the current AHCA contract manager as soon as they are announced.

Should a subcontractor experience an unscheduled system disruption, the subcontractor is required to notify Magellan Complete Care’s Vendor Management team as soon as possible, who in turn, notifies the appropriate Plan staff. The subcontractor then initiates their Business Continuity plan and follows predetermined procedures for review, assessment, and communication to staff, Magellan Complete Care and AHCA. Our Senior Director of Account Management is included in Business Continuity plan distribution list, who then notifies the AHCA contract manager of the system disruption.

When system enhancements and/or system modifications occur as a result of an AHCA announcement, Magellan Complete Care maintains communication with the AHCA contract manager should any barriers toward implementation be encountered and notifies the contract manager upon completion of the project.

Magellan Complete Care’s vendors follow a process that mirrors Magellan Complete Care’s communication of system changes process. The need for system changes are communicated to the affected vendor(s) from our Vendor Management team. The vendors then makes changes to their systems and communicate, via reports to the Vendor Management team, that the changes...
have been completed. These reports show that the vendor system processing matches the correct system enhancement configuration. Once the reports are audited and approved by our Vendor Management team, a file is sent to Magellan Complete Care for testing. We then run the files through our claims adjudication engine edits to verify the changes were made on the vendor system(s) and that the changes are accurate.

CRITERIA 5: THE ADEQUACY OF THE RESPONDENT'S APPROACH TO SYSTEM INTERNAL TESTING..

Magellan Complete Care is experienced in delivering code, interfacing with, and providing application updates to AHCA. We will continue to be a trusted partner by executing system(s) projects in distinct phases, with each phase having specific activities and deliverables and following a formal, customized work plan that controls every step to ensure system changes are accurate and timely.

When we complete the development process, our programmers perform program- and unit-level testing. After satisfactory testing, both the program source code and objects are promoted to a secure testing environment. In this environment, the systems analyst performs more in-depth system integration testing before turning the project over to the business owners for UAT.

During the testing phase, our systems analyst ensures all code mapping has been programmed correctly before moving it into Magellan Complete Care’s production environment. We develop and document various test scenarios, giving the testers a roadmap of the changes and expected outcomes of the testing scenarios. This activity is designed to ensure that the mapping of data from our vendor’s system to our system is accurate and that there are no adverse impacts resulting from the system changes. The data transfer process is tested during the file exchanges to ensure there are no issues with connectivity. The testing steps are as follows:

1. Development testing
2. AHCA/vendor/user testing
3. Internal quality assurance testing
4. Management approval of testing

When testing the implementation of, or changes to, a file exchange with AHCA or vendors, Magellan Complete Care requires at least two successful tests. Each of these tests includes the generation of the file, FTP exchange, and format mapping. In an iterative process, if any defects are found, the source code and objects are rejected from the secure testing environment and moved back into the programmer’s development environment for correction. After we correct all of the errors, the source code and objects are moved back into the secure testing environment.

A sample of a recent test plan for Magellan Complete Care is attached [General SRC #28, Attachment 2: Test Scenarios for UAT]. Upon completion of the Testing Phase, source code changes are moved to a staging environment for implementation. Communications to affected users are sent using our centralized notification process, and the required approvals from IT management, and the Change Management process are recorded in GetIT.

At the assigned time, authorized individuals move any code or technical changes to the production environment. The project team validates the changes and then notifies AHCA and affected departments that the changes are ready for use.
Vendors follow the same Software Development Lifecycle as Magellan Complete Care for their internal testing procedures. Once vendor internal testing is completed we perform additional testing to verify the system changes are processing as expected. The vendor then produces reports of system processing output and submits them to our Vendor Management team. These reports are then audited for accuracy and, if the results meet our expectations, then the reports are approved. After the reports are approved, test files are submitted to Magellan Complete Care by the vendor. We then run the test files through our claims adjudication engine to verify the configurations were made and processing correctly. We then generate a response file and submit this file to the vendor for processing. Once these files are successfully tested, through a complete cycle, the changes are moved to production.

CRITERIA 6: THE ADEQUACY OF THE RESPONDENT’S APPROACH TO INTEGRATION TESTING…

As the incumbent vendor of services for AHCA, we have our systems configured to serve the contract and anticipate no issues with additional configuration changes going forward. All development work, including configuration changes, are performed on a development environment to determine whether the requested changes will have an adverse effect on other systems.

During implementation, test files will be exchanged to ensure all mapping has been programmed correctly before moving it into Magellan Complete Care’s production environment. There is a minimum requirement of two successful test file exchanges to ensure mapping of data from one system to the other is accurate and there are no adverse impacts. The data transfer process is tested during the file exchanges to ensure that there are no issues with connectivity. The steps for testing are as follows:

1. Development testing
2. AHCA/vendor/user testing
3. Internal quality assurance testing
4. Management approval of testing

Magellan Complete Care will continue to work collaboratively with AHCA and our vendors to ensure that we use the most efficient data integration approach and make efficient use of the AHCA subject matter experts’ time. We design our streamlined process flows to alleviate as much of the administrative burden as possible for AHCA personnel.

Post-implementation testing is required for all data exchanges and must be completed immediately following the first scheduled execution of the job in the production environment, which may or may not immediately follow promotion of the project to the production environment. We complete post-implementation testing to ensure that data are accurate, are in the correct format, and that there has been no enrollee protected health information (PHI) violation. Both the Magellan Complete Care analyst and the programmer work together to complete the necessary documentation.

6.1. Post-Implementation Verification:
>Should contain the same tests that were completed in the secured test environment.
6.2 Data Integration
At the core of Magellan Complete Care’s value proposition is integration. As a standard starting point, our care management system includes an application that provides information on vendors, protocols, nuances and other cross-referral information to ensure ease of engagement with vendor partners as appropriate to meet treatment needs.

We find that a tailored approach to vendor interface best serves our customers. Magellan Complete Care’s current interface protocols with AHCA and vendors include ongoing data exchange, in which we send and receive eligibility, claims, provider authorizations, and pharmacy, vision, transportation, and lab claims for integration purposes. We provide a custom approach to working with AHCA and our vendors to deliver integrated programs and receive and exchange data.

Magellan Complete Care has extensive experience in establishing interfaces and data exchanges with our many customers’ diverse systems. We currently support 3,810 data exchanges in multiple formats, including secure file transfer protocol (SFTP), file transfer protocol secure (FTPS), file transfer protocol (FTP) with PGP encryption, EDI, real-time SOAP/XML, API, and RESTful exchanges. FTP with PGP encryption is Magellan Complete Care’s preferred process for transmitting and receiving files. The key to successful vendor interface efforts is pre-implementation dialogue with all vendors to identify and solidify AHCA’s health objectives and to diligently and collaboratively build interface processes that are seamless to the consumers, can be effectively supported by vendors, yield measurable outcomes, and ultimately result in holistic service delivery that improves health.

6.3 Complete and Accurate Data Exchange
Magellan Complete Care uses strict internal processes, procedures, and controls to maintain the quality and integrity of data received for and data conveyed to AHCA. Our systems validate transactions at various control points through loads, audits, reconciliation processes, and cross-reference reports. Operations staff monitors process outputs and reports to validate data integrity. These procedural and automated controls operate at appropriate points throughout the cycle. Magellan Complete Care’s standard data exchanges include the building of quality and monitoring measures using header, trailer, file counts, record counts, totals, etc. whenever available. Header and trailer records are utilized to track the completeness of any feed. Record level edits track and report all data additions, deletions, and changes.

Some of the many procedures that we use to ensure data quality and maintain the integrity of reference information include the following safeguards for processing inbound files:
Restricting critical fields to appropriate data types

Restricting critical fields to pre-defined lists of values

Linking associated fields to ensure data follows business rules

Comparing inbound files, before loading, against file specifications to confirm:
  >> Proper formatting
  >> Presence of required fields
  >> Number of records sent matches number received

Using secure transmissions to ensure against data loss
Safeguards for outbound files include the following:

Define formats according to appropriate data types, pre-defined lists, and business rules

Compare outbound files, before release, against file specifications to confirm:

Proper formatting

Presence of required fields

Number of records selected for sending matches number processed

Job transmission completion and statistics

We complete the following steps in support of support internal completeness and customer-initiated audits:

1. Log inbound and outbound files
2. Retain a copy of received and sent files
3. Retain records of items that required editing before filing or sending
4. Retain audit trails of critical data edited
5. Retain records of implementation of system changes, including requirements gathering through deployment of a new interface
6. Perform two full cycles of user acceptance testing before deployment of any system changes

Magellan Complete Care complies with all HIPAA Transaction and Code Set standards for the electronic processing of covered transactions. We commit to maintaining compliance with HIPAA, industry-standards, and AHCA data quality standards throughout the term of the contract.

CRITERIA 7: THE ADEQUACY OF THE RESPONDENT’S APPROACH TO APPLICABLE CLAIMS REPROCESSING...

Magellan Complete Care recognizes that events can occur that dictate a need to reprocess a set of claims. When system changes occur, for example retroactive changes to eligibility, our claims system automatically reads those changes and applies the updated eligibility to allow reprocessing of the claim using the updated information. By maintaining eligibility history within the system showing when an enrollee eligibility record was updated and for what date spans of
coverage, the process maintains a record of the state of the eligibility at the time of processing. This record allows for a complete audit cycle showing why a claim was paid or denied. We run a monthly Retro-Eligibility Listing report, which we use to perform monthly audits against claims paid or denied before eligibility corrections so they may be reprocessed accordingly. There are also circumstances where mass adjustments to claims are needed based on unforeseen events. As this need arises, Magellan Complete Care is equipped to reprocess claims in an automated fashion for outpatient claims with no coordination of benefit billing. We apply the following steps:

1. Our operations team works to clearly define the claims that need reprocessing.
   a. Providers are contacted to ensure their understanding of events to come and to communicate and agree to the list of claim lines for reprocessing.
   b. Our IT team is engaged to secure resources and identify timing for the reprocessing.

2. Claims Operations develops an Excel spreadsheet of claim lines that need reprocessing in a pre-defined format, which includes the definition of a note that is programmatically attached to claim history within the system for audit purposes. At this time a decision is made as to whether timely filing edits override is performed within the system (as applicable).

3. IT then processes these claims from the spreadsheet using an automated process built into the claims system.

4. IT performs a review of the results and sends the results back to the originator in Magellan Complete Care operations for their final review and approval.

5. Providers receive their standard notification of claims adjudication upon completion. By reprocessing claims, encounter submissions and appropriate adjustments are triggered automatically. No intervention is required to complete encounters.

7.a Subcontractor/Vendor Claims Processing
Magellan Complete Care is processing the majority of claims. In instances where a subcontractor/vendor is processing claims, we coordinate with our dedicated claims resource at the subcontractor/vendor to initiate and implement the same process outlined above. Once a system enhancement is identified there are a series of detailed business requirements and design sessions. These enhancements and system modifications that are identified go through a rigorous collaborative testing process between the subcontractor/vendor and Magellan Complete Care. Magellan Complete Care’s subcontractors/vendors follow a process that mirrors ours for processing claims for retroactive system and eligibility changes. The subcontractor/vendor takes a snapshot of claims for audit purposes to show how claims were originally processed. The vendor then makes changes to their systems and communicates, via reports to our Vendor Management team, that the changes have been made.

We audit these reports and verify that the reprocessing of claims on the vendor system match the correct system enhancement configuration. Once we complete our audit of these reports and the results have been approved by the Vendor Management team, a claim file is sent to Magellan Complete Care. The claims are reprocessed based on date of service, with the retrospective claims submitted to us on an 837 file. The claims are processed through our claims adjudication engine to verify the claims are being reprocessed correctly, and an 835 response file is generated back to the vendor verifying the changes made were accurate. To ensure the vendor and our
systems remain in sync, we perform ongoing monthly audits. To verify that all retrospective claims were processed, this monthly audit reconciles encounter counts on the vendor system match the counts on our system. These audits are also used to verify the accuracy of claims to ensure the retrospective claims are processed correctly.

Evaluation Criteria:

1. The adequacy of the respondent’s IT processes addressing internal modifications for its core systems and subcontractor’s systems.

2. The extent to which the respondent’s IT processes documented for implementing Agency-directed modifications is less than ninety (90) days.

3. The adequacy of the respondent’s processes documented for handling production IT system issues.

4. The adequacy of the respondent's communication process used when system issues/updates are identified and resolved by the respondent and/or its subcontractors throughout the change control process.

5. The adequacy of the respondent's approach to system internal testing to ensure the respondent's and/or subcontractors' system changes/updates are accurate.

6. The adequacy of the respondent's approach to integration testing to ensure the respondent's and/or subcontractors' system changes/updates do not adversely affect other systems, including systems operated by Florida Medicaid and subcontractors' systems.

7. The adequacy of the respondent's approach to applicable claims reprocessing for retroactive system changes, including processing performed by its subcontractor(s).

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.
a. The respondent shall submit a flow chart and narrative description of its encounter data submission process including, but not limited to, how accuracy, timeliness and completeness are ensured.

b. Completeness of encounter submissions requires that key fields are populated accurately for every encounter submission. The respondent must describe quality control processes that will ensure key fields including, but not limited to, recipient Medicaid ID, provider Medicaid ID, claim type, place of service, revenue code, diagnosis codes, amount paid, and procedure code are accurately populated when encounters are submitted.

c. The respondent shall demonstrate quality control procedures to ensure documentation and coding of encounters are consistent throughout all records and data sources (ASR, FMMIS, special submissions) and across providers and provider types. The description should include tracking, trending, reporting, process improvement, and monitoring of encounter submissions, encounter revisions, and methodology to eliminate duplicate data.

d. The respondent shall include any feedback mechanisms to improve encounter accuracy, timeliness and completeness.

e. The respondent shall include documentation of the most recent three (3) years of encounter data submission compliance ratings, corrective actions, if indicated, and timeframe for completing corrective actions for Florida Medicaid.

f. The respondent shall submit documentation describing the tools and methodologies used to determine compliance with encounter data submission requirements.

Response:

OVERVIEW
Magellan Complete Care is dedicated to the delivery of quality encounter data reporting and has implemented robust and comprehensive processes which are compliant with AHCA requirements associated with ensuring the accuracy, timeliness, and completeness of our encounter data submissions.

Since the inception of our current contract with AHCA, we have collaborated with AHCA to successfully design, develop, and implement Encounter Data Management processes that support multiple transmission standards in conjunction with the establishment of quality control measures and procedures to support operational objectives and compliance with encounter data submission requirements.

CRITERIA 1: THE ADEQUACY OF THE RESPONDENT’S PROCESS...
Magellan Complete Care has successfully managed, processed, and transmitted encounters with the state of Florida for each of the last three years. Accurate and complete encounter data starts with claims submitted by the provider, edits supported by our comprehensive Encounter Data Management process, and in our claims adjudication and payment system (CAPS) business rules, which have been configured specifically for Florida. Our encounter data submission process
begins with the automated selection of eligible encounters as defined by specified criteria resulting in the extraction of finalized paid and adjudicated claims, which is completed by our IT Claims Interface team to ensure data completeness. The next step involves the completion of data integrity validation and quality assurance, to ensure the accuracy in accordance with FMMIS 5010 specifications. We run an automated job scheduler to ensure timeliness.

Magellan Complete Care continues to refine all encounter related processing initiatives and will continue to adhere to contractual standards and measures to meet and exceed metrics and timeframes. Magellan Complete Care also continues to adhere to encounter submission standards in accordance with the ASC X12N 837 data exchange format, as outlined within the National Implementation Guides and FMMIS 5010 Companion Guides.

Magellan Complete Care’s standard format for exchanging encounter data is the ASC X12N 837. Magellan Complete Care has developed a Standard Companion Guide for this format that provides detailed information on exchanging electronic information with our trading partners. This Standard Companion Guide outlines our overarching requirements and includes security information, file format requirements, testing, response times, and interchange specifications. We use the interchange specifications provided in the National Implementation Guides and FMMIS 5010 Companion Guides to ensure the accuracy and completeness of Encounter data submissions. We also enforce multiple internal standards and controls. We pull adjudicated encounters directly from CAPS once claims processing is complete.

Upon completion of the 837 extraction process, we use the testing application defined by the state, EDIFECS Ramp Manager, as a testing and verification mechanism to ensure encounter claims pass syntax requirements, and that the specifications and guidelines for 5010 transactions are met prior to their submission to the state.

We schedule transmission of encounter data, including vendor data, as required by the State. Magellan Complete Care uses the HIPAA-compliant code sets for encounter submissions. We have implemented Sarbanes-Oxley guidelines that ensure accuracy, timeliness, and completeness of encounter data submissions for all Magellan Complete Care business.

1.1 Required Timeframe for Submitting Encounters

Magellan Complete Care recognizes the importance of meeting the contractual requirements for the submission of complete, accurate, and timely encounter data as defined below:

>For all services rendered to enrollees (excluding services paid directly by the Agency on a fee-for-service basis)

>After seven days following the date on which the Managed Care Plan adjudicated the claims

CRITERIA 2: DEMONSTRATED KNOWLEDGE OF THE COMBINATION OF KEY FIELDS NEEDED TO IDENTIFY SERVICES.

2.1 Encounter Selection Criteria

Magellan Complete Care supports the accuracy and completeness of encounter data throughout our entire data management process. We use our claims system to extract key fields associated with the encounter data, which then converts the data into the 837 format programmatically. Key fields, such as service-based procedure and enrollee diagnostic codes and provider demographic data are included in the encounter data extraction process. These key data elements associated
with the claims data that are selected for extraction are loaded to a Reconciliation File, which serves as an Encounter Tracker repository to support our claims tracking, trending, monitoring and reporting activities. Our system automatically performs a protected health information (PHI) check to ensure only appropriate claims are included. In addition, the following steps are performed:

> Fund IDs are assigned to eligibility in Magellan Complete Care’s claim system specifically by AHCA and line of business differentiations.

> Magellan Complete Care’s claim extraction logic extracts claims associated only with AHCA’s dedicated Fund ID(s) to ensure that encounters are for AHCA’s Managed Medical Assistance program enrollees only.

>> Claims finalized in the prior period or those specifically flagged to be resubmitted are extracted. Modified claims, including adjustments and voids are selected accordingly for the specified extraction time period and submitted as replacement or voided encounters respectively. Corrected encounters are marked for resubmission in the Encounter Reconciliation Application (ERA) tool and resubmitted off cycle.

>> Claims lacking a national provider identifier (NPI) or denied for certain “administrative” reasons are excluded from the extract due to the potential for encounter rejects for reasons such as missing procedure code, diagnosis code, enrollee not eligible, etc.

>> Plan denied claims are not included in the selection criteria.

CRITERIA 3: ADEQUACY OF PROCEDURES, INCLUDING QUALITY CONTROL PROCEDURES…

3.1 Encounter Data Quality Control

Magellan Complete Care has developed and received AHCA approval for our current Encounter Data Policy and Procedures [General SRC #29, Attachment 1: Encounter Data Policy and Procedures]. This document functions as the foundation for how we support the overall accuracy, completeness and timeliness of our encounter data management processes. Specifically, this document references and describes our internal processes, procedures, and controls to identify, validate, and maintain the quality and integrity of data received and selected for extraction. We perform a number of validation steps to ensure that electronically transferred claim or encounter files are accurately captured, received in their entirety and uploaded accordingly:

> Systems transactions are validated at various control points through loads, audits, reconciliation processes, and cross-reference reports.

> Operations staff monitors process outputs and reports to validate data integrity. Monitoring activities also include a review of the Encounter Combined Timeliness Report, published weekly by AHCA. This report is based on encounter data captured by DXC (AHCA’s fiscal agent). DXC uses the adjudication date that is sent at the line level of the encounter record (DTP segment) to determine timeliness span.

> Procedural and automated controls operate at appropriate points throughout the cycle.

> Magellan Complete Care’s standard data exchanges include the incorporation of quality and monitoring measures using header, trailer, file counts, record counts, totals, etc.
Header and trailer records are used to track the completeness of any feed. Record level edits track and report all data additions, deletions, and changes.

3.2 Safeguards
Magellan Complete Care uses the procedures listed below to ensure data quality and maintain the integrity of reference information as safeguards for processing outbound files:

> Define formats according to appropriate data types, pre-defined lists, and business rules

> Compare outbound files, prior to release, against file specifications to confirm:
  >> Proper formatting
  >> Presence of required fields
  >> Number of records selected for sending matches the number of records processed
  >> Job transmission completion and statistics

3.3 Delivery and Responses
Magellan Complete Care uses an automated job scheduler to ensure timely delivery of encounters. This process is scheduled to automatically run according to our contractual requirements to meet the guaranteed delivery date. Our Data Center Operations team regularly monitors our job scheduler and addresses any errors which may occur. We have also established a procedure where we manually review any job or FTP failure.

We use a reconciliation file to track all sent and not sent records, as well as responses. This step ensures all claims are accounted for and followed through the entire process to completion.

CRITERIA 4: ADEQUACY OF PROCEDURES TO ENSURE ENCOUNTERS ARE CODED CONSISTENTLY...

4.1 Encounter Responses
Magellan Complete Care applies our Encounter Data Policy and Procedures [General SRC #29, Attachment 1: Encounter Data Policy and Procedures] and related administrative rules in a manner that ensures encounters are coded consistently to all providers and provider types. Responses for the ASC X12N 837 transaction files are received by Magellan Complete Care via the 277, 999, and 835 formats, including the TA1 response file.

> The 277U identifies encounters/claims that are pended in FMMIS due to a provider related issue. These encounters are not finalized in FMMIS and thus not returned on the 835 response file

> The 999 acknowledges receipt of the file and identifies whether or not the file has complied with the syntax requirements

> The TA1 indicates that the file was received, but also indicates that errors exist within the envelope segments of the X12 file. Receipt of a TA1 response file is reflective of a full file rejection. In the event of receipt of a TA1, the IT Claims Interface representative works with the IT EDI and programming teams to resolve the errors for resubmission

> The 835 contains information regarding the status of the claim after it has been processed at FMMIS. This file identifies the 837 transaction records containing errors (denied encounters) requiring immediate attention and remediation
Denied encounters are loaded into the Encounter Reconciliation (ERA) tool for identification, analysis, and reporting.

We review errored transaction records using a root cause analysis methodology and we work these records accordingly to resolve for resubmission on the next outbound encounter file. To achieve consistent results in the accuracy of encounters submitted, the Magellan Complete Care EDM team follows a systematic approach to the monitoring, auditing and resolution of errors. The EDM team reviews all processes that impact the accuracy and completeness of the data received from providers, the processes used to generate the encounter files submitted to the FMMIS, and the actions required to correct and resubmit encounters as necessary. These processes include:

- Provider contracting and registration with FMMIS
- Provider loading
- Enrollment files
- Claims system configuration
- Appropriate service coding
- Benefits
- Provider submission of clean claims
- EDI Clearinghouse Issues
- Conversion of paper claims
- Claims pre-processing and other edits
- Claims adjudication issues
- Claims payment
- Encounter data extraction and file elements
- Submission and acceptance
- FMMIS rejection and encounter data correction.

Encounters that fail NCPDP edits, X12 (EDI) edits, or FMMIS system edits, that can be remedied are resubmitted within 30 days of receipt of notification of the failure. Further consideration is given to aged encounters exceeding recovery time limits or is not considered for an upcoming rate setting period. These encounters are marked as No Further Action in ERA.

Post reconciliation occurs as a follow up to each file submission. This process entails a validation of the claim counts reported on auto-generated file notifications against the file counts auto-populated on the attestation report that is submitted to the state.

CRITERIA 5: ADEQUACY OF PROCEDURES TO ENSURE ENCOUNTERS...ARE CONSISTENT ACROSS DATA SOURCES...
Magellan Complete Care applies our Encounter Data Policy and Procedures [General SRC #29, Attachment 1: Encounter Data Policy and Procedures] and related administrative rules (e.g., volume, categorization, dollar amounts, and dates) consistently to all subcontractors. We use the following internal processes, procedures, and controls to maintain the quality and integrity of data received from subcontractors:

- Systems validate transactions at various control points through loads, audits, reconciliation processes, and cross-reference reports
- Operations staff monitors process outputs and reports to validate data integrity
>Procedural and automated controls operate at appropriate points throughout the cycle.

>Magellan Complete Care’s standard data exchanges include the building of quality and monitoring measures using header, trailer, file counts, record counts, totals, etc.

>Header and trailer records are used to track the completeness of any feed. Record level edits track and report all data additions, deletions, and changes.

Our encounter reconciliation process is applicable to our data as well as our subcontractor data. We use a number of reporting sources and tools to identify finalized adjudicated paid claims in comparison encounters submitted to AHCA. We reference the Magellan Complete Care Medicaid (ITN) Finalized Claims and Total Paid Dollars report, generated by our Claims Reporting team, to obtain finalized and revised claim counts. These claim counts are reconciled against total encounters submitted, including encounters representative of new claims, resubmissions, and voids and replacements. Further consideration is noted for accepted and denied encounters, as a previously denied encounter submitted for a paid adjusted claim results in the submission of a new day original encounter, whereas a paid adjusted claim submitted for a previously accepted encounter results in the submission of a replacement encounter. We record variances to further support our monitoring, tracking, and oversight activities. We have also developed a subcontractor reconciliation process for the encounter data subcontractors collect. This process is a coordinated and collaborative effort requiring the actions and responsibility of multiple Magellan Complete Care departments. The overall objective is to ensure that each vendor meets Magellan Complete Care’s contractual obligation of a 95% Accuracy and Acceptance rate for encounters that are submitted to the state. Magellan Complete Care’s internal reconciliation target for encounter data received from subcontractors is 100%. We hold monthly internal meetings with representatives from each internal department, including the EDI, Encounter Data, Reporting, and Vendor Management teams. The purpose of these meetings is to ensure that all respective encounter performance targets are met and the prompt identification of corrective actions taken to resolve if targeted thresholds are not met. More importantly, the encounter reconciliation process serves as a control measure to ensure the completeness and integrity of encounter data received from sub-contractors.

CRITERIA 6: THE COMPLETENESS OF THE RESPONDENT’S FLOWCHARTS…
Magellan Complete Care has a fully defined and well-designed claims encounter data submission process, as illustrated in [General SRC #29, Attachment 2: Encounter Data Submission Process Flowchart]. This flowchart depicts how we ensure accuracy, timeliness, and completeness of encounter data. This process shows our approach to tracking, trending, reporting, process improvement, and monitoring of encounter submissions and encounter revisions. This comprehensive end-to-end process is comprised of activities completed by Magellan Complete Care’s IT Claims Interface, Encounter Data and Reporting, Information Technology, and other departments throughout the organization, including but not limited to Claims, Provider Network, Finance, and Compliance, including Magellan Complete Care’s Chief Operating Officer (COO) for oversight. Activities completed by the State, AHCA, and DXC, the State’s designated fiscal agent, are central to the encounter data submission process.
CRITERIA 7: THE ADEQUACY OF THE RESPONDENT’S MECHANISMS FOR TRACKING.
Magellan Complete Care’s comprehensive Encounter Data Management (EDM) approach includes an EDM team, robust claims payment systems, systematic processes for data extraction and data scrubbing, and, workflows and processes for resolving errors.

Magellan Complete Care’s Chief Operating Officer (COO/Contract Manager) is responsible for our EDM team activities. The Chief Operating Officer collaborates with internal and external business partners to ensure that high quality services are delivered according to state contract deliverables. Our EDM team is led by the Magellan Complete Care Claims/Encounter Manager, with direction from the Director of Analytics, and includes, but is not limited to, representatives from Claims, IT, EDI, Finance, and Provider data teams. Magellan Complete Care’s parent company, Magellan, provides additional expertise and IT expertise to support encounter data submission and error resolution as needed. Our Chief Executive Officer and COO or delegated representative, provides attestation to the accuracy and completeness of the data submissions to the Agency. Magellan Complete Care participates in Agency-sponsored workgroups directed at continuous improvements in encounter data and quality operations.

Our Claims/Encounter Manager is responsible for oversight of timely and accurate claims and encounters submittals and processing. This Manager establishes, monitors, and continuously improves processes and supporting policies and procedures that ensure the timely and accurate processing of claims and submission of encounter data and collaborates with the Compliance and Contract Manager as required. This Claims/Encounter Manager is also responsible for ensuring that claims are processed in accordance with reimbursement, timeliness, and accuracy requirements as well as developing and implementing processes that ensure accurate claim processing. The Manager is responsible for maintenance of applicable Magellan Complete Care policies and procedures, and supports claims payment integrity and procedural accuracy, as well as ensures turnaround time standards are met in accordance with the Magellan Complete Care’s AHCA contract. The Manager also identifies training needs, oversees the identification and pursuance of third party liability for enrollees who are enrolled in Magellan Complete Care with casualty insurance, tort claims and settlements or personal injury, and coordinates with the IT Administrator to ensure timely, accurate transmission of encounter files.

7.1 Magellan Complete Care Receipt of Inbound Claims Data
A provider creates a claim and submits it to Magellan Complete Care via EDI (Clearinghouses, Direct Submit, or the Magellan Complete Care Web Portal) or paper. The files from the Clearinghouses and Direct Submit are in X12 format and are validated using the EDIFECS system. Responses to these files are sent back to the submitting Trading Partner in the 999 and 277CA formats. All accepted claims are sent to the Claims system for auto adjudication processing.

Magellan Complete Care Web Portal claims are entered into the system by the provider and are auto adjudicated in real-time. The claims are validated for HIPAA compliance. No 999 or 277CA responses are created for this process. The provider immediately receives a status for the claim entry.

Magellan Complete Care receives, processes, and stores all encounter data files from our vendors. During the process of loading the data into the claim system, any error rejected is submitted back to the vendor to correct and resubmit to Magellan Complete Care. We retain submitted historical encounter data for a period of at least six (6) years.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Magellan Complete Care ensures the accuracy of the submitted claims through the claims adjudication process. The CAPS system is configured in accordance with the Florida Coverage and Limitations Handbooks. All incoming electronic claims are subject to WEDI SNIP 5 compliance and syntax checks. All claims, whether paper or EDI, are subjected to additional pre-processing edits to validate the quality of the data. These edits include additional syntax and compliance checks along with enrollee eligibility. Once incoming claims are accepted, claims are loaded into the CAPS claims system for processing. The claims are subjected to additional standard system edits such as verifying enrollee eligibility, checking provider status, validating that authorization requirements are met, ensuring the services are covered, services are coded correctly, and checking for duplicate claims.

CRITERIA 8: THE ADEQUACY OF THE RESPONDENT’S ENCOUNTER DATA SUBMISSION HISTORICAL COMPLIANCE RATINGS.
Magellan Complete Care has experience in the submission of quality encounter data and outcomes as supported by historical compliance ratings. Encounter data submission quality standards are met as established by the agency and as defined within the contract. The three key measures applicable to encounters are timeliness, accuracy, and completeness. In a review of the three year time period 2014 – present, timeliness submission measures have consistently exceeded 99%. Accuracy and completeness compliance ratings have consistently exceeded 95%, with emphasis on continual increased performance.

The most challenging encounter data we receive have been in relation to provider data. Therefore, Magellan Complete Care ensures the provider information supplied to the AHCA is sufficient to ensure providers are recognized in the state’s Medicaid system, for data acceptance purposes. Magellan Complete Care also works very closely with AHCA to provide feedback, examples, and suggestions for resolving any encounter related issue, as requested by the agency, to ensure the accuracy, timeliness, and completeness of encounter data as it pertains to enrollees and providers.

CRITERIA 9: THE ADEQUACY OF THE RESPONDENT’S ABILITY TO IMPLEMENT TIMELY CORRECTIVE ACTIONS TO COMPLIANCE RATINGS, IF INDICATED.
Although we have not implement corrective actions during our time as the incumbent, Magellan Complete Care is prepared to enforce stringent practices to promptly address corrective actions to compliance ratings, in the event corrective actions are assigned. This practice entails immediate internal escalation, documentation of the identified risk/problem, and the completion of root cause analysis along with required actions to address. The most important step entails the identification of efforts and execution of enhancements to ensure prevention of future occurrence(s).

Magellan Complete Care has worked closely with AHCA and DXC, the Florida Medicaid Management Information System (MMIS) Fiscal Agent, to develop efficient process innovations related to the MMIS. Examples of such improvements include the resolution of known issues as reported and published periodically by DXC via the Florida Medicaid Web Portal. As a result of these collaborative efforts, we have helped the state realize the following improvements:

>Updates to contract billing rules as a result of the root cause analysis associated with the assignment of FQHC denials. The inquiry submitted by Magellan Complete Care resulted in the
generation of OPS 5320. The MMIS changes implemented are tracked under CO# 94943. (Podiatry Contract Billing Rules). – xref 06-16-2016 Magellan Complete Care Visit Summary.

>File maintenance update to address the assignment of encounters containing modifier 91 which indicates “same day service”. The inquiry submitted by Magellan Complete Care resulted in DXC’s completion of CO 93635. This maintenance update prevents the duplicate edit from posting duplicate denial 97 N111 in this scenario. – xref 04-16-2016 Magellan Complete Care Visit Summary.

>The DXC onsite meetings also provide an opportunity for Magellan Complete Care to receive Information pertaining to the publication of updates pertaining to Expanded Benefits, Nursing Facilities, Patient Responsibility, and durable medical equipment (DME). Clarifications surrounding CORE/CAQH Compliant EOB documents and MMIS processing are also discussed. – xref 04-16-2016 Magellan Complete Care Visit Summary and the Managed Care Encounter Transactions 835 page of the Florida Medicaid Web Portal.

More recently, Magellan Complete Care has provided detailed examples of encounter scenarios to assist AHCA in reviewing the ongoing Medicaid policy decisions surrounding CSU, SIPP, Auto Crossover, Intensive Outpatient Substance Abuse, and Intensive Outpatient Chemical Dependency, along with the addition of new Bill Types. The final policy decisions will direct our encounter resolution efforts.

Magellan Complete Care serves as a key contributor to agency policy initiatives and the identification of encounter data anomalies with descriptions of the process submitted to the agency for review. These proactive measures have, and will continue to be beneficial to all participating plans. Magellan Complete Care will continue to participate in Agency-sponsored workgroups directed at continuous process improvements in encounter data quality and operations.

Magellan Complete Care is committed to ensure that the collection and submission of encounter data for all services rendered to enrollees are in accordance with established agency data quality standards. Magellan Complete Care will continue to enforce measures reflective of the standards as defined by the Agency to ensure receipt of complete and accurate data for program administration.

CRITERIA 10: THE ADEQUACY OF THE TOOLS AND METHODOLOGIES USED TO DETERMINE COMPLIANCE.
To support our efforts for ensuring accurate, timely, and complete encounter data, we monitor our performance through a set of Encounter Performance Statistics. These statistics, which we track and regularly report to AHCA, monitor our Claim Level Acceptance Rate, an internal measure, and the Florida Compliance Accuracy Rate for Medical Encounter submissions. The Florida Compliance Accuracy Rate is a contractual measure. Our methodology to calculate these measures is set at the error-code level, so if a single encounter submitted for a claim receives 3 separate errors, the encounter error is counted 3 times at the claim level. This rule is further compounded when it is applied at the claim line level. <<We meet with AHCA and DXC regularly and consistently receive positive feedback of our continuous process improvements.>>
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Magellan Complete Care collects and submits encounter data to DXC, the Agency’s fiscal agent, and we are responsible for errors or noncompliance resulting from our own actions or the actions of an agent authorized to act on our behalf. We maintain Encounter Data Policy and Procedures [General SRC #29, Attachment 1: Encounter Data Policy and Procedures], an established quality program, and systems to support our compliance with applicable standards, regulatory requirements, and the ability to consistently and reliably provide the covered services. We use our Encounter Reconciliation Application (ERA) tool for encounter reconciliation and performance tracking purposes. Any failures or rejections we identify during the extraction process are promptly resolved. Only fully compliant 837 files containing no errors are uploaded to the FMMIS web portal.

CRITERIA 11: THE ADEQUACY OF THE RESPONDENT’S PROCESS FOR CONVERTING PAPER CLAIMS...

We have developed and administer standardized encounter data management processes for paper and electronic claims. Our response will include references when we deviate from this common encounter data management process for a specific claim submission type (paper vs. electronic). Otherwise, our encounter data management policies and procedures apply to both paper and electronic claims.

11.1 Process for Converting Paper Claims to Electronic Encounter Data

Magellan Complete Care continues to offer providers the option of submitting their claims on paper. Paper claims are received and processed by Magellan Complete Care’s Claims Adjudication and Payment System (CAPS). Each day our mail room staff reviews, sorts, date stamps, and prepares the paper claims for scanning. We image all paper claims in-house through our Health Axis imaging system, which enables us to route the claim electronically within the department, eliminating paper handling. This feature improves our efficiency for processing claims and enhances our claim storage and retrieval process. Upon receipt, paper claims are sorted so claims that can be read by optical character recognition (OCR) are routed to our OCR transformation process. Claims that are successfully read by OCR are electronically transferred to the claims system. Claims that cannot be read by OCR or do not pass the OCR transformation process are routed to the appropriate data entry workflow queue. Magellan’s batch entry claim unit uses a desktop application (Image Worker) to view the image of the claim within the data entry workflow queue and enter the claim into the claims system.

We run compliance and syntax checks against the converted files using the Pervasive HIPAA validator tool. Claims that pass all check edits are loaded into the CAPS system and assigned a unique claim ID number. Our processors review applicable claim images to ensure that all data are correct before processing the claim. Claims that do not pass all check edits drop to an error report and the claims are not loaded into the system. The error report is worked daily by the Claims department and monitored by the Claims Manager. The processor pulls all images that were listed on the error report so that the claims can be reviewed to determine why the claim failed the edits. If the processor can verify that all information necessary to process the claim is present and correct, the processor enters the claim manually and the claim is processed accordingly. If data are missing or the claim is not eligible, it is returned to the provider along with a written explanation for the action taken. We generate a report for these claims, and use the results in our trending analysis and to identify potential provider education opportunities. Magellan Complete Care proactively conducts outreach to providers who are submitting paper claims to ensure they are aware of the multiple claim submission options available to the provider.
community. Currently Magellan has a 92% electronic claims submission rate, which enhances the provider’s practice management and cash flow objectives.

CRITERIA 12: THE ADEQUACY OF THE RESPONDENT’S APPROACH TO IDENTIFYING AND CORRECTING SPECIFIC PROCESSING/SYSTEMS ISSUES…
Magellan Complete Care has instituted several quality control measures to avoid the submission of invalid data to AHCA. Our approach to identify processing and systems issues involves quality assurance and safeguards. Magellan Complete Care applies internal editing tools, completes a weekly reconciliation that we review during our weekly claims operations meeting, and uses the Encounter Reconciliation Application (ERA) tool. Magellan Complete Care has implemented an encounter denial resolution process that incorporates system enhancements and explores opportunities as reported to the agency.

Magellan Complete Care’s Encounter Data Policy and Procedures [General SRC #29, Attachment 1: Encounter Data Policy and Procedures] describe the internal processes, procedures, and controls we have in place to maintain the quality and integrity of data received from subcontractors and selected for extraction. The following validation steps are performed to ensure that electronically transferred claim or encounter files are accurately captured, received entirely, and uploaded accordingly:

> We validate our claims and encounter systems and related transactions at various control points through loads, audits, reconciliation processes, and cross-reference reports

> Our operations staff monitors process outputs and reports to validate data integrity. These monitoring activities also include a review of the Encounter Combined Timeliness Report, published weekly by AHCA. This report is based on encounter data captured by DXC, the AHCA fiscal agent. DXC uses the adjudication date that is sent at the line level of the encounter record (DTP segment) to determine the timeliness span

> Procedural and automated controls operate at appropriate points throughout the cycle

> Magellan Complete Care’s standard data exchanges include the incorporation of quality and monitoring measures using header and trailer records, file counts, record counts, totals, etc.

> Header and trailer records are used to track the completeness of any feed. Record level edits track and report all data additions, deletions, and changes

12.1 Safeguards
Magellan Complete Care uses the procedures listed below to ensure data quality and to maintain the integrity of reference information as safeguards for processing outbound files:

> Define formats according to appropriate data types, pre-defined lists, and business rules

> Compare outbound files, prior to release, against file specifications to confirm:  
  >> Format files correctly
  >> Verify the presence of required fields
  >> Validate that the number of records selected to send matches number of records processed
  >> Document the completion of job transmission completion and statistics
12.2 Process Improvement and Collaboration

Internal Encounter Denial Work Group meetings – In these working sessions, individual claim examples are reviewed for in-depth analysis and investigation of claims adjudication and system configuration. The goals are to perform complete collaborative root cause analysis and to identify resolutions for encounters that can be remedied for resubmission to state, improving encounter accuracy, timeliness, and completeness.

DXC onsite meetings occur every 6 – 8 weeks. The purpose of the meetings is to discuss any relevant encounter related issues with direct input from DXC and AHCA. We also discuss process clarification, upcoming initiatives, and denied encounters requiring further direction and feedback. Magellan Complete Care is an active contributor by raising and identifying issues and inquiries, as well as solutions and remedies sponsored by AHCA, which are subsequently beneficial to all plans.

CRITERIA 13: THE ADEQUACY OF THE TOOL TO ENSURE THAT ALL ENCOUNTERS ARE SUBMITTED.

13.1 Tracking and Reporting

Magellan Complete Care has defined specific criteria, which are invoked within the automated identification and selection of eligible encounters, resulting in the extraction of finalized paid and adjudicated claims. This activity is completed by our IT Claims Interface team to ensure the completeness of encounter data reporting.

Our Encounter Data and Reporting team also performs weekly reconciliation and generates monthly performance statistics to further support our monitoring efforts. Once we upload and deliver the 837 files to AHCA 999, 277U, and 835 response files are generated by AHCA. We retrieve these response files via an automated process, which is initiated by our IT Claims Interface team. The response files are placed in an internal Magellan Complete Care FTP folder. We load these response files into our Reconciliation File, which is maintained by our IT Claims Interface team. A further review of the response files is performed via an automated process, to determine if the encounter was accepted or denied by the state. If the encounter was accepted, no further action is needed and the process is ended.

If the encounter was denied, the denied transaction is loaded into the Encounter Reconciliation (ERA) tool maintained by our IT department. The ERA tool enables us to load all response files from FMMIS, and matches negative responses to the original encounter submission and identifies the encounters that need to be reworked and retrigged. ERA also sorts and categorizes encounters to allow Magellan Complete Care staff to identify mass resubmissions as corrections are made. Furthermore, encounter details along with selected claim details are loaded into our Business Analysis and Reporting Tool (BART) that is accessible via an internal website. This internal website contains interactive reporting tools dedicated to encounters. Reports include Encounter Trends, Encounter Performance Summary, and Encounter Details, which further support process improvement and monitoring initiatives. Our Encounter Data and Reporting team is responsible for ensuring the completion of root cause analysis and resolution of all denied claim and encounter data. Final resolution of these cases frequently involves further review and confirmation of the root cause by the applicable Magellan Complete Care department, such as our Claims or Provider Network teams. There are also instances in which the root cause analysis requires submission of an inquiry to AHCA, via the Contract Manager, or DXC, via the Encounter Data and Reporting team for further clarification regarding the denied claims.
We follow our reconciliation processes, as previously described, to further support our monitoring and control objectives. We use a number of tools to support this effort beginning with the claims adjudication system, and including associated system platforms used for encounter extraction, tracking, and reporting purposes.

All denied encounters are loaded into the Encounter Reconciliation Application (ERA) tool. Encounter denial reports are generated from this tool. These reports are used to create the Encounter Performance Statistics and Encounter Denial Summary reports. The Encounter Performance Statistics report provides data pertaining to the Claim Level Acceptance Rate and the Florida Compliance Accuracy Rate for Medical Encounter submissions.

Currently, we prepare the majority of the reports manually, resulting in additional time and validation of resources to ensure accurate completion. Magellan Complete Care continues to leverage technology to increase efficiencies through our continuous process improvement approach and we have developed an interactive dashboard that allows for even more real-time management of the encounter process.

The development of an Encounter Data Warehouse or Repository is also currently underway to further support our continuous process improvement approach. We will incorporate additional controls in our data warehouse to further ensure the accurate capture of data for reporting optimization and efficiency.

**Evaluation Criteria:**

1. The adequacy of the respondent's process to ensure accurate, timely, and complete encounter data.
2. Demonstrated knowledge of the combination of key fields needed to identify services.
3. Adequacy of procedures, including quality control procedures, to identify key fields and ensure they are accurately populated during encounter data submission.
4. Adequacy of procedures to ensure encounters are coded consistently across providers and provider types.
5. Adequacy of procedures to ensure encounters (volume, categorization, dollar amounts, dates) are consistent across data sources, including applicable subcontractors.
6. The completeness of the respondent’s flowcharts describing its encounter data submission process.
7. The adequacy of the respondent’s mechanisms for tracking, trending, monitoring encounter submissions and revisions, including the type and frequency of activities, and methodology to eliminate duplicate data.
8. The adequacy of the respondent’s encounter data submission historical compliance ratings.
9. The adequacy of the respondent’s ability to implement timely corrective actions to compliance ratings, if indicated.

10. The adequacy of the tools and methodologies used to determine compliance.

11. The adequacy of the respondent’s process for converting paper claims to electronic encounter data.

12. The adequacy of the respondent’s approach to identifying and correcting specific processing/systems issues that could result in invalid data being submitted to the State.

13. The adequacy of the tool to ensure that all encounters are submitted.

Score: This section is worth a maximum of 65 raw points with each of the above components being worth a maximum of 5 points each.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 30 – Encounter Submission for Sub-Capitated, Subcontracted, Non-Pay and Atypical (Statewide):

The respondent shall describe how it will work with providers, particularly subcapitated providers, subcontractors, atypical providers, and non-participating providers to ensure the accuracy, timeliness and completeness of encounter data.

Response:

OVERVIEW

Magellan Complete Care recognizes the importance of accurate, timely, and complete encounter data for all providers, including subcapitated providers, subcontractors, atypical providers, and non-participating providers, and we are in full compliance with AHCA’s requirements. Overall, we have developed a standardized approach and we apply the same encounter data management processes consistently with all provider types and subcontractors. Our response will include references when we deviate from this common encounter data management process for a specific provider type or subcontractor. Otherwise, our standard encounter data management policies and procedures apply to subcapitated providers, subcontractors, atypical providers, and non-participating providers.

Since the inception of our contract with AHCA, Magellan Complete Care has designed and successfully implemented a comprehensive Encounter Data Management (EDM) approach that includes ensuring timely, complete, and accurate processing of encounter data from our providers. Our EDM process supports multiple transmission standards working with health plans and state designated fiscal agents. We understand the challenges of providing consistent support across all provider stakeholder systems. We have dedicated staff to manage the technical aspect of the encounter data management process, and we also have staff who work proactively with the provider community and our other trading partners to educate, train, and support their ability to effectively participate in the encounter process.

Our provider support and EDM teams will continue working together to implement iterative processes to ensure the accuracy, timeliness, and completeness of encounter data. Magellan Complete Care Provider Optimization Delivery System (PODS) teams regularly review and annually revise their comprehensive, detailed plans, which are designed to ensure prompt payment to our providers and support the collection of high-quality encounter data.

PODS is at the core of our provider network management and relations activities and provides an integrated provider relations team organized for each region in the state. Each region-specific team has a Contract Manager, Field Network Coordinators and a Contract Network Coordinator, all of whom report to a Director of Network Management who reports to the National Vice President of Network Development. Each region-specific team also includes a local Provider Support Specialist team. These teams consist of licensed behavioral health clinicians or RN’s with significant behavioral health experience. These highly trained and qualified clinicians, who are expert at working with enrollees living with serious mental illness (SMI), enable us to be more effective with providers and their office staff. Magellan Complete Care offers this approach because it provides the optimal structure to accentuate our existing medical and behavioral health provider knowledge base, and our existing knowledge of resources, community, and other provider stakeholders. The same teams are responsible for all medical and behavioral health
providers, facilities, and ancillary providers in their assigned regions. The teams are charged with supporting the contracting process, providing management and technical assistance, conducting site visits, and providing education to network providers. This model reinforces our continued commitment to our high-touch involvement with our providers to maximize plan operations and enrollee outcomes. The following points demonstrate the value of the PODS approach.

> Provider collaboration and information sharing is the foundation for the success of our model. PODS revolves around provider engagement by building solid and meaningful relationships, which ultimately drive provider satisfaction and Magellan Complete Care’s success through membership growth and quality of care.

> PODS creates a structure for integration and provider collaboration between medical and behavioral health providers as well as community support services (e.g., nursing, ARTS, LTSS, housing, residential, etc.). This integrative structure provides a primary account manager for all business units when dealing with issue identification and resolution, and medical and quality management initiatives.

> PODS individuals are cross-trained teams of network and provider relations specialists who focus on specific areas of the State and regions in providing continuity and consistency for the providers.

> PODS specialists work in close coordination with the enrollee’s assigned Magellan Complete Care Health Guide.

> PODS specialists are accountable across multiple Magellan Complete Care departments, including credentialing, health services (utilization management, care coordination, case management, disease management, and health promotion), claims, marketing, training, quality, customer service, and other department representatives, as appropriate. PODS specialists address issues related to network access and monitoring availability, quality issues, continuous performance improvement, innovative reimbursement methodologies, and new program development.

> The PODS structure offers a mechanism to enhance seamless collaboration with all functional areas to ensure quick and efficient issue resolution within the provider networks.

The PODS model has been a useful approach in helping us foster healthcare integration at the systems and services level by ensuring superior collaboration and communication with our providers to lead to better healthcare outcomes.

CRITERIA 1: THE ADEQUACY OF THE RESPONDENT’S APPROACH TO ENSURE...

Magellan Complete Care will continue to leverage its existing infrastructure to effectively submit encounters. For Magellan Complete Care encounter data to be accepted by the Florida Medicaid Management Information System (FMMIS), providers must be known to our system through enrollment in the fee-for-service (FFS) program or registration as a Magellan Complete Care provider. We ensure all providers, including capitated and subcapitated providers, as well as <<atypical providers and non-participating providers>> who serve our enrollees (whether inside or outside our network) are eligible for participation in the Medicaid program. A reconciliation process occurs for all encounters.
Monthly, we apply a full end-to-end reconciliation process of encounter data received from capitated and subcapitated providers to verify and ensure providers are performing the activities we have established in our capitated or related contractual arrangements. This reconciliation ensures that all encounter data that is received electronically, is captured within our claims adjudication system (where applicable), and is selected for submission to AHCA successfully. The reconciliation process for both capitated and subcapitated providers is a coordinated and collaborative process requiring actions and responsibility of multiple departments, including EDI, Encounter Data and Reporting, Claims, and Vendor Management.

The results of this cross-departmental process are to identify variances or anomalies specific to a capitated or subcapitated provider, to further support educational and outreach efforts, where applicable. We require each provider to have a unique Florida Medicaid provider number, Medicaid provider registration number, or documentation of submission of the Medicaid provider registration form.

For those providers submitting encounter data without Medicaid IDs, we work with the provider to complete the registration options as defined by AHCA. These options consist of either registering directly through Magellan Complete Care, or applying directly to Medicaid via the online enrollment for Limited or Full Enrollment. Either option results in the assignment of a Medicaid ID for the submission of encounter data.

Our PODS teams also work with providers to obtain accurate information at the time of contracting and credentialing to ensure complete provider loading, including the completion of provider registration with FMMIS as described above. These dedicated resources actively monitor who has and who has not registered with Medicaid. These teams also provide training and support to providers, to make the registration process as effective and efficient as possible.

Encounter transaction records that are returned due to the assignment of a denial on the 835-response file, are reviewed for root cause analysis and worked accordingly to resolve for resubmission on the next outbound encounter file. We use the Provider Master List (PML) for initial verification and to reconcile demographic data between Magellan Complete Care and Medicaid. Magellan Complete Care will continue to work closely with AHCA and the fiscal agent, as an active contributor in defining solutions and remedies to mitigate provider related denials.

CRITERIA 2: THE ADEQUACY OF THE RESPONDENT’S APPROACH TO EDUCATING...
To ensure the accuracy of encounter data, Magellan Complete Care provides extensive training to providers regarding claims submission and the importance of key field combinations, such as service-based procedure and enrollee diagnostic codes and provider demographic data, coding accuracy, consistency, and completeness associated with the services provided [General SRC #30, Attachment 1: Encounter Data Training Material]. Education on claims submission and payment processes is a core component of Magellan Complete Care's provider training activities. Our goal is to ensure that all providers are comfortable with the claims submission process well in advance of submitting their first claim to Magellan Complete Care, as well as throughout term of our contract with AHCA. Our initial provider training addresses consistent coding and encounter submission requirements. In the first 12 months following the implementation of our current contract, we also addressed these claims, encounters, and key field-related issues during our regular claims training sessions. Currently, we provide claims processing and payment training.
as dictated by the needs of our provider network. This training is also provided to internal Magellan Complete Care departments to support ongoing awareness.

Extensive reporting identifies root-cause analysis to improve encounter acceptance rates continuously. Provider engagement and education opportunities are reviewed during weekly multi-department calls. General education opportunities are addressed via a portfolio of global communication channels, and targeted educational opportunities are addressed directly and in collaboration with providers. Joint education includes SMEs as needed from Magellan Complete Care and form the provider to address the educational opportunities. This focused provider education is conveyed through a number of direct provider conduits, including joint operating committees, network contracting, provider relations managers, claims and encounter experts, operations, and other SMEs as needed.

Magellan Complete Care collaborates with providers to jointly improve encounter acceptance through data completion and coding consistency. Education is an ongoing topic through all provider communication channels and incorporates guidance from our provider advisory board, joint operating committees, and direct engagement through our internal Provider Network, Provider Relations, and Health Services departments as well as our call center. Key indicators are tracked and monitored to ensure that the intended progress is realized. All channels of provider engagement are tracked to ensure continuity of messaging and education as well as ongoing improvement, e.g. provider inbound and outbound call reports, encounter acceptance and root cause statistics, provider and Magellan Complete Care collaborative meetings, etc.

CRITERIA 3: THE ADEQUACY OF THE RESPONDENT’S APPROACH TO ENSURING THAT ALL PROVIDERS...PROVIDE AN AMOUNT OR COST OF THE MEDICAID SERVICE PROVIDED....

Magellan Complete Care contractually requires all providers, including subcapitated providers and subcontractors, to submit all of the costs associated with the Medicaid service they provide (including pharmacy paid amount). For pharmacy claims, we document the amount or cost of the Medicaid service provided that was actually paid to the pharmacy excluding any PBM or other administrative costs.

For example, Magellan Complete Care uses an integrated plan pharmacy benefit management MagellanRx, (MRx) model. For pharmacy network management, we use the established MRx national contracts with chain drugstores, Pharmacy Services Administrative Organizations (PSAOs), and other independent pharmacies including clinics and hospitals. Due to our integrated module, MRx is able to pass-through actual pricing charged by the pharmacy for dispensing medications (ingredient plus dispensing fee).

What this means is that Magellan Complete Care, as the plan sponsor, pays the actual contracted discounts and dispensing fees that MRx has negotiated with the retail pharmacy network and accordingly, the network rates negotiated by MRx with pharmacy network providers are identical to the pricing invoiced to Magellan Complete Care. As improvements or changes are made in these contracts, they are immediately available to Magellan Complete Care. There is no spread pricing in place, where MRx would pay the pharmacy provider one fee and pass on another to Magellan Complete Care.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Transparency is accomplished through auditing as well as by having complete and unfettered access to the pharmacy claims processing system which shows how a claim is paid. MRx provides a complete claims file to Magellan Complete Care quarterly and annually as well as access to our pharmacy provider contracts. In addition to using this file for monitoring fraud, waste and abuse, Magellan Complete Care conducts random and quarterly audits on all claims to ensure that the cost of the medication provided is the amount that was actually paid to the pharmacy excluding any PBM or other administrative costs.

CRITERIA 4: THE ADEQUACY OF THE RESPONDENT’S APPROACH TO EDUCATING AND SUPPORTING PROVIDERS WHO SUBMIT PAPER CLAIMS

Magellan Complete Care actively encourages providers to submit their claims through EDI, and we deliver information regarding the benefits of electronic claim submission through routine education and training sessions as well as on-site office visits. Providers who have questions about submitting paper or electronic claims, can reach us at our provider line: 800-327-8613, by physical mail at our mailing address, or by using a dedicated Magellan Complete Care email box. Providers can also reach us directly through their provider (POD) representative.

We know electronic claims submission is less costly to the provider and allows Magellan Complete Care to expedite payment of their claims and improve the integrity of the encounter data we submit to AHCA. We have learned, by working with providers who support our enrollees who are living with SMI that many providers are not part of larger health systems and may be more inclined to work in smaller or solo practices. This provider model sometimes results in providers not being able to invest in, or take advantage of, EDI technology. Our PODS team and Provider Support Specialists (PSS), who are licensed clinicians provide administrative support to our providers, work with these providers to explain the EDI claims submission process and sometimes just expose providers to opportunities for streamlining their administrative practices. We believe the PODS team and our PRM team bring credibility to provider practices. For example, the PRM team provides education about the advantages and benefits of electronic claims submission, which include:

>Minimizing claim rejections and resubmissions  
>Delivering claims to health insurers in real time  
>Expediting payer responses and increase cash flow  
>Freeing up time for revenue-enhancing functions, such as ensuring correct payment  
>Reducing claims submission costs

Magellan Complete Care will continue to provide technical assistance and facilitate enrollment in services that provide the capability for electronic claims submission. One resource we use is the American Medical Association Claims Submission Toolkit. This online resource is available to providers and can assist them in the transition from paper to electronic claims submission. In addition to the provider outreach activities delivered through our PODS personnel and PSS representatives to encourage adoption of EDI claims submission, Magellan Complete Care reinforces the advantages and benefits of electronic claims submission versus paper submission through our routine use of newsletters, provider bulletins, orientation webinars, and provider workshops.

For those providers who cannot immediately or easily transition to electronic claims submission, Magellan Complete Care’s PODS personnel and PSS field representatives provide technical
assistance to promote the timely submission of complete and legible paper claims, such as the proper use of HIPAA compliant CMS 1500 and CMS 1450 forms.

Magellan Complete Care receives quality data from submitted paper claims converted to 837 files and entered into the claim system. Once the claim is entered into the system, the claim is processed and subject to the same edits as claims submitted via EDI. If a claim is missing data or the claim is not legible, the claim is returned to the provider with a letter of explanation. Magellan Complete Care’s PSS field representatives track and trend this information and provide feedback and follow-up education to improve the accuracy. Our Claims Adjudication and Payment System (CAPS) system captures and stores the original raw data for triage and provider follow-up.

CRITERIA 5: THE ADEQUACY OF THE RESPONDENT’S APPROACH TO ENCOURAGING PROVIDERS, PARTICULARLY SUBCAPITATED PROVIDERS, SUBCONTRACTORS, ATYPICAL PROVIDERS...

5.1 Provider Training for Claims Submission
Educating providers, particularly <<subcapitated providers, subcontractors, atypical providers, and non-participating providers>>, on claims submission and payment processes is a core component of Magellan Complete Care’s provider training activities. Our vendor management team initiates regular claims-specific training sessions in all regions for the first twelve months of our contract, and continues to provide ongoing claims processing and payment training as dictated by the needs of the providers in our network, subcontractors, atypical providers, and non-participating providers.

Orientation and Initial Set-Up: Magellan Complete Care regularly conducts provider orientation sessions at various locations in each region of the state. A core component of these orientation sessions is education on service documentation, encounter data, claims processing and payment as well as incentives and penalties associated with submitting accurate, timely, and complete encounter data. Our goal is to make sure that all providers are comfortable with the claims submission process well in advance of them submitting their first claim to Magellan Complete Care. This provider claims training includes an explanation of common claims submission errors and how providers can avoid making those errors.

Provider orientation topics include, but are not limited to:

> The importance of the submission of clean claims to timely and accurate provider payment, HEDIS performance measures and related reimbursement incentives, and potential pay for performance programs
> Affordable Care Act state requirements for complete and accurate encounter data
> How to submit electronic claims to Magellan Complete Care
> The advantages and benefits of electronically submitted claims (EDI)
> How to submit paper claims
> Frequently asked questions regarding billing and claims including common errors
> How to file claims, processes to follow for coordination of benefits and third-party liability (TPL)
> The process for checking enrollee eligibility with every appointment
> Technical resources in support of proper coding and use of modifiers, process for prior authorizations, timely filing standards
> An explanation of the “life” of a claim, including system edits such as clearinghouse edits, ClaimCheck, and the process for provider claim disputes or escalation procedures
We also assist providers with setting up electronic claims submission and payment, which speeds payment, and we regularly identify and resolve provider barriers to electronic submission and payment.

Magellan Complete Care’s provider Web portal contains a wealth of information to assist providers in navigating the claims process. Magellan Complete Care’s provider claim support topics are summarized below:

> Preparing Claims -- Includes claim filing procedure, elements of a clean claim, claim do’s and don’ts, coordination of benefits

> Paper Claim Forms -- Includes CMS-1500 and CMS-1450(UB-04)

> HIPAA -- Includes coding information, professional services (claims submitted primarily on CMS-1500), facility/program services (claims submitted primarily on CMS-1450 (UB-04))," Where Do I Find the Code Sets?", facilities and programs, state-specific code sets for Medicaid, “Making HIPAA Work”, security, resources

> National Provider Identifiers (NPI) -- Magellan Complete Care requires providers to submit their National Provider Identifier (NPI) on all HIPAA-standard electronic transactions. All standard electronic transactions received without NPIs are rejected

> Electronic Transactions -- Provides numerous tools and resources to assist providers in preparing to send to and receive electronic communication from Magellan Complete Care. Magellan Complete Care’s claims tools are designed to save providers time and eliminate paperwork burden while supporting accurate, timely claims payment

> Companion Guides -- The Magellan Complete Care Companion Guides provide detailed instructions on exchanging HIPAA compliant ASC X12N transactions with Magellan Complete Care. These Companion Guides include information regarding Working with Magellan Complete Care, Connectivity, Contact information, Control segments, Magellan Complete Care business rules, Acknowledgments, and Testing. The transaction-specific Companion Guides include Magellan Complete Care’s business rules specific to the individual type of transaction.

> Electronic Funds Transfer -- Providers can take advantage of online Electronic Funds Transfer (EFT) for claims payments. Providers can request to have certain claims payments directly deposited to their business bank account. EFT is available to organizations and individual providers who own the Taxpayer Identification Number (TIN) linked to the submitted claim. Individual providers within an organization are not able to receive EFT claims payment.

5.2 Continuous Improvement
The Magellan Complete Care PODS teams are currently providing and will continue to provide proactive and ongoing personalized assistance to providers to ensure and improve the accuracy, timeliness, and completeness of encounter data. These cross-trained teams, including the provider group’s PSS, initiate a comprehensive and detailed plan with each new provider/provider group, to ensure prompt payment to our providers and the quality of encounter data required by AHCA.
The PSS staff have access to and use a broad set of analytical tools, resources, and routine reports to support our continuous quality improvement efforts associated with provider claims and encounter submissions. Staff also assist with problem solving with our internal clinical, operations, and other stakeholders to achieve positive outcomes and/or improve workflows. Complementing these quality improvement efforts, our joint operating committee regularly monitors a number of provider engagement metrics to ensure accurate, timely, and complete encounter data is being submitted.

Working in tandem with Magellan Complete Care claims staff to transform data into actionable information at the practice and enrollee level, both our PODS and PSS staff collaborate with providers to improve the completeness and accuracy of encounter data. These staff are available to meet with providers at their office location as well as via the toll-free provider line, so providers have easy access to encounter related information. We also provide detailed encounter submission instructions on our dedicated Florida Web site, in our provider manuals, and in our other provider communication activities.

We have developed several quality initiatives that incentivize providers for submitting complete and accurate encounter data. One example of this incentive program is promoting increased utilization of primary care services and decreased emergency department and inpatient services. We have developed a three-year, weighted capitation strategy where providers are paid for a combination of process measures that improve encounter submission data and quality measures associated with their specialty area. Our overall encounter-related goals are to improve data capture and data accuracy rates.

CRITERIA 6: THE ADEQUACY OF THE RESPONDENT’S DESCRIPTION OF HOW IT WILL CONNECT...
Magellan Complete Care follows a systematic approach to identify and resolve underlying causes of encounter submission errors.

When working with our network providers, our provider, vendor management and encounter data teams hold weekly and monthly Encounter Data Management (EDM) meetings, which are lead by our COO, to identify and quantify provider claim issues that might ultimately impact encounter processing. They review issues identified related to provider claims disputes, issues raised during provider visits, and encounter data error reports, perform root-cause analyses, and correct systemic/global issues to prevent recurrence. The EDM team works very closely with DXC (AHCA’s fiscal agent) and providers to identify and resolve provider-related denials that are dependent on a hierarchical match of provider data that is on the Provider Master List (PML), published by AHCA. Magellan Complete Care has been instrumental and effective in communicating these issues with DXC, the State’s designated fiscal agent, which has further resulted in enhancements to the Provider Master List. Root cause encounter denial analysis has resulted in escalation to the PODS team to initiate provider outreach and educational efforts.

For individual provider or facility issues, the PODS team is tasked with ongoing, expeditious follow-up as soon as errors are detected and working directly with providers to help them correct their encounter submission errors. These efforts may take place during scheduled meetings and phone calls, or as soon as is feasible when our PODS team is notified of the submission errors.
Magellan Complete Care also uses provider fax or e-mail blasts and schedule periodic webinars and trainings as needed to follow-up on global issues or changes. Information is also posted on our dedicated Florida Web site, updates to provider manuals, provider newsletters and bulletins. Providers requiring outreach and education are identified promptly during the referenced root-cause analysis and their names are forwarded to the Provider Network and Claims teams, respectively. This support is most needed when the billing provider has multiple records on the PML, but fails to use the Billing NPI associated with their Medicaid ID, for the appropriate provider registered services.

Our subcontracted vendors also provide us with regular reports and status updates to support our understanding of issues impacting encounter submission errors. These reports address issues such as:

> The status of eligibility and enrollment file processing, for example results of audit files or eligibility files issues
> Provider data loading into the system, for example timeliness issues with incomplete data
> Claims processing and payment, for example number of rejected and denied claims, rejection and denial reasons, or volume of duplicate claims
> Encounter data submission, for example submission issues, error reports from AHCA

CRITERIA 7. THE ADEQUACY OF THE RESPONDENT’S APPROACH TO WORK WITH PROVIDERS...
Magellan Complete Care ensures that the provider information supplied to AHCA is sufficient to ensure providers are recognized by AHCA’s Medicaid system, for data acceptance purposes. Magellan Complete Care has purchased and uses ClaimCheck Plus, a claim auditing software package developed by McKesson, for Florida Medicaid and other Magellan Complete Care business. This tool is integrated with our CAPS system and the current edit logic. This tool means that Magellan Complete Care can take advantage of McKesson’s expertise regarding Medicaid medical edits. A big part of McKesson’s editing tool is a variety of industry standard edits. Magellan Complete Care Claims Management directs IT, CAPS, and Configuration to configure these edits. Input files are sent to ClaimCheck, and then the output from ClaimCheck is put into a log file so that a ClaimCheck edit translates to an EDI message history note and the claim line is either pended or denied in CAPS.

Our PSS staff regularly work with providers, in their offices, to provide extensive pre- and post-contract implementation training on how to use the ClaimCheck software to improve the accuracy and completeness of the claim submissions. We use training examples and various case scenarios to help providers understand and structure their administrative systems to align with encounter documentation and submission requirements. For example, we ensure providers clearly understand our key field requirements and our PSS walk through specific examples of correct formatting and submission of encounter data for these key fields. Our system also uses includes a number of internal processes, procedures, and controls to maintain the quality and integrity of data received from subcontractors as well as the encounter data conveyed to AHCA.

CRITERIA 8. THE ADEQUACY OF THE RESPONDENT’S APPROACH TO ENSURE THAT ALL ENCOUNTERS...
8.1 Tracking and Reporting
Magellan Complete Care has defined specific criteria, which are detailed within the automated identification and selection of eligible encounters, to extract finalized paid and adjudicated claims. This activity is completed by our IT Claims Interface team to ensure the completeness of encounter data reporting. In addition, the reconciliation process, as previously described, is followed to further support our monitoring and control objectives. We use a number of tools to support this effort including the claims adjudication system and associated system platforms used for encounter extraction, tracking, and reporting purposes.

The comprehensive end-to-end encounter data submission process is comprised of activities completed by Magellan Complete Care’s IT Claims Interface, Encounter Data and Reporting, Information Technology, and other departments throughout the organization, including but not limited to Claims, Provider Network, Finance, and Compliance, including Magellan Complete Care’s Chief Operating Officer (COO) for oversight. Furthermore, an Encounter Activities, Status, and Compliance meeting, is scheduled monthly to ensure compliance oversight of measures and controls.

Our comprehensive encounter data management approach includes: a robust claims payment system, systematic processes for data extraction and data scrubbing, workflows and processes for resolving errors, and use of the Encounter Resolution Application (ERA). Adjudicated finalized medical encounter data is extracted directly from our claims system, CAPS. The data is put into the 837 format programmatically. The procedures used to ensure data quality and maintain the integrity of reference information include the following safeguards for processing outbound files:

>Define formats according to appropriate data types, pre-defined lists, and business rules

>Compare outbound files, prior to release, against file specifications to confirm:
  >> Proper formatting
  >> Presence of required fields
  >> Number of records selected for sending matches number processed
  >> Job transmission completion and statistics

Claims finalized in the prior period or those specifically flagged to be resubmitted are extracted. Transmission of encounter data will occur weekly (no later than seven calendar days following the date the claim was adjudicated) or monthly in accordance with the timeliness specifications provided in the contract and Florida Companion Guides.

8.2 Magellan Complete Care’s Setup and Validation Checks to Ensure That Encounter Data Is Accurate before Transmission

We use an automated job scheduler to facilitate the timely delivery of the encounters. To ensure that contractual obligations are met, this process is scheduled to automatically run to meet the guaranteed delivery date. Our IT Claims Interface team monitors the job scheduler to identify and quickly resolve errors. There is also automated review and reporting on any job or FTP failures sent to the team to be reviewed manually. A Reconciliation file, which is an Encounter Tracker repository, is used to track all records, as well as responses. This ensures all claims are accounted for and followed through the entire process to completion. In addition, to further aid in data submission validation, internal email notifications and attestation worksheets are auto generated. The email notifications serve as an internal alert and a reporting tool for tracking and reconciliation purposes. The individual email notifications correspond to the encounter data files reported on the attestation worksheet. The attestation worksheet is a required encounter...
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

submission deliverable which further supports adherence to encounter data integrity and submission requirements.

Evaluation Criteria:

1. The adequacy of the respondent’s approach to ensure that all network providers, including subcapitated providers, are known to the Florida Medicaid Management Information System (FMMIS) for the purposes of encounter data submission.

2. The adequacy of the respondent’s approach to educating all providers about the importance of key field combinations in accurately identifying the service/s provided, the importance of populating all key fields, and the importance of consistency in coding across all records, providers, and provider types on encounter data submissions.

3. The adequacy of the respondent’s approach to ensuring that all providers, including subcapitated providers and subcontractors, provide an amount or cost of the Medicaid service provided (including pharmacy paid amount). For pharmacy claims, this includes the adequacy of the respondent’s approach to ensuring the amount or cost of the Medicaid service provided must be the amount that was actually paid to the pharmacy excluding any PBM or other administrative costs.

4. The adequacy of the respondent’s approach to educating and supporting providers who submit paper claims.

5. The adequacy of the respondent’s approach to encouraging providers, particularly subcapitated providers, subcontractors, atypical providers, and non-participating providers to submit accurate, timely, and complete encounter data, including the type and frequency of activities and any incentives/penalties.

6. The adequacy of the respondent’s description of how it will connect with providers to revise encounter submissions in a timely manner.

7. The adequacy of the respondent’s approach to work with providers to comply with correct coding.

8. The adequacy of the respondent’s approach to ensure that all encounters are included in submissions.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 31 – Fraud and Abuse/Compliance Office (Statewide):

The respondent shall describe its compliance program including the compliance officer’s level of authority and reporting relationships. The respondent shall describe its experience in identifying subcontractor fraud and internal fraud and abuse in managed care programs. The respondent shall include a résumé or curriculum vitae for the compliance officer. The respondent shall also include an organizational chart that specifies which staff are involved in compliance, along with staff levels of authority.

Response:

OVERVIEW
To support Magellan Complete Care’s culture of compliance and business integrity, as well as our focus on ensuring that our enrollees living with serious mental illness (SMI) get the high quality services they need, we have developed a robust and proactive Compliance Program that provides direct, practical, day-to-day support to our business operations. Our formalized and well documented Compliance Program complies with all federal and state requirements as well as with industry best practices. The success of this program lies in several core components, as more fully outlined below. The dedicated Magellan Complete Care Compliance Officer and team based in our Miami, Florida, office provide federal and state regulatory guidance to Magellan Complete Care’s senior leaders. Our Compliance Officer is a Senior Director in the organization and has been in the position since the inception of the Magellan Complete Care health plan.

Along with her team, she is the key staff member charged with executing the Compliance Program, evaluating the overall compliance of Magellan Complete Care, ensuring that business is conducted in a legal and ethical manner, and regularly communicating the status of the compliance program and anti-fraud activities to our Board of Directors.

Our Compliance Program is tailored to most effectively serve our enrollees who are living with SMI. The Compliance Officer brings special expertise and experience to bear in this regard. In addition to her compliance leadership, she also has a clinical background as a licensed mental health counseling professional, which makes her acutely aware of the critical aspects of serving this population. She reports to and is supported by the Magellan Complete Care National Vice President and Chief Compliance Officer (CCO), and she has a direct relationship with and access to the Magellan Complete Care CEO, COO and other members of the senior leadership team, as well as to Board of Directors. See [General SRC #31, Attachment 1: Compliance Department Organizational Chart], and [General SRC #31, Attachment 2: Compliance Officer Resume].

A central feature of our Compliance Program is ensuring program integrity, which includes detecting, preventing, and effectively following up on fraud, waste and abuse (FWA). Magellan Complete Care’s Compliance Officer works closely with the company’s Special Investigations Unit (SIU), which is responsible for the investigation of potential and actual fraud as well as abuse or overpayment. Magellan Complete Care’s Compliance and Anti-Fraud Plan describes, among other things, how the Compliance and SIU teams work together to ensure we maintain the highest possible level of program integrity through proactive, comprehensive approaches, processes, policies, and protocols. The SIU also has procedures in place to ensure that Magellan Complete Care complies with all FWA reporting provisions, including immediate reporting to Medicaid Program Integrity (MPI) and the Department of Financial Services (DFS) within the required
timeframes, along with quarterly FWA reporting and annual FWA reporting to MPI. More information on the composition, operation, and effective results of the SIU is included below.

CRITERIA 1: THE EXTENT TO WHICH THE COMPLIANCE PROGRAM COMPLIES….
Magellan Complete Care has a robust and proactive Compliance Program, as well as a dedicated Compliance Officer and team based in our Miami, Florida, office.

We address all of the elements of a Compliance Program as detailed by the Office of the Inspector General (OIG), including the underlying processes and policies that support each element. All elements are designed to support the health plan in understanding and complying with all contractual and regulatory requirements, and to amend processes and policies as state and federal requirements change. The compliance program includes education, risk management, and auditing/review processes that support business leaders’ efforts to adhere to requirements in the most enrollee-centric and ethical manner possible.

Descriptions of the components of the Magellan Complete Care Compliance Program are included below.

1.1 Compliance Program in General
The Magellan Complete Care Compliance Program outlines our approach for:

> Ensuring ongoing compliance with all applicable federal and state standards and regulations
> Internal and external communication processes regarding compliance matters
> Compliance education and training programs
> Ongoing compliance monitoring and auditing process
> Activities and structures in place to prevent, detect, and correct known or suspected fraud and abuse

All of the elements of our Compliance Program comply with Florida Statute 409-91212 (Medicaid Managed Care Fraud), the U.S. Department of Justice Sentencing Guidelines, U.S. Department of Health and Human Services requirements, and all other applicable state and federal requirements. At the same time, this Program is designed to be agile and proactive to adapt to changing requirements in the highly-regulated Medicaid managed care business as quickly and effectively as necessary.

As the foundation of our Compliance Program, all employees are expected to represent Magellan Complete Care and conduct business on its behalf in an ethical and compliant manner – that is, do the right thing in the right way. This expectation of our employees is outlined in compliance-related policies, procedures, our Code of Conduct and the Magellan Complete Care Compliance and Anti-Fraud Plan, all of which are made readily available to all employees. Information regarding The Magellan Complete Care Compliance Program is available on the health plan website and is available to all employees through a common virtual location within the health plan computerized document repository.

Our Code of Conduct clearly articulates and underscores the importance of our culture of compliance and ethics, as well as the specific aspects of our Compliance Program to which all employees must adhere. Our compliance training curriculum strengthens this emphasis. All employees are required to take Compliance Program training at the time of hire and on an annual
basis after that, with significant adverse consequences – up to and including the possibility of
termination – if they do not fulfill these requirements.

Our credo - to do the right thing in the right way - is reinforced and modeled by management and
supervisors, including the CEO, COO, Compliance Officer, and all other members of senior
leadership. We set the tone and tenor of compliance and ethics at the top of our organization.
Then, through policies and training, Magellan Complete Care provides specific information to
employees. Our policies and training cover, but are not limited to: the material standards to which
our employees must adhere, whistleblower protections, freedom to report compliance issues
directly to state and federal agencies, employee accessibility to the Compliance Officer, and the
structures in place that empower employees to seek guidance, report issues, and have their
questions answered.

1.1.a Magellan Complete Care’s Commitment to Comply with All Applicable Federal and State
Standards
Magellan Complete Care has written policies and procedures as well as a written Code of
Conduct, which are approved by our Board of Directors. These documents clearly articulate and
strongly affirm Magellan Complete Care’s commitment to comply with all applicable rules, laws,
and regulations. These documents describe the expectations that Magellan Complete Care has
for all employees, vendors, subcontractors, providers, and members of our Board of Directors.
Policies, procedures, and the Code of Conduct are communicated to all employees and made
available on the Magellan Complete Care public website, our intranet, and our provider and
enrollee handbooks. Training on policies, procedures, and the Code of Conduct occurs for
employees at new employee orientation (within 30 days of hire) and annually thereafter.

Magellan Complete Care policies and procedures are reviewed on an annual basis and updated
as needed based on changes in applicable laws, regulations, and Magellan Complete Care’s
contract with the State of Florida. When laws, regulations, contractual requirements, or even
industry standards (in some cases) change, the Magellan Complete Care change management
process is used to ensure that effective and timely revisions are made to existing processes, or
that new processes are implemented. Through the change management process, we record and
track process and policy changes to completion, using the Magellan Complete Care change
management control document. Additionally, the status of each change is reviewed during weekly
compliance meetings that include all department heads and responsible parties.

The Compliance Officer also reviews the compliance, FWA policies, procedures, and training
materials for vendors and subcontractors before contracting and annually thereafter. The
Compliance Officer makes the final determination as to whether each vendor or subcontractor
compliance program is designed to effectively ensure that their operations meet contractual and
regulatory requirements. If the documents are not in alignment with Magellan Complete Care’s
contract, this is noted as a gap in the pre-delegation evaluation. The Compliance Officer is
available to discuss the needed changes with the subcontractor and vendor as needed and has
provided this guidance to various subcontractors over the life of the Magellan Complete Care
contract. If an employee, vendor, subcontractor, or provider has any questions related to the
expectations set forth by Magellan Complete Care, they may contact the Compliance Officer
directly to discuss their concerns and to receive education and clarification.

In addition, our commitment to comply with all federal and state requirements and standards
includes an effective internal change management process to ensure that contractual and
regulatory changes are reviewed, analyzed, and communicated to employees in a timely fashion. The Compliance Officer and the senior director of account management coordinate the change management process. In this process, they analyze and distribute all notices from AHCA to Magellan Complete Care supervisors and managers of affected departments. They also provide education as needed to ensure that needed procedural and operational changes have been implemented.

Upon notification of a regulatory or contractual change, a notification email is sent out by the senior director of account management to the affected departments with a copy to the Compliance Department describing the change and requesting an acknowledgement of receipt. The senior director of account management also gives a timeframe for the affected departments to submit a plan for change implementation, including any policy or procedural changes that need to be made. Every week at regularly scheduled meeting, the Compliance Department and the senior director of account management review all AHCA policy transmittals, contract amendments and state/federal regulatory updates with Magellan Complete Care senior leadership, supervisors and management staff. Once the timeframe for implementation has passed, the affected senior leader attests that the changes have been made, and the compliance auditor conducts validation reviews to ensure that the changes were effectively implemented in a timely fashion. The auditor issues corrective actions as necessary and conducts additional reviews as needed until issues are fully resolved.

1.1.b Conflict of Interest
Each employee is expected to act in the best interest of our enrollees, our company, and the State of Florida. Employees must avoid situations where there are actual, potential, or perceived conflicts of interest with Magellan Complete Care in their professional and personal relationships. Through our compliance training program, all employees are educated when hired and annually thereafter that they are expected to disclose any transaction or relationship that the employee reasonably expects could result in an actual, potential, or perceived conflict of interest. The Compliance Officer confers with the vice president and national chief Compliance Officer on all conflict of interest issues, and the potential impact to Magellan Complete Care and to Magellan nationally is evaluated. Feedback and required actions, if any, are provided to the employee once a determination has been made. The Compliance Department tracks all conflict of interest reviews, the determinations, and any required actions.

1.1.c Policies and Procedures
Magellan Complete Care maintains and makes readily available to all employees a library of policies and procedures that provide the formality and structure needed to ensure ongoing compliance with contractual and regulatory requirements. These include, but are not limited to: the Health Insurance Portability and Accountability Act (HIPAA) and all applicable Florida state laws in the protection of personal health information (PHI) and individually identifiable data. Magellan Complete Care’s policies and procedures also provide clear accountability guidelines to ensure compliance. To support Magellan Complete Care at an enhanced level, Magellan has purchased and is implementing Compliance 360, effective September 2017. Compliance 360, a software product of SAI Global, is a compliance management software system that includes functionality to manage the policy review and approval process, as well as a repository for all local and corporate level policies, procedures, workflows and other documents. The enhancements included in the Compliance 360 module include automatic notifications of pending policies, management "at a glance" reports that show policies coming up or overdue for review, references to CMS regulations, Florida statutes, and our AHCA contract.
The Compliance Program includes training and education on health plan policies and procedures to ensure that critical information, legal/regulatory requirements, and company expectations are available and communicated clearly. Everyone has access to all policies and procedures and through this access, as well as training, understands intent and implications of non-compliance with these company policies and procedures.

Subcontractors, vendors, and providers also receive our compliance training or attest to conducting their own (approved by the Compliance Officer) when they enter into a contract with Magellan Complete Care and whenever regulatory or contractual changes affect the services they provide to Magellan Complete Care. In addition, subcontractor and vendor policies and procedures are reviewed by appropriate senior health plan leaders, including the Compliance Officer, before contracting with these third parties and at regular intervals thereafter, to ensure that these documents include the relevant requirements for the third party to fulfill their obligations to Magellan Complete Care, its enrollees, and AHCA.

1.1.d The Designation of a Compliance Officer and a Compliance Committee Accountable to Senior Management

Our Compliance Program is led and organized by the Compliance Officer [see General SRC #31, Attachment 2: Compliance Officer Resume]. The Compliance Officer is a member of the National Magellan Complete Care Compliance program. The National Magellan Complete Care Compliance Program is led and overseen by the Vice President, National Chief Compliance Officer (CCO) of Magellan Complete Care. The Compliance Officer is supervised and supported by the CCO. The Compliance Officer chairs the Magellan Complete Care Florida Compliance Committee, has the authority and access to report issues directly to the CEO of Magellan Complete Care, to senior leadership, to the Magellan Complete Care Compliance Committee, and to the Magellan Complete Care Board of Directors.

The CCO is supervised and supported by the Corporate Compliance Officer for Magellan Health, and the CCO also has the authority to report compliance issues directly to the Board of Directors. Our Compliance Officer and the CCO have direct access to the Corporate Compliance, Privacy and Legal teams on issues related to HIPAA privacy, training, regulatory review, and changes in applicable laws.

The Compliance Officer is responsible for coordinating and conducting the Magellan Complete Care Compliance Committee in Florida. This Compliance Committee meets at least quarterly or ad-hoc when needed. Representation from Magellan Complete Care Senior Management and critical operating departments are on the committee, including Pharmacy, Delegated Vendor Management, SIU, Utilization Management and Provider Network. The Committee oversees the implementation and operation of the Compliance Program including but not limited to the following responsibilities:

> Review and revise as needed the Compliance Program including the Compliance Risk Assessment at least annually, and recommend these to the Board of Directors for approval

> Ensure that the Compliance Officer has sufficient resources to execute the Compliance Program and make recommendations to the Board as needed
>Assess the corrective action steps management has taken or proposes to take to minimize the impact of regulatory, legal or other types of risk to enrollees and to the company, and to periodically review compliance with such steps

>Review audit outcomes, required corrective action plans, regulatory reports, statements of deficiency, etc., that have been submitted to or received from AHCA, the Office of Insurance Regulation and other state and federal agencies

>Review the Compliance Officer’s analysis of new legal and regulatory developments and how they affect the organization

>Evaluate trends in grievances and appeals for compliance issues, as well as review corrective actions

>Review trends in unauthorized disclosures and breach reports, and evaluate corrective actions

>Review results of internal audits, ongoing monitoring, and cases of potential or actual FWA

>Review corrective action plans proposed or implemented as a result of auditing, monitoring or reporting

Our Compliance Officer provides the Magellan Complete Care Board of Directors with both a verbal and written Compliance Report on at least quarterly, detailing the activities and outcomes of the Compliance and Anti-Fraud program, actual or potential issues, corrective actions to be taken to mitigate issues and a plan for prevention of recurrence. The Compliance Report includes but is not limited to the following topics:

>Significant Compliance violations
>Status of Audits and Corrective Action Plans
>FWA activities and investigation updates
>Internal and external auditing and monitoring outcomes; and
>Risk status update

Magellan Complete Care will also be using Compliance 360 for the administration of policies and procedures. Compliance 360 will also serve as a repository and distribution mechanism for all Compliance Committee and Board materials, providing a single source that contains final documents and minutes for these important meetings. This process will be fully implemented in Q4, 2017.

1.1.e Effective Training and Education of the Compliance Officer and Magellan Complete Care Employees

As mentioned previously, we maintain a culture of compliance and ethics that is aimed at ensuring that our employees do the right thing in the right way. For them to conduct themselves in this manner, however, they have to know what means, not just in principle but also in practical terms. Compliance training sessions are conducted for all new employees (including full-time, part-time, contracted, temporary employees and volunteers), physician advisors and health care professional advisors, within thirty (30) days of hire. In addition, compliance training is part of the orientation for all new appointments to chief executive position, senior management positions, and the Board of Directors. The initial training for all new employees and professional staff
includes in-depth review of the Code of Conduct, key policies and procedures related to those standards of conduct, as well as a HIPAA privacy and FWA training. All Magellan Complete Care employees including the Compliance Officer must complete three compliance trainings annually. The compliance trainings support a culture of compliance and a “do the right thing in the right way” approach to business. These qualities are reflected in our training program, which includes the Magellan Code of Conduct, HIPAA Privacy and Security, and Fraud Investigation Recognition and Education training. Consistent with Sections 6032 of the federal Deficit Reduction Act (DRA) of 2005, Magellan Complete Care Compliance training also includes detailed information on:

a. The False Claims Act  
b. Penalties for submitting false claims and statements  
c. Magellan’s role in preventing and detecting FWA  
d. Each person’s responsibility relating to FWA detection and prevention  
e. The toll-free state telephone numbers for reporting FWA  
f. Applicable federal and state whistleblower protections

Trainings are offered through on-line modules in our automated SABA application and include a post-test that employees must pass with an 80 percent score or better. The on-line training system records employee/contractor completion and sends reminders to employees if they have not completed the course(s). The system maintains logs of the employee/contractor, course and date of completion. The system maintains the test scores for 10 years. An employee’s repeated inability to complete the courses and pass the post-tests is noted through the testing results review process which is managed by the Corporate Compliance Department. The Compliance Officer and the employee’s supervisor are informed of the issue. The supervisor works with the Compliance Officer and Human Resources (HR) to impose disciplinary action on the employee, up to and including termination of employment, if requirements are not met.

Specialized compliance and FWA training is provided to those Magellan Complete Care permanent and temporary employees who are involved in work that poses specific compliance risks based on the employee’s job function. Specialized training is conducted in-person, and is comprised of detailed job task training integrated with the compliance guidelines related to those job tasks, so that the employee understands the regulatory guidelines that govern the functions he/she will be performing, the purpose of those guidelines, and any potential impact on our enrollees and/or on Magellan Complete Care if they are not followed. The supervisors and managers are primarily responsible for ensuring that specialized training is completed satisfactorily and for retaining training records. The Compliance Officer supports this process and reviews specialized compliance training documentation to ensure that the training is complete and effective. Examples of specialized training include the following:

1.1.e.1 Utilization Management
Focus on watching out for abuse of units versus what is actually medically necessary. Approving these units would exhaust benefits and contribute to the waste.

1.1.e.2 Call Center
Watching out for people calling in to impersonate an enrollee and watching out for aggressive people who are yelling and trying to force Magellan Complete Care to give enrollee identifiable information. Falling prey would result in unauthorized disclosures or possible identify theft.
1.1.e.3 Network Management
Focus on watching for FWA in billing practices. Insist on compliance with both the provider’s contract and the requirements within the AHCA Provider Manuals. Failure to monitor and provide oversight of providers allows providers a wide berth and no oversight, thereby promoting excessive and uncontrolled abuse of Medicaid dollars.

Throughout the calendar year, Magellan Complete Care publishes numerous educational pieces and conducts various activities and programs designed to educate employees and raise awareness of compliance and compliance related issues. Training topics are reinforced through posters located in each site, printouts from the training systems, monthly articles in the employee electronic newsletter, and special event weeks such as “International Fraud Awareness Week,” Health Information Privacy Week, and National Ethics Week. Magellan Complete Care also conducts an annual “Compliance Awareness Week,” which is a week-long series of activities and programs designed to educate and raise awareness of compliance and compliance related issues, including FWA.

1.1.f Effective Lines of Communication
Magellan Complete Care and the Magellan Code of Conduct require employees, enrollees, vendors and others to report actual or potential compliance, FWA issues to their supervisor, any member of management, the Magellan Complete Care Compliance Officer, or another member of the Compliance team, as well as to any member of the SIU team. To establish and maintain an atmosphere of trust with Magellan Complete Care employees, the Magellan Complete Care Compliance Officer has an open door policy that allows any employee to speak directly to her on any matter, get advice, report a problem, or to obtain information. Further, the Compliance Officer and the Compliance Team attend all new employee orientations to introduce themselves and initiate and encourage this atmosphere of trust. At Magellan Complete Care, this culture of openness and trust is supported at the Board of Directors and by the CEO, as well as by the senior leaders and management of the company. Through our Compliance Program, we have a number of mechanisms in place to receive, record, and respond to compliance questions or reports of potential or actual non-compliance from employees, enrollees, and subcontractors/vendors, and providers.

1.1.f.1 Management
Our culture of compliance and ethics is established by appropriate tone at the top of our company, starting with our CEO and these senior leaders. But we recognize that to many of our employees, this tone is established and evident in the level right above them in the organization – with their supervisor or manager.

In addition to the compliance training conducted with all employees, our entire management team is trained to anticipate and encourage the employees who report to them to come directly to management with compliance-related questions, concerns, and issues. A similar message of encouragement is given to all employees during our all-employee, required compliance training. If a manager has any questions regarding the handling of a matter raised by an employee, our management team knows that they can seek additional guidance from the Compliance Officer for proper follow-up with the employee or refer that employee to Compliance for this follow-up, as appropriate.
1.1.f.2 Compliance Hotline
Our anonymous and confidential telephone hotline for compliance issues is another line of
communication that is accessible to all employees. The hotline is easy to navigate and is available
every day, 24 hours a day, including holidays and weekends. This communication mechanism
allows callers to have the option of reporting issues anonymously and confidentially. If a caller
chooses to identify him- or herself, confidentiality is maintained to the greatest extent possible.
Magellan Complete Care has adopted related confidentiality and non-retaliation policies to
encourage open communication and the reporting of incidents of suspected FWA or compliance
concerns. All matters received through this hotline – and any other communication mechanism -
are reviewed by the Compliance Officer and reviewed and investigated in a thorough and timely
manner.

Magellan Complete Care will use the Compliance 360 software system, which will be
implemented by Q4 2017, to record and track investigations related to complaints, hotline calls,
reports of potential or actual compliance and FWA issues, etc. Compliance 360 will be further
used by the Compliance Officer to manage the steps in the investigation process, record notes
from interviews, attach data files, document key decisions and produce aggregate reporting for
risk level evaluation. Compliance 360 also has functionality that allows the Compliance Officer
to connect supporting documentation, such as a corporate or local policy, regulation or contract that
resides in the system, to an investigation. All of this functionality will enhance communication,
documentation, and effective investigation and follow up. It will also give the Compliance Officer
the ability to aggregate information from different sources to more quickly identify trends and
issues, to take proactive action, and to refine the risk assessment processes.

1.1.f.3 Communication With and by the Magellan Complete Care Compliance Officer
The Compliance Officer is located in the Magellan Complete Care headquarters in Miami.
Employees, enrollees, and subcontractors/vendors have unrestricted access to the Compliance
Officer in person, or for staff working remotely, via telephone, email or through the Compliance
Hotline. The enrollee handbook contains information and phone numbers that an enrollee can
use to report compliance issues and FWA to the health plan or to regulatory agencies. Any callers
who request to speak with the Compliance Officer are transferred by Customer Service directly.

The Compliance Officer is also a member of various Magellan Complete Care committees,
including the Joint Operations Committee (JOC) meetings of the health plan. These JOC
meetings occur regularly with subcontractors, providers and vendors. At these meetings, the
Compliance Officer discusses issues of non-compliance, provides education and guidance, and
reminds committee members of the many avenues available to report compliance issues to the
health plan. Additionally, the Compliance Officer gathers information that can assist in the
Compliance monitoring and auditing process.

The Compliance Officer has regular meetings with the CEO, COO and senior leadership of
Magellan Complete Care and has direct access to Magellan corporate officers such as the
Magellan Complete Care National Chief Compliance Officer of Magellan Complete Care and the
Magellan Corporate Compliance Officer.

The Compliance Officer has unrestricted access to the Board of Directors. The Compliance
Officer is a required and regular presenter to the Board of Directors at their quarterly meetings
and is charged with providing Compliance program status information and Compliance issues to
the Board. The Compliance Officer provides both a written and oral report on the compliance activities and issues at each Board of Directors meeting.

1.1.f.4 Special Investigations Unit
If any of our employees has an FWA question, issue, or concern, they can also reach out to the company’s SIU. They can reach out to the SIU in one of at least a few different ways. More specifically, an employee can call the toll-free SIU Hotline, send an email to the SIU mailbox and/or submit a written SIU referral form with the inquiry or report to our SIU team. In addition, local SIU staff are embedded in our Florida Care Management Center and have an open door policy for employees to report FWA issues. This team, deep in experience and expertise in matters of program integrity, will follow up on the matter by consulting with the Compliance Officer, conducting an FWA review or investigation, and reaching out to the employee for assistance and/or any steps that they consider to be appropriate.

1.1.f.5 Orientation for New Employees
The required compliance training for all employees stresses the importance of coming forward with any compliance-related questions, concerns, and issues. The training curriculum also informs them of possible communication mechanisms. The Compliance Department also participates in all new employee orientations. In this forum, the Compliance team similarly encourages employees to contact the Compliance Officer or any other member of the team directly at any time.

To promote the communication of compliance matters through any of the mechanisms outlined above, Magellan Complete Care has a policy and practice of non-intimidation and forbids retaliation for good faith reporting and participation in the Compliance Program. Any employee found to be in violation of Magellan Complete Care’s policy of non-intimidation or non-retaliation is subject to disciplinary action, up to and including termination of employment.

1.1.f.6 Outreach and Reporting by Providers and Subcontractors/Vendors
The Compliance Officer is readily available to providers as well as subcontractors and vendors. The Provider Handbook contains information on how providers can report compliance issues and report FWA to our health plan and to regulatory agencies. More specifically, a provider is advised to report FWA concerns or issues to Magellan Complete Care via the Compliance Hotline or email box, or the SIU hotline or email box, with contact information provided.

In the event the provider wants to report these issues or concerns directly to the government, contact information is also provided for Florida’s Bureau of Program Integrity, Office of the Attorney General Medicaid Fraud Control Unit, and Department of Financial Services, as well as the U.S. Department of Health and Human Services Office of Inspector General. In addition, a provider can raise a compliance question, issue, or concern while being visited by our Provider Support Services and Provider Relations teams, who would then refer the matter to our Compliance Officer.

Further, subcontractor and vendor agreements include language that requires them to (i) comply with Magellan policies and procedures related to reporting compliance issues, including suspected or actual FWA (ii) cooperate with activities of our Compliance Program and (iii) adhere to obligations to comply with all applicable laws and regulations. Due to the Compliance Officer’s regular participation in subcontractor Joint Operating Committees as part of our strong monitoring
and oversight, subcontractors have access and availability to raise these matters effectively and efficiently.

1.1.g Enforcement of Standards and Related Disciplinary Policies through Well-Publicized Guidelines
To help ensure that our employees do the right thing in the right way, we take a number of screening and vetting steps to try to hire individuals who have a propensity to act with trust and integrity.

As an initial matter, any offer for employment with Magellan Health, Inc. (Magellan), its subsidiaries and affiliates, including Magellan Complete Care, is contingent upon the successful completion of a satisfactory background investigation. All prospective employees, regardless of level or position, are required under company policy to undergo a standard background check and mandatory drug screen before employment. Our rigorous pre-employment vetting and professional references includes a criminal background check, employment verification, credentialing/re-credentialing validation of specific licensure, and professional reference interviews.

In addition, state-specific requirements are complied with as applicable and appropriate. For example, our Statewide Medicaid Managed Care Contract with AHCA requires that candidates for select positions be fingerprinted (or verified through a state clearinghouse for previous fingerprinting) and HR tracks adherence to such a requirement very closely.

Even more rigorous background checks are conducted for executives (Vice President and above) and members of the company’s Boards of Directors. All background investigations of employees are adjudicated by the Security Department, with support and consultation from HR, including in some cases, an HR Compliance Manager.

Magellan also checks the following sources for names of employees, enrollees, members of our Board of Directors, subcontractors, vendors, providers, and volunteers barred from participation in Medicare, Medicaid, other federal health care programs, federal contracts, and state health care programs:

> U.S. Department of Health and Human Services (HHS) Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE), or its equivalent
> Federal Excluded Parties List System (EPLS) or its equivalent
> The U.S. General Services Administration’s (GSA) web-based System Award Management Exclusion Database (SAM)
> U.S. Treasury Department Office of Foreign Assets List of Specially Designated Nationals and Blocked Persons
> Applicable state exclusion/sanctioned/terminated lists

Furthermore, Magellan Complete Care is committed to ensuring that the standards outlined in the Code of Conduct are followed for all employees. Disciplinary action is taken when an employee authorizes or participates directly in a violation of applicable state or federal law, the Code of Conduct, standards of conduct, or policies and procedures, and when an employee deliberately fails to report such a violation or hinders an investigation.
Magellan may use disciplinary actions to assist supervisors and staff in resolving unsatisfactory job performance, misconduct, or behavior that violates Magellan policies, procedures, or practices, including failures to report compliance issues. These disciplinary procedures are formalized in documents and policies such as the Code of Conduct, Employee Handbook, Magellan’s disciplinary process for compliance issues, and policies that describe each employee’s duty to report potential compliance issues. These are readily available to all employees.

1.1.h Provision for Internal Monitoring and Auditing
As part of the Compliance Program, Magellan Complete Care conducts frequent and regular monitoring and auditing activities based on the occurrence of identified issues. Compliance auditing is done by the Compliance Department as issues are identified, and corporate auditing of internal controls is done by the Internal Audit Department.

An annual and mid-year compliance risk assessment and compliance work plan is completed that defines the areas at most risk for the health plan. Those risks are then incorporated into the monitoring and auditing work plan, which is coordinated and overseen by the Compliance Officer and executed by the Compliance Audit team. The functions and processes that are determined to be of greatest risk are audited by the Compliance Team. As risks or issues are identified, the Compliance Officer determines if the issue appears immediate and serious enough to warrant a request to the Internal Audit Department for a formal audit.

The Corporate Internal Audit Department provides independent audits for the health plan to test operational controls, policies, and procedures. Upon conclusion of an audit, Internal Audit will provide a report to Senior Management and the Compliance Officer that identifies strengths and control weaknesses. When weaknesses are identified, the audited department will complete a corrective action plan for each weakness. The Compliance Department will conduct monitoring and follow up auditing. If issues are identified, the Compliance Department will discuss this situation with Internal Audit, and may request another formal audit. If Compliance requests an audit from IA that is not on the audit schedule, the teams meet and discuss the need to re-prioritize the audit list depending on the risk level of the issues that had not been corrected. In this way, Magellan Complete Care ensures that critical, time-sensitive issues are corrected through the audit process, and in the timeframe determined by the Compliance Officer.

The Compliance Department also performs routine and frequent monitoring of operational processes, including activities like verification reviews on health plan operations and report submission processes. Monitoring involves measuring performance against standards derived from the Magellan Complete Care Contract with the State of Florida, state and federal regulatory requirements, and other applicable regulations, laws and guidance.

The Compliance Department monitors key performance metrics such as the enrollee’s toll-free help line or the adverse benefit determination notification metrics to ensure that the health plan is in compliance with the contract and to ascertain that enrollees’ notification rights are fulfilled. The Compliance Department uses operational metric reports to compare current performance against the contractual requirements to validate and verify compliance. Additionally, enrollee cases are selected and reviewed longitudinally, beginning with enrollment and continuing through the course of services. In these tracer cases, staff are able to identify gaps in health plan operations, barriers to care and services, and determine if the proper and timely communications were provided to the enrollee if indicated.
Monitoring and auditing conducted by other Departments including Vendor Management are incorporated into the Compliance Department’s oversight program. The Compliance Department oversees these efforts, and reviews their effectiveness. The Compliance Department participates in the vendor/subcontractor risk assessment process and incorporates vendor risks into its Compliance risk assessment and work plan. The Compliance Team participates in the pre-delegation vendor/subcontractor review meetings, initial credentialing and re-credentialing processes for all vendors/subcontractors and joint operations meetings.

In addition to the compliance risk assessment, the SIU Department conducts a FWA risk assessment and work plan that supports the overall Magellan Complete Care Compliance Program. The Compliance Department and the SIU have established a process for identifying and assessing FWA risks on a continuous basis. The process includes an annual identification, evaluation and assessment of risks using various sources of information such as the following:

> Department of Health and Human Services Office of Inspector General (HHS-OIG) Annual Work Plan
> State-specific FWA activity reports
> Internally identified areas of risk
> Risks identified by the Federal Bureau of Investigations (FBI) or Federal Office of Personnel Management (OPM)
> Leads and schemes learned at information sharing events
> Local fraud task force meetings
> Published news articles
> Results of data analysis and data mining
> Other sources

The SIU identifies potential areas of risk on an ongoing basis through ongoing education, research and monitoring, and information sharing. The assessment process considers compensating controls, exposure, impact, and likelihood of the risk. This helps determine the content and priorities for the departments’ specific work plans.

In addition to routine auditing and monitoring, ad hoc auditing and monitoring is also conducted by the Compliance Department when there is the suspicion that a significant compliance issue exists. Audits are conducted on site, via desktop, or a combination of both when applicable. Audits can include a review of systems, data, and documentation, as well as staff interviews. All monitoring and auditing activities are reported to the Compliance Committee and to the Board of Directors by the Compliance Officer.

1.1.I Provisions for Prompt Response to Detected Offenses and for Development of Corrective Action Plans

Magellan has many avenues for employees, enrollees, subcontractors, and vendors to report compliance or fraud, waste, overpayment and abuse issues, as well as a robust process for investigating and responding to such reports. These reporting routes include but are not limited to the employee’s supervisor, the Compliance Officer, any member of health plan leadership, and the SIU Manager.

All reported issues are reviewed promptly by the Compliance Department and the SIU, regardless of method of notification or issue type. The issue/incident is investigated within one week of receipt. If the information collected indicates and is related to FWA, this will be reported by the
Compliance Officer promptly and within requirement timeframes to MPI and to DFS. These cases are also reported quarterly and annually in the required reporting format to MPI.

After the investigation, the Compliance Officer determines if the compliance issue necessitates a corrective action. The corrective action process mitigates the compliance issues, serves to document and identify accountability, tracks progress towards completion, and is aimed at preventing recurrence. Throughout the process and at relevant points indicated in the corrective action document, the Compliance Department will regularly monitor progress and request demonstration and evidence that completed actions were indeed completed and completed correctly. Should operational departments, subcontractors, or vendors fail to satisfactorily implement and maintain the corrective action, the Compliance Officer confers with the Magellan Complete Care CEO and the senior management team as well as the Compliance Committee to determine further actions to be taken, including but not limited to termination of employment or contracts.

The Investigations module in the Compliance 360 system will be used to document and track the steps in the Corrective Action Plan, as well as automatically send reminders to the Compliance Officer and to leaders who are expected to take mitigation actions. As with the other functionalities of Compliance 360, this will enable more effective, timely, and consistent resolution.

The Magellan Complete Care Compliance Program further includes self-reporting of significant compliance issues to the State. The Compliance Officer reviews each issue against contractual and regulatory requirements, guidelines issued by AHCA, and Magellan’s Code of Conduct, and makes an assessment of the impact on enrollees and the company to make a self-disclosure reporting decision. Further, historical audits from customers and corrective actions and/or financial penalties are considered as these provide some detail as to the reporting expectations of the State. The decision about what should be reported is ultimately made by the Compliance Officer.

CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT HAS IDENTIFIED A QUALIFIED INDIVIDUAL...

The Compliance Officer is qualified by experience and training to hold the position and manage the responsibilities of the Compliance Officer position. Magellan Complete Care requires the Compliance Officer to have a graduate degree and over five years of experience in a compliance role in a health care environment including managed care/health plan experience.

We have included the Compliance Officer’s full resume [see General SRC #31, Attachment 2: Compliance Officer Resume], but noteworthy experience and expertise of our Compliance Officer includes:

>More than 20 years of managed care compliance, health care risk management and federal and state government funded program experience

>Served as the Compliance Officer with Magellan Complete Care since its inception in 2013 and before that was the Compliance Officer for the Magellan Pre-paid Mental Health Program

>For more than 19 years, has held and continues to hold an active and clear license in the State of Florida as a Licensed Mental Health Counselor
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

>For more than six years, has held and continues to hold an active and clear Certification in Health Care Compliance

> Earned a Bachelor's in Behavioral Health, a Master's Degree in Mental Health, and a Master's Degree in Business Management

The Compliance Officer is embedded in the business of Magellan Complete Care as a member of our executive and senior management teams. She is involved in the day-to-day operations of the health plan and routinely provides compliance and regulatory guidance on significant business decisions.

As previously mentioned, our Compliance Officer reports to the Vice President, Magellan Complete Care National Chief Compliance Officer, who oversees all of the Magellan Complete Care’s national compliance programs. This National Compliance Officer’s extensive experience includes:

> More than 20 years in managed care operations and compliance
> More than 15 years direct senior-level management of Medicare, Medicaid and dual eligible programs in managed care
> Has held a Registered Professional Nursing license in New York State for 24 years
> Holds a Bachelor’s degree in Psychology and a Master’s degree in Health Services Administration
> Actively holds a Certification in Healthcare Compliance from the Compliance Certification Board
> Was nationally recognized by CMS as having one of the top 5 compliance programs for Medicare Advantage/Dual Eligible programs in the country (2012)

This leader has served as the national Chief Compliance Officer for Magellan Complete Care since 2013 and is a member of the Magellan Health Corporate Compliance team overseeing and providing support for Magellan Complete Care compliance programs supporting Medicare, Medicaid and Dual Eligible programs in New York, Florida, Wisconsin and Virginia.

Magellan Complete Care’s commitment to serving our enrollees and ensuring that their needs are paramount in the design of the Compliance Program (as well as other key areas of business operations) is reflected in the clinical background of our Compliance Officer and the National Magellan Complete Care Chief Compliance Officer. This background and the perspective it brings ensures that these leaders appropriately account for the physical and psychological welfare of our enrollees as a clear priority and that Magellan Complete Care’s programs, policies, and processes properly support the enrollee as the center and purpose of our compliance-related work.

The National Magellan Complete Care Compliance Officer reports to and is supported by the Magellan Health Senior Vice President, Corporate Compliance Officer (CCO). The CCO has served as the Magellan Health Corporate Compliance Officer for over 11 years, and has an extensive background in overseeing and successfully operating compliance programs in healthcare settings, as well as in managed care programs. His strategic leadership helps these Compliance leaders set the right compliance culture and effective direction for the Compliance Program that supports Magellan Complete Care’s business.
Our Compliance Officer, the national Magellan Complete Care Chief Compliance Officer and the Magellan Health, Inc. CCO maintain open and frequent communication regarding Magellan Complete Care health plan operations and related matters across the company, its affiliates, and the industry to ensure that our Compliance Program remains effective, innovative, and agile.

The Magellan Complete Care Chief Compliance Officer and Florida Compliance Officer prepare quarterly reports on the status of the Magellan Complete Care Florida Compliance Programs, risks, and activities. The quarterly report, together with the reports from the other Magellan Complete Care health plans, are compiled by the Magellan Complete Care Chief Compliance Officer and included in the Magellan Corporate Compliance Committee discussions. The Magellan Corporate Compliance Committee meeting discussions are then included as part of the quarterly compliance report made by the Corporate Compliance Officer to the Magellan Board of Directors.

The Magellan Complete Care Florida Compliance Officer has a cooperative and collaborative relationship with Medicaid Program Integrity Unit and the Bureau of Plan Management Operations employees. She works closely with the Magellan Complete Care Florida Board of Directors, Executive Management, Senior Management, and the Special Investigations Unit on all matters related to compliance and FWA issues and activities.

CRITERIA 3: THE EXTENT TO WHICH THERE ARE SUFFICIENT STAFF…

In essence, all employees at Magellan Complete Care implement and safeguard the company’s Compliance Program. Doing the right thing in the right way is everyone’s job.

But with respect to more formal accountabilities in ensuring that our Compliance Program is effective, it is led, maintained and operated by a dedicated Compliance team with experience and expertise in the field, supported by other teams in related disciplines.

To that end, the Compliance Department is staffed with four Florida-based staff: the Compliance Officer, Compliance Manager, Compliance Auditor and the Compliance Coordinator.

In addition to the Compliance Officer’s experience described earlier, the team’s experience includes:

> Compliance Manager: Certified in Health Care Compliance, health plan experience in auditing and monitoring; appeals and disputes; customer service and claims. She also holds a Master’s in Business Administration

> Compliance Auditor: Nationally Certified Pharmacy Technician; Florida Registered Pharmacy Technician; extensive experience in pharmacy including health plan pharmacy auditing and monitoring and pharmacy provider operations

> Compliance Coordinator: Medicaid health plan experience in compliance activities, customer service and claims resolution

The Compliance Officer also has access to subject matter experts as needed. The Magellan compliance organizational chart, covering Magellan Complete Care, is included as [General SRC #31, Attachment 1: Compliance Department Organizational Chart]. This includes not only our
Compliance Officer but also regional compliance directors and compliance attorneys, all of whom have extensive specialized training in the major compliance areas such as HIPAA regulations, FWA and other areas of specialization. Another resource for the Compliance Department is the Corporate Legal Department and the Magellan Complete Care dedicated Associate General Counsel. The Legal Department works closely with the Compliance Officer on significant compliance issues and provides legal guidance and interpretation of contract and regulatory language.

As additional support, the segment of Magellan’s Special Investigations Unit that is dedicated to protecting program integrity at Magellan Complete Care is managed by the Magellan Complete Care of Florida Fraud Investigations Unit (FIU) Manager, and staffed with an investigator and two compliance and claims auditors located in Florida. The FIU Manager is supported by a corporate SIU infrastructure as the Florida team reports to the Senior Manager, Operations SIU who in turn reports to the Vice President, leader of the corporate SIU. The SIU team is represented in an organizational chart in [General SRC #31, Attachment 3: SIU Organizational Chart]. The FIU Manager uses corporate shared systems, data analytics and specialty subject matter experts such as the corporate SIU pharmacy program integrity experts.

The Internal Audit Department is managed by the Senior Vice President, Audit and Chief Internal Auditor, and staffed with three Managers, three Accountants and seven auditors. The Internal Audit team, which is represented in an organizational chart in [General SRC #31, Attachment 4: Internal Audit Department Organizational Chart], is a corporate resource that confers on an ongoing basis with our Compliance team on risk and compliance issues, and provides independent auditing of the health plan and its operations in support of the Compliance Program.

CRITERIA 4: THE EXTENT TO WHICH THE RESPONDENT’S COMPLIANCE PROGRAM…

Given the robust and proactive nature, effectiveness, and maturity of our Compliance Program, Magellan Complete Care has extensive experience in identifying, investigating, and resolving fraud and abuse in managed care programs with our subcontractors and our internal staff as well as other parties. This experience has been developed through the use of various controls and checkpoints further outlined below.

As it relates to our subcontractors, our Compliance Officer and SIU team partner with Magellan Complete Care’s Delegated Vendor Management to ensure appropriate oversight of these third parties, particularly related to potential FWA. Compliance and SIU’s close and ongoing partnership with Delegated Vendor Management is critical to ensuring our subcontractors not only meet AHCA as well as our requirements, but that they do so with a clear and convincing focus on program integrity.

Compliance and SIU’s involvement in the Magellan Complete Care subcontractor management process begins with the initial vetting of vendors and continues throughout the contract and into post-contract activities. Consistent with the construct of Magellan Complete Care’s Compliance Program, described in detail above, our Compliance Officer ensures that Magellan Complete Care subcontractors have the appropriate tone, tenor, policies, and protocols of their own to enable adherence to applicable requirements, including those pertaining to compliance and program integrity. For example, our Compliance Officer, in partnership with our SIU team, validates that, among other things, Compliance/FWA training is administered by our subcontractors for their respective workforce – either by adopting and using Magellan Complete Care’s compliance
training curriculum or deploying their own (with the approval of content and process by our Compliance Officer). Through their contractual obligations to Magellan Complete Care, our subcontractors and their employees know how to recognize FWA, to report it to us and through what mechanisms they should report it.

In addition, our Compliance Officer and SIU staff conduct assessment and ongoing monitoring activities specific to FWA and participate in ongoing operational meetings with Delegated Vendor Management so we have insight into any operational changes that may affect the Compliance Program, including the work of our SIU. This approach, which has been in place for some time now, has proven to be very effective in allowing us to identify opportunities for new or emerging FWA risks on an ongoing basis.

In addition, the SIU consistently participates in a vendor/subcontractor risk assessment informed by various external sources, including the U.S. Department of Health and Human Services, Office of Inspector General work plan, Federal Bureau of investigation, Office of Personnel Management, and state-specific reports. Each subcontractor is scored based upon potential area of FWA risk. The subcontractor’s compliance and program integrity plan(s) is also reviewed by the SIU staff as well as the Compliance Officer to ensure effective approaches and processes exist for prevention, identification, resolution, and reporting of FWA issues.

In addition, SIU staff work closely with the Magellan Complete Care financial management team to review subcontractor invoices, conduct data analysis, and complete audits of subcontractor claims and encounters on a routine basis. All findings are shared with the subcontractor as well as internal stakeholders, including Delegated Vendor Management and Compliance for appropriate follow-up.

We have many procedures in place that have proven to be effective in the identification of subcontractor fraud. These include but are not limited to:

> Provider Chart Audits & Onsite Reviews
> Verification of Services Providers to Enrollees Audit
> Verification of Network Providers, Employees, Subcontractors Medicaid/Medicare Sanctions Status
> Prior Authorization System Edits
> Claim System Edits
> Pre-payment Reviews
> Post Payment Reviews
> Enrollee Complaints
> Utilization Management procedures inclusive of prior and concurrent reviews

To the extent that as part of any of this activity evidence is found to support suspected FWA, it is reported to AHCA within required timeframes.

As another control, the Magellan Internal Audit Department works with the Compliance Department as well as management from various areas of operations during an annual and mid-year risk assessment process to identify areas for inclusion on the Internal Audit Plan. This includes a previously-mentioned fraud risk assessment. Also, all audits performed as part of the Internal Audit Plan undergo a SAS 99 fraud brainstorming session where specific fraud scenarios are evaluated and included within the scope of review. Any potential fraud that is identified is
discussed with the relevant areas and levels of management and communicated to ACHA as appropriate.

As another critical element of this program serving as a control of and experience in identifying fraud and abuse, every Magellan Complete Care employee is trained, upon hire and at least annually thereafter, on our expectation that each individual is required to do the right thing in the right way. This training educates on, among many other topics, what constitutes FWA, and what to do if an employee becomes aware of or thinks he/she may have information regarding suspected FWA. This training, as well as other compliance-related communications, such as employee newsletters, consistently convey that if an employee sees, hears, or knows something of concern, they need to say something – if they do, they are protected from retaliation, and if they do not, they are subject to disciplinary action up to and including termination.

We also use GPS locator services to manage internal Magellan Complete Care staff, particularly those who work in the field, such as Provider Support Specialists, Health Guides, and Community Outreach Specialists. In collaboration with Xora, a market leader in mobile workforce management, and its mobile applications, we can identify the location of individual field staff on a Google Map, drilling down to ascertain where someone has been, the route they have driven, and where they are now. This serves as another control to ensure that our employees are doing the right thing in the right way (not to mention that our providers and enrollees are getting the best support from Magellan Complete Care).

We take further steps to ensure integrity in our workplace, to include prevention and detection of fraud by employees/contractors, providers, and subcontractors, through robust screening and verification of these parties in accordance with applicable comply with applicable state and federal requirements.

More specifically, Magellan Complete Care, as well as its corporate parent, Magellan Health, Inc., its subsidiaries and affiliates, check the Health and Human Services (HHS) Office of Inspector General (OIG) List of Excluded Individuals/Entities (OIG’s LEIE), Cumulative Sanction Report and General Services Administration’s (GSA) web-based System Award Management (SAM) Exclusion Database, and applicable state exclusion lists for names of excluded employees, members of the Board of Directors, volunteers, contractors, providers, and vendors barred from participation in Medicare, Medicaid, other federal health care programs, federal contracts, and state health care programs. As a matter of company policy, as well as to ensure adherence with applicable federal and state regulations, excluded individuals or entities are not hired, employed, or contracted by Magellan Complete Care, nor for any other of Magellan’s federally and state funded health care contracts.

Every efforts is made to identify these excluded individuals and entities before they ever do business with us. If during their relationship with Magellan Complete Care, the resolution of any criminal charges or proposed debarment or exclusion, employees, members of the Board of Directors, volunteers, contractors, or vendors with whom Magellan currently contracts who are charged with criminal offenses related to health care, or proposed for debarment or exclusion are pending, that individual must be removed from direct responsibility for or involvement in any federally-funded health care program. If this resolution results in conviction, debarment, or exclusion of the employee, member of the Board of Directors, volunteer, contractor, provider, or vendor, Magellan immediately ceases doing business with that Ineligible Person as defined by the applicable regulatory requirements.
In addition, and consistent with corporate policy as well, Magellan Complete Care conducts background investigations for every prospective employee before employment begins. Credit investigations may also be conducted for designated positions. Our process in this regard is done in accordance with applicable laws and regulations, and respects the privacy and dignity of those subject to it. Final approval of an applicant’s eligibility to occupy the position applied for is based on a set of adjudication criteria defined in Magellan’s personnel security procedures to ensure integrity in the workforce as well as legal and ethical outcomes for the company and the applicant. To that end, all of this screening and verification work is carried out by our internal HR and Personnel Security teams in partnership with reputable third parties. Any vendor facilitating or conducting screening or inquiry must meet all applicable licensure, certification, and other related requirements. To the extent that additional investigation is necessary regarding any employee, HR and Personnel Security involve Compliance and SIU staff in any follow-up and consult with legal staff as necessary.

**Evaluation Criteria:**

1. The extent to which the respondent’s compliance program complies with all State and federal requirements.

2. The extent to which the respondent has identified a qualified individual with sufficient authority and adequate corporate governance reporting relationships to effectively implement and maintain the compliance program.

3. The extent to which there are sufficient staff to implement the compliance program.

4. The extent to which the respondent’s compliance program has experience identifying subcontractor fraud and internal fraud and abuse in managed care programs.

**Score:** This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.
SRC# 32 – Fraud and Abuse Special Investigations Unit (SIU) (Statewide):

The respondent shall describe its Special Investigations Unit (SIU) program and its controls for prevention and detection of potential or suspected fraud and abuse and overpayment, including the use of biometric or other technology to ensure that services are provided to the correct enrollee, including verification of home-based visits and services, to ensure those services are being appropriately provided and that services billed were received by the correct enrollee.

Response:

OVERVIEW
As part of our efforts to improve the healthcare system, Magellan Complete Care has made a formal, long-standing, and engaged commitment to detecting, correcting, and preventing fraud, waste and abuse (FWA), including overpayments. Success in these efforts is essential to maintaining a healthcare delivery system that uses limited resources in the most effective and efficient way for the individuals we serve who are living with serious mental illness (SMI), as well as for AHCA and Florida taxpayers. To that end, Magellan Complete Care has established adequate staffing, resources, internal controls, and policies and procedures to prevent, reduce, detect, investigate, correct and report known or suspected FWA activities.

A keystone of Magellan Complete Care’s overall compliance is our comprehensive fraud and abuse approach, which is designed to ensure program integrity through prevention and detection. This ensures that we identify and address emerging trends of FWA in accordance with our current AHCA contract as well as state and federal law.

The Magellan Complete Care fraud control unit, a dedicated part of the Magellan Health, Inc. (Magellan) Special Investigations Unit (SIU), works diligently and proactively to detect, prevent, and assertively address allegations of health care FWA in Magellan Complete Care’s Specialty Plan. The SIU is a specialized and experienced unit responsible for assuring program integrity within Magellan's Internal Audit Department. It is led by the Vice President, SIU Investigations, who reports to the Senior Vice President, Audit and Investigations and Chief Audit Officer.

This Unit includes a local Florida team with a designated employee qualified by training and experience to oversee the SIU for the investigation of possible fraud, abuse and overpayment and ensures mandatory reporting as required by Magellan Complete Care’s contract with AHCA, as well as applicable state and federal law. For more information regarding the SIU's organizational structure, please see [General SRC #20, Attachment 1: SIU Organizational Chart] and additional details outlined below.

In accordance with Magellan Complete Care’s Compliance and Program Integrity Plan, the SIU works in close partnership with our Compliance Officer. This partnership ensures a comprehensive and integrated approach to our compliance and program integrity efforts by serving several critical objectives; it helps to ensure adherence with applicable Federal and State requirements and State Medicaid Managed Care Contract obligations, as well as to buttress Magellan Complete Care program integrity activities and programs through a range of activities described in detail in this section.
Our SIU relies on a host of tried-and-true, as well as emerging, information collection/referral mechanisms, investigative approaches, and technological and other tools to combat FWA. The work of the SIU is conducted in manner that meets all AHCA requirements and expectations, as well as applicable state and federal regulations; it also supports effective and efficient business operations and quality of care for Magellan Complete Care enrollees in AHCA’s healthcare benefits programs.

Our approach to FWA prevention, detection and reporting is comprehensive and includes the following components:

- Routine and ongoing assessment of FWA risks and development of work plans to address these risks
- Detection of FWA through the use of data mining and expert vendors
- Application of prepayment controls including pre-authorization and automated claim edits
- Monitoring and investigation through pre-payment and post-payment audits
- Education of Magellan Complete Care staff, providers, and enrollees
- Providing 24/7 access to avenues for confidential and anonymous reporting of suspected FWA
- SIU team training, experience, and expertise
- Subcontractor assessment, monitoring and auditing
- Communication and coordination with internal and external stakeholders, including AHCA, the Bureau of Medicaid Program Integrity (MPI), and other oversight and law enforcement agencies
- Ongoing application of new tools and technologies

This approach is outlined in more detail below.

CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT USES VARIOUS TYPES...
Magellan Complete Care uses a comprehensive approach to prevent and detect, as well as investigate and appropriately resolve, potential or suspected FWA. This approach is risk-based and grounded in well-defined programmatic objectives supported by expert staff, detailed policies and procedures, and the use of tested and proven processes and protocols. Indeed, through the second quarter of 2017, the Magellan Complete Care SIU has demonstrated a cumulative value of $28 million achieved (recoveries and avoidance, net of related vendor fees), representing 1.8% of revenue.

Similarly, the SIU has developed strong partnerships internally with the other areas of Magellan Complete Care’s business of operations, including claims, network, health services, quality management, and data analytics. These relationships spur, among other things, internal referrals of possible fraud and abuse to the SIU team and multi-disciplinary follow up on them. That in turn leads to more effective utilization of precious and limited resources that can be applied to the services that our enrollees need.

Over the years in its various business lines, including Magellan Complete Care’s Specialty Plan under the Statewide Medicaid Managed Care Contract with AHCA (the Contract), we have learned that referral-based pay-and-chase approaches to FWA prevention are resource intensive and less effective than other proactive techniques. We still assertively pursue recoveries when necessary and appropriate. But identification of potential FWA through a multi-pronged approach that includes risk assessment, data mining, audit and investigation,
employee/provider/subcontractor education, and prepayment edits is the methodology we favor whenever and wherever possible.

Our proactive and predictive methodologies and processes provide opportunities for faster and more effective identification of possible FWA, improved controls to ensure integrity of our programs, and greater savings through cost avoidance. Each of these elements builds upon the others to deliver a more effective FWA program by helping us focus our attention, efforts, and resources on the areas of highest risk. Add to that a strong partnership with providers to ensure their knowledge of and adherence to regulatory and contractual requirements, and we believe we have a winning formula to minimize FWA and maximize program integrity.

1.1 Risk Assessment and Work Plan
The foundation of our approach is an FWA assessment of risk. The SIU has established a formal process for identifying and assessing FWA risks on a routine and ongoing basis. This process includes an annual identification, evaluation, and assessment of risks using various sources of information and guidance. These include the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) Annual Work Plan, state-specific FWA activity reports, risks identified by the Federal Bureau of Investigations (FBI) or Federal Office of Personnel Management (OPM), internally-identified areas of potential concern, leads and schemes learned at industry events, local fraud task force meetings, published news articles, and data analysis and mining reports.

The SIU also identifies potential areas of risk continually through routine and repeated education, research and monitoring, and information sharing by and between law enforcement, other managed care plans’ SIUs, subcontractor and vendor SIUs, program integrity units, and professional workgroups. All of this information collection and assessment considers likelihood of material exposure to significant FWA risk as well as compensating controls and mitigation of that risk; this consequently helps determine the SIU’s activities on a prioritized basis.

More specifically, the results of our risk assessments inform the SIU Work Plan, a documented outline of the activity our SIU staff will perform over a pre-determined period of time to address the most significant risks we have identified. For example, through our ongoing evaluation of risk, we know that lab services rendered by independent labs are at high-risk for fraud and abuse based upon exposure, and we recognize the likelihood that the risk will be realized if left uncontrolled. So, the current SIU Work Plan includes program integrity focus on and follow up these services and associated billings.

This Work Plan, while a primary tool for the SIU to prioritize its attention, efforts and resources in the most effective and efficient manner, involves other areas of business operations as well, because a multi-disciplinary perspective in combatting FWA is essential to success. Our Work Plan priorities inherently include activities requiring cooperation and partnership with many other areas of the company and our subcontractors. These activities may include, for example: pre-payment claim edits; pre-payment review of claims; post-payment claims audits and investigations; data mining and reporting; and education of internal staff, providers, and/or enrollees.

The SIU reviews the risk assessment and the associated work plan with the Compliance Officer (and in the Compliance Committee meeting as appropriate) to ensure all leadership and management staff have a thorough understanding of the FWA risks identified and to gain input
about and support for the implementation of compensating controls. This communication also
serves as an opportunity for SIU to identify new or emerging risks based upon operational,
procedural, contractual, or regulatory changes.

Following through on our lab services example, our most recent SIU Work Plan identified this as
a risk. Through our Claims Department, we implemented an automated edit to deny out-of-
network lab claims where no pre-authorization exists, resulting thus far in more than $23.3 million
in avoidance, accompanied by ongoing monitoring of in-network claims. The SIU is also working
with our Network Team to ensure any other labs applying for in-network status moving forward
are reviewed even more stringently.

1.2 Data Mining and the Use of Expert Vendors
The SIU analyzes claims for potential FWA abuse on a post-payment basis using several data
analysis/business intelligence tools, including SPSS Statistics and Modeler, as well as Tableau,
Cognos and other current tool standards in business intelligence.

SPSS Statistics and Modeler is a data mining workbench and software application from IBM. As
the name suggests, SPSS Statistics provides descriptive and advanced statistics. This tool
includes a range of advanced algorithms, data manipulation, and automated preparation
techniques to build various analytic models and thus uncover hidden patterns in data. It delivers
a comprehensive analytics platform, designed to leverage predictive intelligence that allows our
SIU to go beyond traditional data mining. The broad range of capabilities offered by this tool
enables fully integrated analytics that directly support broader assessment of potential FWA,
maximized use of various data sources, such as data warehouse, database, and flat files, and
more effective preparation and presentation of data reporting for the SIU and its internal as well
as external partners.

Tableau is software that focuses on data visualization, dashboards and data discovery. With
Tableau, large datasets can be analyzed to identify trends and opportunities for actionable items
using a variety of graphs, charts, and geospatial representations and reports.

Magellan Complete Care has built a centralized, automated self-service, point and click, web-
based Business Analytics and Reporting Tool (BART) using several sophisticated business
intelligence software solutions. These tools support various data management requirements of
our SMI specialty plan, including those of our SIU. Among other things, BART enables us to track
our standard Key Performance Indicators (KPI)/trend metrics around utilization management,
quality improvement, cost of care, operational efficiencies and our program outcomes. BART also
helps us to visualize/mine data and gain new insights around enrollee/provider/facility behavior
and utilization patterns.

This relatively new, flexible analytics system is now being made available to the SIU, and its
capabilities further our program integrity. More specifically, BART is the latest evolution of tools
created by Magellan to empower the SIU in combatting FWA through technology. BART puts
regression, outlier identification, and quickly generated detail directly in the hands of SIU staff, far
surpassing earlier generations of technologies used to identify potential services.

Through the use of all of these tools, our data analysis is more automated and sophisticated than
ever. It thus better enables reviews for known schemes, examination of provider-outliers in
utilization and cost, and the use of predictive modeling and algorithms – all of which provide
enhanced insights to our SIU staff regarding new or emerging areas of risk. The tools also allows us to monitor program integrity controls as designed to prevent FWA. Our previously-described comprehensive and robust FWA risk assessment process guides us in determining which analyses should be prioritized for development and deployment. This occurs on a regular basis through a host of information sources and resources outlined above and on an ad hoc basis for investigation-specific or regulator-specific requests.

Results of all of this claims analysis serve as leads for investigations, identification of overpayments for recovery, opportunities for additional claim edits or provider education, and/or the need for implementation of other compensating controls. In addition to collaborating with the Compliance Officer, the SIU shares results with clinical and medical staff when appropriate, regarding provider or enrollee treatment patterns that may also warrant clinical or medical review and/or intervention.

In addition, we use external vendors with expertise in specialty areas to assist in the analysis and audit of claims for FWA. We employ vendors for evaluation and audit of inpatient claims paid through a Diagnosis-Related Grouping (DRG) methodology and for analysis of pharmaceutical claims and audits of pharmacies. We have selected our vendors based upon their extensive knowledge and experience, as well as their advanced processes to understand FWA risk associated with claims in their respective areas. We have direct oversight and input into our vendor activity and have ongoing coordination through reports and meetings to ensure efficient and effective activity as well as identification of emerging trends, suspected FWA and opportunities for additional prepayment controls.

1.3 Exploration of Additional Technology and Tools
Magellan Complete Care very well understands not only the need to be proactive but also the importance of being strategic in its approach to combatting FWA. The program integrity battle cannot be won one investigation or one audit at a time. The more that technology can help our SIU set its course for automated and thus, more effective and efficient approaches and tools, the better. As mentioned above, we already have electronic data analysis tools to support the SIU in its program integrity efforts on an automated basis. But to further that end, the SIU and its internal business partners continue to grow and expand our technology assets to ensure we are exceeding our partners’ expectations.

To enable the SIU and other business intelligence users within Magellan with near real-time alerts and analysis, Magellan has implemented a data lake, which is a large data storage repository used to collect vast amounts of data from disparate sources, cleanse test and ensure its accuracy, and publish the resultant data structures as appropriate to various Magellan teams. The idea of a data lake is to have a single store of all data in the enterprise ranging from raw data (exact copies of source system data) to transformed data which is used for various tasks including reporting, visualization, analytics and machine learning. The data lake includes structured data from relational databases (rows and columns), semi-structured data (CSV, logs, XML, JSON), and unstructured data (emails, documents, PDFs). The repository now includes domains of data including claims, membership and enrollee demographics, service authorizations, care management information, provider demographics and history and pharmacy claims. Efforts are underway at the present time to add HEDIS Gaps in Care, telehealth activity, satisfaction surveys, analytics from other 3rd party data tools such as ImpactPro, and publicly available data such as census and consumer household information.
Magellan Complete Care’s data lake is in production and currently provides information in a “drill-through” model showing discrete service, claim or demographic information at the enrollee or provider level, up through the identification of trends or outliers in service deliveries. These analytics are easily viewed by diagnosis, provider, enrollee demographic, state region or other identifying attributes. The many levels of analytics provided to the SIU and other teams enable us to quickly and accurately identify providers or services with high potential risk of FWA, and guide us to implement pre-payment reviews in those cases.

More specifically, the data lake and our associated SIU dashboard allows our SIU to:

- More effectively and efficiently collect data to support investigations;
- Detect patterns of potential fraud hidden in vast amounts of claims data;
- Perform search, ad hoc and exploratory analysis on collected data;
- Reduce time to action for specific fraud investigations by integrating what might otherwise be segregated source data into a centralized data location;
- Optimize higher quality and more automated fraud monitoring, detection, prevention and investigation overall, not just for Magellan Complete Care, but its affiliates and customers, including AHCA, as well.

Magellan’s BART, the SIU dashboard and our data lake are now proven state-of-the-art tools that will continue to be enhanced and expanded to support of Magellan Complete Care and our SIU efforts.

As another example, the Machine Learning Risk Scoring Tool was developed by data scientists and uses machine learning – giving computers the ability to learn without being explicitly programmed – to enhance the immediate discovery and prediction of potential fraudulent activities in claims data. This data-driven and risk-stratified technology provides a strong backup to existing rules and logic statements, provides accuracy and speed of decisions, increases insights into fraudulent trends, and reduces manual review of claims data leading to more complex investigations and return on investment. While still under development and review, we anticipate that this tool is expected to be ready for SIU use by the end of 2017.

1.4 Pre-payment Claim Edits and Pre-payment Review of Claims

As a matter of routine practice, and to better prevent improper claims payments and detect potential fraudulent claims, Magellan Complete Care implements a number of edits during claims adjudication. Magellan uses Claimcheck, an industry standard tool which includes NCCI edits to provide claim edits, including:

- Enrollee eligibility
- Valid HIPAA compliant coding for place of service, CPT-4, HCPCS, modifiers, ICD-10 and UB-04 data sets
- Covered procedures and diagnoses for the enrollee’s benefits
- Incidental and mutually exclusive services edits
- Unbundling edits for all services, which includes evaluation and management, pre- and post-operative care, laboratory and radiology services, and unilateral/bilateral procedures
- Outpatient Code Editor (OCE), which includes age and gender editing against diagnoses and procedure codes
- Medically Unlikely Edits (MUE) which edits max units per procedure per day
>FWA, which edits for services rendered on weekends and holidays and billing more units than are likely to be performed in one day
>Duplicate claim edits

Our claims system is agile and adaptable enough to allow for pre-payment edits to be implemented based upon areas of FWA risk identified as part of our ongoing risk assessments. We leverage this agility and adaptability as much as possible, and our pre-payment edits are applied to specific providers, provider types, procedure codes or other identifiers on a differentiated and prioritized basis. As a result of our effective approach and processes, Magellan Complete Care implemented specific FWA-based pre-payment edits for laboratory, emergency transportation and other services rendered by out of network providers that prevented improper payments of more than $23.3M.

In addition, through our continuous improvement efforts, the SIU is working with others areas of the business, such as Health Services, Claims and IT, to develop and implement new initiatives in this area as well. For example, the SIU is working with Claims to streamline the process for implementing additional pre-payment, claim check edits on an ongoing basis. One edit we are evaluating is for level 4 and level 5 evaluation and management codes in combination with psychotherapy add-on codes and a modifier indicating prolonged evaluation and management services.

1.5 Pre-payment and Post-payment Audits and Investigations
Our SIU conducts both pre-payment and post-payment audits of providers who submit claims for services identified as having potential FWA risk, as indicated through ongoing risk analysis, data mining, leads and tips, and emerging schemes. More specifically, statistical analysis of claims data identifies providers with submission and utilization patterns outside expected parameters based upon the enrollee population served and those are considered for audit. These audits may be onsite audits or desk audits. The type of audit conducted is determined on a case-by-case basis and takes into consideration the provider type, size, and volume, the allegation or issue of concern, results of prior audits, and other relevant factors. Audits are conducted by SIU staff experienced and certified in proper coding to ensure compliance with industry standards and Medicaid rules.

For example, an SIU targeted pre-payment review of advanced life support (ALS) emergency transportation claims found that more than 55% were not coded properly when compared to AHCA guidelines, resulting in the prevention of over $1.2M in improper payments for these services since 2016. We are currently reviewing other areas of emerging risk for the development of pre-payment edits and implementation of pre-payment audits, including review and audit of providers with unusual patterns of billing high-level professional emergency room evaluation and management services when the patient is not admitted to the inpatient facility.

As another example, based on some admittedly modest post-payment recoveries on DRG up-coding since late in 2016 – approximately $15K/month – Magellan Complete Care is developing an expanded initiative to perform DRG reviews on a pre-payment basis with our Health Services and Claims Departments to prevent improper leakage. We anticipate being able to implement this initiative by early 2018.
Audits may identify overpayments, non-compliance with required standards, potential FWA, and/or other opportunities for improvement. Our SIU auditors use an internally developed browser-based audit tool to track and report all audit results. They coordinate with other areas of business operations, such as Provider Network, Claims, Health Services, and Compliance to ensure appropriate education, corrective action, and overpayment recovery. As required, reporting of suspected FWA to AHCA occurs. SIU audit and vendor staff conducted proactive audits year-to-date through August 2017, resulting in education of 36 providers and more than $3.4M in identified overpayments on behalf of Magellan Complete Care.

Despite our best proactive efforts, some FWA investigations involving health care providers are identified post payment. So, in most instances after the SIU receives the initial allegation, Magellan Complete Care continues to process subsequent claims until the allegation is considered to be credible. In certain circumstances, e.g., providers submitting claims for services after license revocation, Magellan Complete Care denies the subsequent claims until the investigation is complete. This decision is made by the SIU in consultation with the Compliance Officer, and other leaders at Magellan Complete Care, such as in the Network, Health Services and Quality Improvement departments, to ensure that any impact to enrollees and other stakeholders are effectively anticipated and addressed.

As previously indicated, Magellan Complete Care supplements our own internal resources by contracting with various vendors from time-to-time to conduct audits of claims. Each vendor uses input from the SIU, proprietary algorithms and their own expertise to identify providers and claims for audit. SIU staff coordinate with vendor staff to ensure appropriate oversight, information sharing, and coordination as well as reporting of activity. Currently, for example, post-payment audits are occurring on DRG inpatient hospital claims through our vendor DRG Claims Management, Inc. and select pharmacy claims are being audited through Conduent, Inc. In addition, trends and/or schemes identified through our external vendors’ analysis and audit results inform ongoing SIU risk assessment activities and resulting SIU workplans.

SIU investigators conduct investigations of suspected FWA based upon referrals and leads from a number of sources further outlined below. Investigators use our case management system, Perspective, from Resolver, Inc., to log all referrals and SIU activity. In addition to the tools previously described to enable evaluation of FWA risk and analysis of data at various levels and sets, SIU staff also have access to tools to help them conduct their investigation, including data analysis applications (e.g. SPSS), access to a public records research tool (CLEAR EDD), RAT STATS for audit sampling, and our custom SIU workbench, which is a comprehensive tool that enables the user to access investigative data combined from multiple internal and external sources.

1.6 Education of Internal Staff, Providers and Enrollees
While the SIU has leadership accountability for Magellan Complete Care’s program integrity efforts, the unit relies very heavily on those who might most directly see potential FWA when working with our providers, subcontractors, and enrollees to inform and support its efforts – the Magellan Complete Care workforce. One of the most effective controls we use in detecting and preventing fraud and abuse is to thoroughly train our employees to identify, refer, and cooperate with the investigation and resolution of potential FWA. As part of the overall Compliance Program training curriculum, FWA education is administered to all staff at all levels in the organization, both at the time of new hire and on an annual basis. This training is mandatory and any employee who
does not complete the training on a timely basis is subject to disciplinary action up to and including termination of employment.

Among its primary objectives, this training program required for all employees does the following:

> Educates employees regarding who/what entities commit fraud and how, and provides specific examples
> Quantifies the impact on fraud on the health care industry as well as individuals
> Outlines the responsibilities and expectations of each and every employee in relation to the detection, prevention, and reporting of suspected FWA
> Describes and defines the responsibilities of the SIU
> Lists ‘red flag’ indicators of potential FWA
> Summarizes the procedures for reporting suspected FWA to the SIU
> Outlines policies regarding fraud and abuse
> Addresses potential Medicaid and Medicare fraud more specifically, e.g. facility, professional, and prescription drug), including education on the federal False Claims Act, state false claims law, and AHCA requirements

Similarly, as part of our subcontract management and oversight and in coordination with the Compliance Officer, the SIU reviews the training our subcontractors provide to their staff. In this way, we ensure the content and approach of this training aligns with applicable regulatory requirements as well as our own expectations. This review also most effectively provides direction to subcontractors’ staff, particularly related to the identification of FWA and the importance of and process for reporting it.

Additional training is provided to Magellan Complete Care “front line” staff including customer service specialists, health guides, case managers, UM licensed health professionals, medical directors and other staff as appropriate. This training provides examples of situations that these staff may encounter on a day-to-day basis and guides them in how to respond and report these situations. In addition, a summary of SIU activities, outcomes and performance are provided to ensure that all staff have a working understanding of the scope of FWA risk to the plan.

Also, FWA-related training is provided to our providers and enrollees to ensure that (i) they are appropriately sensitized to and are able to recognize fraud/waste/abuse issues and concerns in their provision of and access to services, respectively and (ii) know how seriously Magellan Complete Care takes its commitment to our program integrity efforts. In the case of providers, this training is included in our general training, administered first when a provider joins our network and then on an annual basis. For enrollees, we include relevant FWA information, including how to contact our SIU, in the Enrollee Handbook.

As stated previously, all employees receive comprehensive FWA training updates on at least an annual basis, with specialized training done on an ad hoc and perhaps more frequent basis. To ensure prompt and complete investigations, employees are expected to immediately refer suspected FWA to the SIU. These internal referrals can be made through a variety of communication mechanisms, including the Compliance or SIU Hotlines, Compliance or SIU email boxes, hard copy sent via regular mail, and/or direct outreach to SIU team members (email, call, or other outreach).
1.7 Avenues for Reporting of and Follow-up on Suspected FWA
Our SIU team ensures effective detection, prevention, audit, and investigation of suspected FWA based at least in part upon referrals and leads from a number of sources, including: SIU audit results, the SIU Hotline, the Compliance Hotline, information sharing initiatives through local workgroups, the National Health Care Anti-fraud Association (NHCAA) and the Healthcare Fraud Prevention Partnership (HFPP), monitoring of published news articles, enrollee complaints, data analysis, vendor reports and other sources. Since allegations of suspected FWA may be received from many disparate sources, both internal and external, such as Magellan Complete Care current or former employees, enrollees, providers, current or former employees of providers, and subcontractors, we try to make reporting of these allegations as easy as possible through several communication mechanisms.

Magellan SIU maintains a corporate toll-free fraud SIU Hotline (800-755-0850) as well as a Magellan Complete Care toll-free SIU Hotline (877-269-7624) for the reporting of suspected FWA. These hotlines are staffed by trained SIU Analysts during normal business hours. In addition, the SIU accepts referrals via an SIU-dedicated email address. This hotline and email box are well-published and readily accessible for employees, enrollees, providers, and the public to report suspected FWA to the SIU; the information is included in employee training, posted in Magellan Complete Care work locations, incorporated into the Enrollee Handbook and Provider Handbook, and shared with subcontractors.

In addition to SIU-sponsored reporting avenues, employees, and other parties may also report suspected FWA directly to the Compliance Officer, local SIU staff, their immediate supervisor, or any member of senior management. This can be done through personal contact or through the Compliance Hotline or Compliance email account. These reports can even be made directly to AHCA or HHS OIG. Again, relevant contact information is provided through the publication methods outlined above.

Once an employee or other referring party makes a referral of potential fraud, waste, or abuse to the SIU, that employee or other party is advised not to conduct further follow-up related to any potentially fraudulent aspects of the allegation unless asked for assistance by our SIU.

1.8 SIU Training, Experience, and Expertise
Our SIU is as effective as it is in significant measure because of the deep experience and expertise of the team and its leadership. The SIU is made up of full-time employees dedicated solely to the prevention, detection, investigation, and resolution of suspected FWA. Magellan Complete Care believes it can only achieve effective and compliant handling of FWA using well-trained and experienced investigators and auditors. All SIU staff, including management, are active members of local and national trade organizations, have completed or are in the process of attaining professional certification, and are required to complete at least twenty-four hours of job-related training per year.

The SIU is led by the Vice President of SIU Investigations, who has been the senior leader of this Unit for more than 15 years. The SIU team has experience in various areas of business operations as well as program integrity detection/prevention/resolution, including Customer Service, Provider Networks and Contracting, Information Technology, Data Management and Reporting, and Security (Personnel, Physical and IT). Leadership on the team includes Accredited Healthcare Fraud Investigators (AHFI), who are actively involved in the National Health Care Anti-fraud...
Association (NHCAA), the NHCAA Behavioral Health workgroup, and other professional associations helping to guide and define industry best practices.

The Florida-based staff of the SIU is designated and dedicated to Magellan Complete Care and includes a senior manager of operations, a manager of investigations, one fraud investigator, and two compliance auditors. These team members maintain various professional credentials that support their work, including AHFI, Certified Internal Auditor, Certified Professional Coder, licensed claims adjuster, and licensed healthcare risk manager. The team also provides risk assessment and subject matter expertise regarding FWA schemes and mitigation activities to the Magellan Complete Care executive and senior leadership, directing investigations, coordinating recoveries, and actively conducting data analysis to identify possible red flags related to FWA.

Their work also includes continuous improvement of critical program integrity processes, policies and procedures, standardization of work papers, and financial analysis. In this year alone, enhancements to the operations of the SIU have been made in areas related to audits in advanced life support (ALS), subcontractor/vendor reviews, and implementation of procedures and metrics to enable the SIU to measure and meet its established goals. On a routine basis, our SIU team interfaces with our internal management, providers, enrollees, law enforcement, state agencies, and other stakeholders.

In addition to the Magellan Complete Care SIU team, the data intake part of our SIU completes preliminary reviews of all allegations that are forwarded to the SIU and proactively communicates their results to the Manager of Investigations at Magellan Complete Care. The corporate SIU team also performs weekly data analysis to identify red flags related to FWA, which includes reviews of claims. Lastly, the SIU Pharmacy team supports all investigations related to pharmacy for Magellan Complete Care, and this team continuously communicates through routine “rounds” with the SIU Manager of Investigations in Florida.

1.9 Subcontractor Assessment, Monitoring and Auditing
The Magellan Complete Care SIU has an active role in the oversight of our subcontractors and continuously monitors these subcontractors to obtain reasonable assurance that their respective FWA compliance plans are effective, updated in a timely manner, and appropriately reflect the regulatory and/or contractual requirements related to Magellan Complete Care’s relationship with and obligations to AHCA.

As part of the review of a subcontractor’s FWA compliance plan, the SIU coordinates with the Magellan Complete Care Compliance Officer to determine the minimum requirements that must be included in the subcontractor’s anti-fraud plan. The SIU reviews the plan to ensure the plan is complete and accurate in support of the contract and regulatory requirements. This plan must include at least:

> A written description or chart outlining the organizational arrangement of the personnel who are responsible for the investigation and reporting of possible overpayment, abuse or fraud
> A description of the procedures for detecting and investigating possible acts of fraud, abuse and overpayment
> A description of the procedures for the mandatory reporting of possible overpayment, abuse or fraud including incident, monthly, quarterly and annual reports
> A description of the program, content, and procedures for educating and training personnel on how to detect, prevent and report fraud, abuse and overpayment
> Existence of a FWA hotline/email for enrollees, providers, and/or employees to report FWA
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If our SIU identifies that the subcontractor’s FWA plan has any critical elements missing, the SIU notifies the Magellan Complete Care Compliance Officer as well as Delegated Vendor via email. Delegated Vendor Management follows up with the vendor to communicate the SIU findings and to request that the FWA plan is updated properly. If an updated FWA plan is not to the SIU within 30 days, then the SIU follows-up to ensure a response is provided. The FWA plan is subject to approval by our SIU, which only provides that approval once it considers the document to be complete, accurate, and otherwise effective.

Further collaborating with the Delegated Vendor Management team, our SIU staff conduct comprehensive pre-delegation and annual reviews of each subcontractor’s FWA program, including review of staffing levels, training, and FWA detection, monitoring and reporting procedures. During these reviews, subcontractors are assessed for potential FWA risk based upon the likelihood of fraud, as well as potential exposure and outcomes, while considering the existence of compensating controls. Each subcontractor is given an overall risk score of low, medium, or high. Those subcontractors that are assigned a high score in risk assessment are included for even more robust monitoring in the SIU Annual Work Plan.

As part of the SIU monitoring process, a “Fraud, Waste, and Abuse – Activity Report” has been developed and implemented for subcontractors to routinely report FWA cases and related activities to a designated SIU contact (one assigned for each subcontractor). In addition to specifics regarding FWA referrals, the report also includes a summary of activity to support our overall FWA prevention, detection, and remediation efforts, such as: (i) data mining activities, e.g., a particular FWA scheme, frequency of analysis, and analysis results and (ii) a referral summary, including the number of referrals received and reported by the subcontractor, number of retractions (reversals) resulting from FWA issues, and total dollar amount recouped.

Our SIU actively consults with our subcontractors’ management staff to ensure that they have strong policies and procedures and that they are carrying out effective and efficient activity to detect and prevent FWA. For any program integrity-related investigations or audits of the subcontractor’s services, the SIU communicates directly with the subcontractor or in collaboration with Delegated Vendor Management to ensure that any findings are timely and clearly communicated as well as properly remediated in a timely manner.

As additional activity in support of our SIU’s robust monitoring of subcontractors, our SIU team participates in routine joint operations calls conducted by Delegated Vendor Management with each subcontractor to discuss customer service issues, FWA referrals, quality concerns or complaints, and other items related to subcontractor performance. The SIU is also an active participant on the Magellan Complete Care Vendor Oversight Committee; as such, our SIU staff reviews monthly reports from and other reported activity conducted by subcontractors. Again, remediation of any concerns or deficiencies related to program integrity that are identified by SIU staff as part of this monitoring are coordinated with Delegated Vendor Management.

1.10 Communication and Coordination with Key External Stakeholders
The SIU knows we are only able to be successful in combatting FWA through strong partnerships with both internal and external partners. As outlined above, that includes collaboration and cooperation with Magellan Complete Care departments, especially compliance, network, claims, health services, as well as subcontractors’ management and SIU teams.
But external partnerships are just as critical for ensuring that the SIU has a broader view of effective approaches and methodologies for combatting FWA, as well as for sharing our perspective regarding what works and how. That includes partnering with AHCA, MPI, MFCU, other SIUs in the industry, providers and enrollees, among others. To the extent that the measure of any Special Investigations Unit is based at least in part on customer satisfaction, the Magellan Complete Care SIU has developed a strong reputation of reliability, proactivity, expertise, and effective results with all of them.

Our SIU team works collaboratively with these stakeholders to ensure open lines of communication and information sharing to identify potential FWA. We participate regularly in various regulatory and law enforcement workgroups and initiatives, and we monitor various information from these stakeholders for FWA issues, trends, cases and schemes.

A pertinent example involves a Miami physician who pled guilty to fraud in July 2017 as part of a multi-faceted, multi-million dollar healthcare fraud scheme. Magellan Complete Care’s SIU identified and investigated aberrational billing and practice patterns with this physician, and our referral to law enforcement in 2014 ultimately assisted in the criminal investigation and plea in this case.

Some of our other more mutually productive partnerships are elaborated upon below.

<<National Health Care Anti-Fraud Association>>
Our SIU leads not just by experience and expertise, but by example. Magellan Complete Care’s parent company, Magellan Health Services, Inc., is a corporate member of the National Health Care Anti-Fraud Association (NHCAA). Magellan is proud to be the first behavioral health care member of NHCAA.

Magellan maximizes quality referrals around fraud/waste/abuse by using the resources available in the NHCAA Special Investigations Resource and Information System (SIRIS), Requests for Investigation Assistance (RIAs) from law enforcement, distribution of published news articles, and other information-sharing initiatives.

Magellan’s SIU personnel also participate on multiple NHCAA committees, including the Accreditation, Anti-Fraud Management Survey, Behavioral Health, Education & Training, Membership, Pharmaceutical Fraud, and Standards Development committees. Magellan’s VP of SIU Investigations currently serves on the NHCAA Board of Directors and has been co-chair of the NHCAA Behavioral Health Workgroup for multiple years.

<<Healthcare Fraud Prevention Partnership>>
Magellan Complete Care’s parent company, Magellan Health Services, Inc., is also a member of the Healthcare Fraud Prevention Partnership (HFPP). The HFPP is a CMS-sponsored, voluntary, public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations. The HFPP aims to foster a proactive approach to detect and prevent healthcare fraud through data and information sharing, and we are proud to serve as an active member of the Partnership. For example, our SIU contributes data for holistic, industry-wide analysis to the HFPP and SIU staff participate in information-sharing initiatives and FWA training workshops.
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<<Association of Certified Fraud Examiners>>
Magellan Complete Care’s parent company, Magellan Health Services, Inc., is additionally a
corporate member of the Association of Certified Fraud Examiners (ACFE). Our membership
helps provide ongoing educational opportunities to SIU staff, thereby ensuring that our knowledge
of emerging technology, trends and investigative methodologies is up-to-date.

CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT USES BIOMETRIC OR OTHER
TECHNOLOGY...
Given its extensive experience in program integrity, Magellan Complete Care appreciates the risk
of FWA at the point of service delivery. While we do not currently use biometrics, we do use other
effective methods to validate that services have been delivered, some of which are further
described below.

Magellan is already using various compensating controls around services where there is high risk
for FWA. These compensating controls, instituted as appropriate, include, but are not limited to:

>Instructions in our Explanations of Benefits (EOBs) for an enrollee to contact Magellan Complete
  Care if anything represented as a delivered service in the EOB was not provided or was otherwise
  unsatisfactory;
>Telephonic verification of services with enrollees within 24 hours of scheduled home health visits
  or delivery of DME devices, as we require of our subcontractor, Coastal Care Services;
>Ongoing analysis of claims for outliers and/or unusual patterns;
>Proactive audits of home health and related high-risk services; and
>Inclusion of high-risk services in our enrollee verification letter initiative.

As another example, our transportation subcontractor, Veyo, uses GPS-powered mobile
applications and cloud-based technology and advanced analytics to track and manage non-
emergency transportation services in real-time. They use proprietary, rules-based algorithms
coupled with machine learning algorithms to identify trips which require enhanced controls (such
as prior authorization) based upon distance, special transportation needs of the enrollee,
transportation history and patterns, and other factors. This technology is used to prevent and
detect FWA by validating trip components including the trip distance, which is defined as the
distance calculated by using publically available mapping service (such as Google Maps API)
component from the enrollee’s origin to their destination using the best, most direct route. Veyo
dashboards also provide real-time trip-tracking from pick-up to drop-off; accumulated trip data can
be quickly filtered to provide meaningful insights into utilization, further enabling our SIU’s
collaboration with Veyo on FWA identification, analysis, prevention, and resolution.

We also use GPS locator services to manage internal Magellan Complete Care staff, particularly
those who work in the field, such as Provider Support Specialists, Health Guides, and Community
Outreach Specialists. In collaboration with Xora, a market leader in mobile workforce
management, and its mobile applications, we can identify the location of individual field staff on a
Google Map, drilling down to ascertain where someone has been, the route they have driven, and
where they are now.

It should be apparent that our multi-dimensional approach to program integrity is successful. But
given our ongoing commitment to trying new approaches as well as our sincere understanding of
AHCA’s interest in the use of biometrics as a potential control mechanism, we are interested in
exploring this mechanism in partnership. Magellan has learned of some apparent resistance from
providers to implement and use, for example, solutions such as electronic visit verification. So, we would anticipate that any future plans would have to proceed thoughtfully, deliberately, and collaboratively with all stakeholders.

**CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT CONDUCTS CLINICAL REVIEWS and SIU INVESTIGATIONS...**

Magellan Complete Care’s Quality Improvement Department systematically conducts clinical reviews of medical records and refers any potential fraud, waste, or abuse concerns to our SIU. Other Magellan Complete Care departments can identify potential FWA in their medical records reviews, such as when Utilization Management is evaluating requests for services on a prior authorization basis or when the Appeals team is discussing an appeal with a Medical Director. In these situations, a referral is made to SIU as well.

The SIU reviews and investigations that result are considered to be integral to the effectiveness and success of our program integrity efforts. In addition to case-specific investigations, audits and reviews are conducted to include a special focus on services and areas identified as prevalent and prioritized during the FWA risk assessment process. Announced or unannounced audits may be conducted pre- or post-payment, as onsite or desk audits, and may be random or targeted. Additionally, Magellan Complete Care conducts joint operations meetings and complex clinical rounds with providers that may identify potential FWA. Any evidence of suspected FWA is referred to our SIU investigator and reported as required to Medicaid Program Integrity and the Medicaid Fraud Control Unit.

To the extent that our SIU team and/or the SIU vendors they use need clinical consultation during these investigations, audits, and reviews, Magellan Complete Care physician and nurse resources are readily available to and are quite accustomed to partnering with SIU to perform clinical review activities, including reviewing medical records, evaluating trends and patterns in data, and providing assessment of a specific case.

Clinical reviews may be initiated based upon one of more of the following:

- Areas of risk identified in the FWA risk assessment
- Ongoing monitoring of industry trends
- Known or emerging schemes
- Leads gained from information-sharing initiatives with other parties
- Enrollee complaints
- Referrals from health services, medical directors, customer service, provider networks, quality improvement, or other internal departments
- Requests from oversight agencies
- In follow-up to industry/contract service or coding changes
- Results of data mining
- Based upon results of prior audits

Our SIU uses several sampling methods to select claims for clinical review, based on the original reason for the audit and specific allegations of FWA presented.

- Discovery Sample (non-statistical): If the investigator or auditor simply requires a small set of claims to be audited, to prove or disprove an allegation, or to test a theory, the investigator may
select (either random or targeted selection) a set of claims. The investigator may choose to select a full sample for audit, if a discovery sample reveals suspicious behavior.

>Full Sample (statistical): We use full samples when inference to a larger population is required. We randomly select claims that are statistically representative of a larger population of claims submitted by a provider and can extrapolate the findings to a population of claims from which the sample was drawn. The SIU uses RAT-STATS as provided by the HHS, OIG, and Office of Audit Services to determine the appropriate statistical sample size.

Clinical review procedures such as these are formalized and designed to review the adequacy of processes and control procedures and to determine the accuracy, completeness, and timeliness of claims and encounters submitted for services associated with the audited provider.

As a result of these audits, clinical reviews, data analysis, procedural changes, or investigation results, the SIU may provide education to providers to ensure compliance with industry standards and best practices, contractual and/or regulatory requirements. Education may be conducted telephonically, in person, or via written correspondence. In addition, corrective action plans (CAPs) may be required where ongoing patterns of more serious deficiencies or findings exist. Ongoing activity by SIU staff, including clinical reviews, review of claim submissions, follow-up audits and site visits, occur as necessary to monitor changes in provider behavior. All CAPs are coordinated with the Compliance Officer to ensure that regulatory requirements are appropriately addressed, corrective actions are complete and effective in addressing identified deficiencies, and ongoing monitoring has integrity in more general terms.

Magellan Complete Care also uses an Enrollee Services Verification review for clinical services. This review verifies whether services billed by providers were actually received by intended enrollees. Magellan Complete Care sends our “Enrollee Service Verification” questionnaire quarterly to enrollees who are selected from a random sample of paid claims, based on the following criteria:

>Select all claims paid within the last 30 calendar days
>Excluding “no-shows” and services defined as confidential by AHCA

One hundred claims are randomly chosen for the sample. To avoid burdening enrollees, once an enrollee has been selected for one report, the enrollee is excluded from selection in subsequent reports for the period of one year. Except for the services excluded above, the selected sample report lists up to five paid services for each enrollee within the prior 30-day calendar period. Magellan Complete Care encourages the enrollee to review the report to identify discrepancies with services actually received. Our Health Guides, who are responsible for helping our enrollees navigate the health care delivery system, are available to assist enrollees in interpreting and responding to the questionnaire. We review each copy of the questionnaire that is returned, and results are recorded in the Enrollee Service Verification Log (ESVL).

If an enrollee indicates that he or she never received the services outlined in the questionnaire, our Compliance Officer contacts the enrollee to verify that he or she understands the procedure billed. If the enrollee maintains the service was not received, the Compliance Officer then forwards the matter to the SIU for further follow up, to include investigation and reporting.
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CRITERIA 4: THE EXTENT TO WHICH THE RESPONDENT USES INNOVATIVE TECHNOLOGY...
We have described in response to Criteria 2 the methods we use to verify the provision of services to our enrollees, including telephonic outreach, enrollee survey letters, and GPS tracking.

While our methods do not currently include technology solutions, we assume that AHCA’s interest in this innovative technology relates, at least in part, to the passage of the 21st Century CURES Act, around which Magellan Complete Care has been watching developments very closely. This legislation includes a number of provisions that are of interest to and that would affect Magellan Complete Care, among other stakeholders, in carrying out its business operations. Of particular note is the host of regulations that affect the home health industry, and more specifically, the use of electronic visit verification (EVV) in the provision of home care services.

In addition to other requirements, the CURES Act contains a new Medicaid requirement for mandatory use of EVV, which allows for nurses and home health aides to check in electronically through software applications or devices and record the exact date, time and location of a visit. The Act includes the requirement but leaves it to states to decide their own implementation strategies. As AHCA is no doubt already aware, EVV is required to be in place by 2019 for personal care services and 2023 for home health services.

There are time and opportunity to meet these requirements, and Magellan Complete Care would like to work with AHCA in partnership and innovation to comply. Some of our Magellan Health, Inc. affiliates have experience in approaches of this type in other states, such as New York. Based on such experience, we would anticipate that, to get appropriate and compliant participation from all stakeholders – including multiple managed care plans and many home care providers—a single, state-sponsored verification approach and system solution may be most effective. In any case, Magellan Complete Care would be willing, for example, to share information regarding our affiliates’ learnings and serve as a beta test-site partner in any proposed approach and solution AHCA may choose to pursue.

Also, Coastal Care Services, Inc. (Coastal Care), Magellan Complete Care’s home care subcontractor, already has EVV capabilities for their care staff and could be of assistance as we consider strategies to comply. We have already engaged in discussions with Coastal Care regarding these existing capabilities, as described below. As a possible approach, both parties could be ready to implement them, with modest lead time, provided that we would have AHCA’s support and home-care providers’ cooperation and engagement.

Coastal Care’s proprietary system, CAMMS, affords an opportunity to measure, monitor, and provide electronic verification for home care visits. CAMMS processes electronic files of plans of care/authorizations, eligible members, and home health agencies. Using a variety of technologies, the system captures caregiver arrival and departure times, location, member and caregiver IDs, and tasks performed during the visit.

The CAMMS system is preloaded with valid and acceptable home phone numbers for each member. The caregiver dials a US-based toll-free number and inputs their personal identification number. The system then uses Automatic Number Identification technology to validate the location from where the call originates. Each call captures the number called from, the call times, the member, and unique staff ID. If the number the call is made from does not match a preloaded
number for the member, it is flagged as "unknown," and manual validation from Coastal Care’s Case Management team is necessary. Once calls are validated, the visit on the authorization is flagged as confirmed, allowing claims to pay.

Coastal Care can also offer mobile visit verification (MVV) as an alternative technology solution when a member does not have a phone and/or services are not being provided in the home (e.g., a homeless shelter). MVV uses a global positioning system (GPS) application that is available on Android and IOS smart phones and tablets. It uses cellular and GPS technologies to pinpoint the location of the caregiver via their mobile device. This verification technology also validates service location, time and duration of service, and tasks performed.

Coastal Care has further indicated to us that its system has unlimited reporting capabilities that are easily customizable for each customer. All data is written in real time to tables, and live processes execute on demand, thus ensuring enhanced availability of real-time data for reporting. All Coastal Care reports are available on demand with the capability of running in detail and/or summary format; they can be reviewed on the screen, printed, and saved to a file. Exported files can be exported in any standard format. Reports can be run at a point in time or for a period of time, depending on the report sorting criteria selected by the user.

Coastal Care has indicated that its solution architecture and experienced data integration experts can ensure the ability to configure its system to meet the needs of Magellan Complete Care. As we already appreciate, home care is a service that can present inherent risk and vulnerability; that vulnerability is amplified in our SMI population, which typically has more complex physical and behavioral health needs and other complicating social determinants. It is not always easy to know whether a necessary service was, in fact, provided, especially outside of facility or office. EVV may well be an effective technology for creating a point of control, allowing us to enhance our management of this service delivery scenario, ensure compliance with CURES Act requirements, and enhance our efforts to combat FWA in home health with a more accountable and trackable system for these services.

In the meantime, Magellan Complete Care requires Coastal Care to conduct telephone calls to all enrollees within 24 hours of a scheduled home health visit or DME service. In addition to verifying the service occurred, this outreach includes a mechanism to assess the client/caregiver’s perception of the safety, adequacy and efficiency of services provided and to evaluate effectiveness of staff performance relative to the staffing process and provider services. Any expression of dissatisfaction with a home visit would be handled through the grievance process while also being evaluated by Coastal Care for further follow-up and referral to the SIU.

Identified issues are assessed and investigated for validity. Appropriate corrective actions are implemented, including following up with the provider and/or enrollee until services rendered are satisfactory. Data collected from the phone calls is compiled and analyzed. Then, repeated complaints or patterns indicating potential FWA are investigated and reported as required. To date, this outreach and follow-up process has proven to be effective.

Evaluation Criteria:
1. The extent to which the respondent uses various types of controls and automated approaches as part of a comprehensive approach to prevent and detect potential or suspected fraud and abuse and overpayment.

2. The extent to which the respondent uses biometric or other technology at the point of service delivery to prevent and detect potential or suspected fraud and abuse and overpayment.

3. The extent to which the respondent conducts clinical reviews and SIU investigations to detect potential or suspected fraud and abuse and overpayment.

4. The extent to which the respondent uses innovative technology for the purposes of verifying home-based visits and services.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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The respondent shall demonstrate its capability and approach to meet the requirements described in Attachment B, Scope of Services, Section X.D.4.h.

Response:

OVERVIEW

The objectives of the Magellan Complete Care Disaster Recovery and Business Continuity Management Program are to identify, prevent, and prepare for potentially disruptive events while providing continuity of care for our enrollees. Our program provides solutions that conform to regulatory, contractual, insurance, and ethical practices. Magellan Complete Care has been a part of the Florida healthcare community since the 1990s, when our parent company began providing mental health and substance abuse services as a subcontractor to several large Florida health plans. During this entire period, we maintained a comprehensive disaster recovery and business continuity plan and related processes to support enrollees, providers and other stakeholders when a disaster occurs. Our current working relationship in Florida with AHCA demonstrates our understanding of the State’s technology infrastructure, requirements, standards and reporting. Over the same period, we have developed a successful working relationship with AHCA on how we jointly plan, prepare and rehearse our approach to managing before, during and after a disaster. Included in our disaster recovery plan are defined recovery roles and responsibilities, systems backup and recovery procedures, off-site media storage information, detailed production system hardware and software configurations / specifications, emergency and critical business contacts information.

Magellan Complete Care’s I/S disaster recovery methodology consists of a mix of traditional backup of real-time data storage of our production systems to offline tape media with an established recovery point and replication of our virtual Microsoft Windows environments to owned storage. In the event that a catastrophic event should disable the data center, the most recent tapes are retrieved from the off-site facility and transported to the DR Service Provider’s location. The systems and data from the tapes are then downloaded to computer systems at the disaster recovery site. A contract exists with the disaster recovery service provider that enables use of specified computing equipment at their location in the event of a significant business interruption or disaster. The contract also includes a semi-annual allowance to exercise the disaster recovery process so that we practice the process and are well prepared in the event of a disaster.

Magellan Complete Care also understands business continuity, during an evacuation or unexpected staff shortage, is vital to support AHCA’s mission. Our business continuity plans are designed to help us and our partner organizations recover from a disruption in service. Specifically, our plan provides policy and guidance to ensure that Magellan Complete Care responds effectively and restores essential services as quickly as possible. We routinely review our business continuity plan and state of readiness. Hurricane Irma recently allowed us to successfully deploy many facets of our business continuity plan throughout Florida to maintain enrollee access to safety and ongoing care needs. It is standard process for all departments to capture opportunities for improvement after each event and to update the business continuity plan accordingly. We also review potential engagement of disaster recovery as many lessons learned...
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could cross over to improve our total state of preparedness regarding business continuity and disaster recovery.

Magellan Complete Care employs several technologies to eliminate or reduce the risk of unplanned data and telecommunications systems outages. We use backup power generation systems, hosted environmental and systems monitoring applications, computer system and network hardware redundancies, mirrored disk, and data replication. Some of these technologies also serve to expedite critical system recovery following a catastrophic event.

In addition to our Disaster Recovery and Business Continuity Management Program, we implement a crisis communications process when severe weather-related events are predicted and/or in the event of a manmade disaster/crisis.

The process includes opening our toll-free hotline to <<anyone>> needing help before, during or after a weather-related catastrophe. It is important to underscore that these services are available to anyone, regardless of their affiliation with Magellan. To ensure we have broadcast the availability of these services, we issue a press release and conduct media outreach in the targeted area(s). Our marketing teams provide our account management teams information about the situation as well as situation-appropriate tip sheets and resource materials that can be shared immediately with clients in affected areas. Our operations teams collect information about local services, including shelters, day care centers, food pantries, etc., to share with affected individuals who may call.

CRITERIA 1: THE ADEQUACY OF THE RESPONDENT’S PROPOSED APPROACH AND CAPABILITY TO DEVELOP...
The objectives of the Business Continuity Management Program are to identify, prevent, and prepare for events that may disrupt business activities. The Program provides solutions that conform to regulatory, contractual, insurance, and ethical practices. Magellan Complete Care maintains and continually updates our strategies for recovering our business facilities, data systems, applications and master files. A copy of our Disaster Recovery Plan’s table of contents, can be found in [General SRC #33, Attachment 1: 2017 Recovery Plan]. This plan, at more than 350 pages in length, details procedures in a step-by-step manner for activation of recovery teams, immediate response, review and assessment, communications, relocation to the recovery site if needed, a detailed recovery process, and the resumption of business functions.

At Magellan Complete Care’s Care Management Center in Florida, as in all offices nationwide, the operations and procedures to re-establish business processes in the event of a natural disaster, pandemic or other catastrophic event are documented and made available to all personnel for their review and action.

Our Data Center publishes updates to our Data Center Disaster Recovery Strategy when there are changes to procedures, upgrades in our equipment, and after each rehearsal to document recovery testing results. The result is that the plan is updated at least quarterly. Our Disaster Recovery Strategy document provides a high-level overview of our policies and procedures for data backup and recovery, offsite storage and transportation of encrypted data, restoration of data at our designated warm site, telecommunication contingency planning, and an outline of our Data Center security, power backup, and fire protection.
CRITERIA 2: THE ADEQUACY OF THE RESPONDENT’S PROPOSED APPROACH AND CAPABILITY TO ENSURE THE DISASTER RECOVERY PLAN LIMITS...
Magellan Complete Care employs a tape-based recovery strategy. With this strategy, data backups are performed and moved daily to a secure off-site storage location. Shared backup computer hardware and warm-site data center facilities are provided by a third-party recovery services provider. In the event of a disaster, recovery teams are dispatched to the warm site with the most recent backup tapes and needed recovery supplies to restore business critical data center operations. The recovery point objective (RPO) is 24 hours.

Testing of Magellan Complete Care’s Disaster Recovery Plan is conducted annually, and a summary of rehearsal and test results is reported to senior management within two weeks of completion. Magellan Complete Care provides a copy of the summary analysis as part of our annual submission of the Disaster Recovery Plan for AHCA’s consideration.

During rehearsals, each of the critical and P2 systems is allocated 40 hours of test time. Historically, these systems have been recovered within 24 hours in rehearsal exercises. The remainder of the test time is allotted to user acceptance testing. Detailed recovery logs are used by IT operations support personnel to update backup and recovery procedures as required at the conclusion of each rehearsal. The plan is regularly updated as changes in the Magellan Complete Care computer operations environment dictate.

2.1 Call Centers
Magellan Complete Care operates geographically diverse call centers across the continental United States. To ensure consistent high quality customer services during temporary office closures or telecommunication disruptions, telephone traffic may be rerouted from any Magellan Complete Care call center, including after hours, to an alternate call center restoring critical customer services within a matter of minutes. We maintain enrollee access to the primary contact center as well as carelines to ensure any required services are received. Secure VPN access is provided to key employees, which enables them to work from home should office facilities be unavailable or unusable due to sustained damages, isolation, quarantine, etc. In combination, these two measures also counter the impact of high absenteeism generally associated with a pandemic event.

CRITERIA 3: THE ADEQUACY OF THE RESPONDENT’S PROPOSED APPROACH AND CAPABILITY TO ENSURE THE RECORDS BACKUP STANDARDS...
Magellan Complete Care has taken steps to eliminate or reduce to a minimum, unplanned data and telecommunication systems outages using current hardware and software technologies. A copy of the table of contents of the Disaster Recovery Plan is submitted to AHCA annually to provide assurance that a plan is in place, updated, and ready to be implemented should an adverse incident occur.

Unplanned downtime exposure during day-to-day operations is significantly reduced with backup power generation systems, hosted environmental and systems monitoring applications, computer system and network hardware redundancies, mirrored disk, and data replication. Some of these technologies also serve to expedite critical systems recovery following a catastrophic event. These proven technologies serve our current contract with Florida. Our plans under a new contract are to continue using these systems to protect and maintain our service level with AHCA.
Our Information Technology team is tasked with keeping current with our data capacity and adding technologies as needed.

Magellan Complete Care’s track record with system uptime has been outstanding—100% availability during scheduled hours over the past 12 months. Though we have not had to implement our Disaster Recovery Plan, we continue to perform due diligence in rehearsing our procedures and documenting our results.

3.1 Backup and Off-Site Data Storage>
Iron Mountain provides secure offsite storage for recovery media and materials. In the event that Magellan Complete Care should declare a ‘Disaster’, Iron Mountain delivers tapes for the last 15 days backups along with pre-assembled recovery materials to the designated recovery site. Iron Mountain transports encrypted backup media between their vaulting facility and the Magellan Complete Care data center daily. The media is transported in locked bar-coded containers. Secure Synch, Iron Mountain’s web based application software, is used to track off-site media inventory. Within Magellan Complete Care, the media is tracked in a consolidated database using various system backup applications.

Backups are performed daily (incremental) and weekly (full save) for all mid-range platforms. Full backups are performed nightly for Intel systems. Magellan Complete Care uses a StorageTek SL8500 tape library system with T10000k encrypted tape drives. An IBM Tape Library system is used to support the backup of production data on the iSeries Power 8. The IBM system uses LTO-5 encrypted tape drives. Tapes are stored off-site for six weeks. When returned, they are placed back into the tape library for re-use. Archive tapes are stored permanently off-site. Archives are full system backups performed on the last full weekend of the month for most mid-range systems or, on the last day of the month for Intel systems and the mid-range iSeries production systems.

3.2 Data Center
*****Trade secret as defined in Section 812.081, Florida Statutes. The information on this also “confidential” and exempt from disclosure pursuant to Section 119.071(3)(a), Florida Statutes.*****
CRITERIA 4: THE ADEQUACY OF THE RESPONDENT’S PROPOSED APPROACH AND CAPABILITY TO ENSURE IT MAINTAINS A DISASTER RECOVERY PLAN...

Magellan Complete Care has developed and continually updates a site Emergency/Disaster Preparedness Plan that outlines the procedures involved in maintaining business continuity in the event of a critical incident at the Florida Care Management Center. This plan defines a Crisis Event Response Team (CERT), comprised of key corporate executives in operations, information technology, physical security, facilities, and communications, as well as team coordinators. The CERT’s purpose is to assist with proactive decision-making, communications flow pre- and post-incident and operational response capability.

At our Florida site the Emergency/Disaster Recovery Team (EDRT), consisting of team coordinators and a Management Response Team of employees in the Florida office, are responsible for specific areas of responsibility such as case management, the site call center, network provider communication, area resources and Florida site staff communication.

The plan includes situations and remedy procedures to be followed in the event of weather-related or other incidents that would render the facilities or systems inoperable. Training of staff on emergency disaster procedures is conducted annually; drill and practice scenarios include unexpected twists such as equipment failure, communications breakdown, power disruption, and other real-life situations. Including these variables help keep employees “thinking on their feet” and not dependent on any one aspect of the plan, such as weather-related scenarios only.

4.1 Alternative Locations
Depending on the time of the event and the degree of destruction due to the emergency/disaster event, the Chief Operations Officer with the National Operations Team may make the decision to close the office due to safety issues. Call center traffic is then re-routed to the Magellan Complete Care of Virginia office to service incoming calls from Florida enrollees.

We provide secure VPN access to key employees, which enables them to work from home should office facilities be unavailable or unusable due to sustained damages, isolation, quarantine, etc. In combination, these measures also counter the impact of high absenteeism generally associated with a disaster or pandemic event.

Most recently, in response to Hurricane Irma, Magellan Complete Care began preparations for a potential office closure and ensuring the continuity of business to assist enrollees during this event. Magellan communicates internally using Workplace, an online resource developed by
Facebook to communicate updates with employees. It is used to communicate with groups or individual colleagues and offers the social networks features in a corporate environment. Workplace can be accessed using a secured application and login via a smartphone, allowing employees to get up-to-date disaster recovery information without being on a computer logged in to Magellan’s network. The communications of Magellan’s preparations began the week before Irma’s landfall. A decision to close was made the Thursday before the weekend of landfall. Arrangements were made with work-at-home employees as well as the Magellan Complete Care of Virginia Call Management Center to take calls as needed.

Disaster planning was implemented across all of our Florida sites, and we opened the toll-free hotline to anyone needing help before, during, or after the hurricane hitting Florida. We issued press releases in English and Spanish to notify the broader community that the hotline was open and followed the release with social media and direct media outreach to blanket the hotline’s availability. Outreach was conducted via email and social media posts directly to the media outlets in Florida.

We began proactively reaching out to our most vulnerable enrollees and to the providers who care for these enrollees to assist with emergency preparations such as helping enrollees fill prescriptions in advance of the storm hitting. We waived prior authorization requirements in many cases.

Our account management team was in contact with the State of Florida with updates on call handling during the disaster. Our commercial health plan account management teams were also reaching out to clients in Florida in affected areas with resource materials, including a guide for surviving hurricanes, as well as with links to the press release and hotline. Our operations team handled nearly 200 phone calls from people needing assistance.

The Friday before landfall, all local servers in the Miami and Orlando offices were cloned and data replicated to servers in the St. Louis, Missouri, data center. This server clone process was performed in addition to the standard backup to provide an extra layer of safety. The onsite backup generator was inspected, and it was verified that there was a two-day supply of diesel fuel along with one day of reserve fuel in the event of a power failure. Arrangements were made for additional fuel supplies to be delivered in the event of a power outage lasting longer than three days.

As another example, our team leapt into action following the devastating shooting in Orlando in June 2016. Our Magellan Complete Care of Florida team spoke about the possible needs of the Orlando staff, the Orlando Regional Medical Center (ORMC; the receiving hospital for the victims), and the Orlando community at large. We reached out to the administrators of ORMC and with local community mental health centers to see how we could assist. We provided these organizations with helpful lists of community resources. Our team was also asked by the Florida Council for Community Mental Health and Aspire Health Partners to share lists of licensed mental health professionals who would be willing to provide face-to-face grief counseling to those in need. There was an emphasis on identifying counselors who speak Spanish. We identified in-network Spanish-speaking behavioral health therapists and reached out directly to these providers to see if they were able to assist.

While this was happening, Magellan team members from across the country immediately worked to get our 24-hour toll-free hotline set up and staffed to handle calls from individuals. The operations team supported 49 callers who were looking for resource materials around resiliency,
speaking about violent acts to children, and coping with loss. We provided more extensive clinical consultations with eight callers who personally experienced a loss. In most of these instances, we helped them get into counseling with their employee assistance plan or benefit plan. In two cases, the callers did not appear to have mental health benefits, and we were able to find community-based counseling resources for them.

CRITERIA 5: THE ADEQUACY OF THE RESPONDENT’S PROPOSED APPROACH AND CAPABILITY TO ENSURE IT MAINTAINS DATABASE BACKUPS...
Magellan Complete Care has traditionally employed a tape-based recovery strategy. With this strategy, data backups are performed and moved daily to a secure off-site storage location. Shared backup computer hardware and warm-site data center facilities are provided by a third-party recovery services provider. In the event of a disaster, recovery teams are dispatched to the warm-site with the most recent backup tapes and needed recovery supplies to restore business critical data center operations. The recovery point objective (RPO) is 24 hours.

5.1 Backup and Off-Site Data Storage
Iron Mountain provides secure offsite storage for recovery media and materials. In the event that Magellan Complete Care should declare a “Disaster”, Iron Mountain delivers tapes for the last 15 days' backups along with pre-assembled recovery materials to the designated recovery site. Iron Mountain transports encrypted backup media between their vaulting facility and the Magellan Complete Care Data Center daily. The media is transported in locked, bar-coded containers. Secure Synch, Iron Mountain’s web-based applications software, is used to track off-site media inventory. Within Magellan, the media is tracked in a consolidated database using various system backup applications.

Tapes are stored off-site for six weeks. When returned, they are placed back into the tape library for re-use. Archive tapes are stored permanently offsite. Archives are full system backups performed on the last full weekend of the month for most mid-range systems or, on the last day of the month for Intel systems and the midrange iSeries production systems.

****Trade secret as defined in Section 812.081, Florida Statutes. The information on this also “confidential” and exempt from disclosure pursuant to Section 119.071(3)(a), Florida Statutes.****
5.2 Recovery Sites
In addition to the primary data center in Maryland Heights, Missouri, Magellan Complete Care also has data center facilities at our Columbia, Maryland, Glen Allen, Virginia, and Phoenix, Arizona, locations. Warm-site recovery services are also provided by SunGard Availability Services in Philadelphia, Pennsylvania. The SunGard Availability Services site in Philadelphia is used for P2 and P3 application recovery. All sites, including the SunGard Availability Services Philadelphia site, are connected to our Multiprotocol Label Switching (MPLS) wide area network. In the event of a data center disaster, all applications are recovered in priority sequence at the recovery site as shown below.

5.3 System Recovery Sites
All category P2, RTO = 72 hours, Recovery Site = Philadelphia

>Applications
>>Data Warehouse
>>Claims Imaging
>>NetBackup
>>Magellan Rx Management – FirstRX, FirstFinancial
>>CAPS, IP, IPD
>>NetBackup
>>Citrix, FTP, SMS, MKS
>>Infrastructure
>>Magnet, WebChecks
>>Ultipro, Data Warehouse
>>JBoss
>>NIA Apps – Informa, FTP, EDI, Perfect Tracker, BizTalk, FAX
>>Magellan Rx Management Apps – Remedy, FirstEnroll, FirstIQ, FirstRebate, FirstDARS, FirstPDL, SeeBeyond, WebRA, Tidal, FirstHCM
>>All Others

<Recovery Hardware>
All category P2, Recovery Site = SunGard - Philadelphia

>Application Group: Data Warehouse
>>Number of Servers: 8
>>Config – O/S: Oracle TAC - Linux
>>Storage (TB): 20

>Application Group: Claims Imaging
>>Number of Servers: 1
>>Config – O/S: IBM P650 - AIX
>>Storage (TB): 1
Application Group: NetBackup
  >>Number of Servers: 2
  >>Config – O/S: IBM P570 - AIX
  >>Storage (TB): 1

Application Group: Rx Apps
  >>Number of Servers: 22
  >>Config – O/S: IBM I770 – OS400
  >>Storage (TB): 75

Application Group: CAPS, IP, Provider Network
  >>Number of Servers: 2
  >>Config – O/S: ESAG – Windows/NT
  >>Storage (TB): 20

Application Group: NetBackup
  >>Number of Servers: 12
  >>Config – O/S: ESAG – Windows/NT
  >>Storage (TB): 1

Application Group: Citrix, FTP, SMS, MKS
  >>Number of Servers: 8
  >>Config – O/S: ESAG – Windows/NT
  >>Storage (TB): 1

Application Group: Infrastructure
  >>Number of Servers: 11
  >>Config – O/S: ESAG – Windows/NT
  >>Storage (TB): 1

Application Group: Magnet, WebChecks
  >>Number of Servers: 9
  >>Config – O/S: ESAG – Windows/NT
  >>Storage (TB): 1

Application Group: Ultipro, Data Warehouse
  >>Number of Servers: 9
  >>Config – O/S: ESAG – Windows/NT
  >>Storage (TB): 4

Application Group: JBoss
  >>Number of Servers: 7
  >>Config – O/S: ESAG – Windows/NT
  >>Storage (TB): 1

Application Group: NIA Apps
  >>Number of Servers: 27
EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

>>Config – O/S: ESAG – Windows/NT
>>Storage (TB): 4

>Application Group: ICORE Auth
>>Number of Servers: 3
>>Config – O/S: ESAG – Windows/NT
>>Storage (TB): 0.6

The full Data Center Recovery Plan details recovery processes for each system. The plan also includes defined recovery roles and responsibilities, systems backup and recovery procedures, off-site media storage details, detailed hardware and software configurations / specifications, and emergency and critical business contacts information. Plan execution should be considered when a (P2) application service outage is expected to exceed 72 hours. The plan is activated at the discretion of the Vice President of IT Operations or his designee. Once activated, all or part of Magellan Complete Care’s data processing activities are restored at the alternate site. Recovery Site

CRITERIA 6: THE ADEQUACY OF THE RESPONDENT’S PROPOSED APPROACH AND CAPABILITY TO ENSURE THE DISASTER RECOVERY PLAN IS FINALIZED...
Magellan Complete Care is an incumbent vendor of services, and we update AHCA annually on our Disaster Recovery Plan, which has been reviewed and approved by AHCA. The plan is continually maintained and our strategies for disaster recovery and business continuity updated as system changes occur. As an incumbent, we maintain the requisite update approach as prescribed and affirm that the current Data Center Disaster Recovery Strategy and the Business Continuity Plan is finalized and is currently available for review.

CRITERIA 7: THE ADEQUACY OF THE RESPONDENT’S PROPOSED APPROACH AND CAPABILITY TO ENSURE IT AMENDS OR UPDATES...
Magellan Complete Care developed the current Business Continuity Plan in 2017 with the specific needs of the Florida population as its focus. We have made continual updates to the plan in order to best serve Floridians and have done so at no additional cost to AHCA. Our plans have been reviewed and approved by AHCA, and we affirm that our updated plan will be resubmitted 30 days before the contract effective date and that it reflects the best interests of AHCA. We will continue ongoing reviews and revisions of our Business Continuity Plan as circumstances dictate in the same manner under a new contract.

CRITERIA 8: THE ADEQUACY OF THE RESPONDENT’S PROPOSED APPROACH AND CAPABILITY TO ENSURE IT MAKES ALL ASPECTS OF THE DISASTER RECOVERY PLAN...
Magellan Complete Care has made our Disaster Recovery Strategy available to AHCA throughout the term of the current contract. We will continue providing AHCA with updated versions of our disaster recovery, business continuity, and plan testing results annually throughout the term of a new contract.
CRITERIA 9: THE ADEQUACY OF THE RESPONDENT’S PROPOSED APPROACH AND CAPABILITY TO... CONDUCT AN ANNUAL DISASTER RECOVERY PLAN TEST...

9.1. Plan Rehearsal and Administration

Annual Disaster Recovery Plan tests are conducted for each platform annually by our staff at the designated recovery sites. (P2) Application testers connect to the backup equipment from SunGard Availability Services’ St. Louis Metro Center. Connectivity to the Magellan Complete Care wide area network (WAN) is tested at the beginning of each rehearsal exercise. The test equipment is then isolated to protect production data during the remainder of the exercise. Disaster Recovery Plan test results are summarized and reported to senior management within two weeks of exercise completion. The recovery teams keep detailed logs for use in updating backup and recovery procedures at the conclusion of each exercise. Recovery plans are reviewed and updated quarterly, at the end of each exercise, and as changes in the Magellan Complete Care computer operations environment dictate.

Upon completion of the tests, SunGard provides Magellan with documentation confirming the testing dates and the positive outcome of those tests. This documentation is shared with AHCA annually, as evidence of our testing process and results.

9.2 Plan Administration

Plan documents are created and maintained by Magellan Complete Care Recovery Team staff. The full recovery plan is distributed to all data center staff in electronic format.

<Recent Exercise Rehearsal History>

A maximum of 40 hours test time is allocated to each P2 system. Historically, these systems have been recovered within 24 hours in rehearsal exercises. The remainder of the test time is typically allotted to user acceptance testing. The data below details the results of our most recent rehearsal.

>Platform: IBM iServices (CAPS, IPD, IP)
   >>Priority: 2
   >>Rehearsal Date: October 2016
   >>Allotted Testing Time: 40 Hours
   >>Number of Users Testing: 10
   >>Number of Locations: 2

>Platform: RS6000 Apollo (Claims Imaging)
   >>Priority: 2
   >>Rehearsal Date: October 2016
   >>Allotted Testing Time: 28 Hours
   >>Number of Users Testing: 1
   >>Number of Locations: 1

>Platform: Intel – MHS (NetBackup and Infrastructure)
   >>Priority: 2
   >>Rehearsal Date: October 2016
   >>Allotted Testing Time: 32 Hours
   >>Number of Users Testing: 3
   >>Number of Locations: 1
Evaluation Criteria:

1. The adequacy of the respondent’s proposed approach and capability to develop and maintain a disaster recovery plan for restoring the application of software and current master files and for hardware backup in the event the production systems are disabled or destroyed.

2. The adequacy of the respondent’s proposed approach and capability to ensure the disaster recovery plan limits service interruption to a period of twenty-four (24) hours and ensures compliance with all requirements under the resulting Contract.

3. The adequacy of the respondent’s proposed approach and capability to ensure the records backup standards and a comprehensive disaster recovery plan are developed and maintained by the respondent for the entire period of the resulting Contract and submitted for review annually by the anniversary date of the resulting Contract.

4. The adequacy of the respondent’s proposed approach and capability to ensure it maintains a disaster recovery plan for restoring day-to-day operations including alternative locations for the vendor to conduct the requirements of the resulting Contract.

5. The adequacy of the respondent’s proposed approach and capability to ensure it maintains database backups in a manner that eliminates disruption of service or loss of data due to system or program failures or destruction.

6. The adequacy of the respondent’s proposed approach and capability to ensure the disaster recovery plan is finalized no later than thirty (30) calendar days prior to the resulting Contract effective date.

7. The adequacy of the respondent’s proposed approach and capability to ensure it amends or updates its disaster recovery plan in accordance with the best interests of the Agency and at no additional cost to the Agency.

8. The adequacy of the respondent’s proposed approach and capability to ensure it makes all aspects of the disaster recovery plan available to the Agency at all times.
9. The adequacy of the respondent’s proposed approach and capability to ensure it conducts an annual Disaster Recovery Plan test and submits the results for review to the Agency.

Score: This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.
G. STATUTORY REQUIREMENTS

SRC# 34 – Statutory Community Partnerships (Regional):

The respondent shall describe the extent to which its organization has established community partnerships with local providers or agencies that create opportunities for reinvestment in community-based services that play a critical role in improving the health and quality of life for enrollees, including:

a. Participation by senior executive leadership staff on local health and human service boards, councils, and commissions.

b. Partnerships with local community organizations focused on addressing the following social determinants of health:

1. Access to Food;
2. Employment;
3. Housing Stability;
4. Education; and
5. Exposure to Crime/Violence.

c. Participation in both grass-roots and grass-tops provider initiatives.

Response:

OVERVIEW
Community relationships are a foundational value of how Magellan Health conducts business. For decades we have committed to improving the communities we serve and supporting grassroots efforts that are critical to ensuring recovery and community inclusion for enrollees. We invest resources into communities to guide, inform and shepherd systemic change in order to reduce stigma, transform the delivery system and create parity for individuals living with serious mental illness nationally. Magellan Complete Care has developed a community- and enrollee-centric approach called Integrated Health Neighborhoods (IHN). IHN builds a support system for enrollees in the neighborhoods where they live, work and seek care. As a part of this innovative model, community resources, stakeholders, care givers, and advocates are a central focus.

This approach recognizes that the demographics of each region vary broadly and significantly from urban to rural, block by block and street by street. Magellan Complete Care understands that each enrollee’s ability to achieve and maintain a long-term recovery as well as a healthy and vibrant life is tied to social determinants of health. These multiple factors beyond healthcare include housing, poverty, education, and access to transportation and healthy food. That’s why we developed and implemented our innovative IHN solution. For a detailed illustration on how our Integrated Health Neighborhood structure interfaces with the community, see [General SRC #34, Attachment 1: IHN Overview, Flowchart, and Flyer].

Through our experience, we know improved overall health and wellness can only be achieved by working with enrollees where they live – meeting them where they are. We facilitate the IHN structure by deploying teams dedicated to each region who have first-hand knowledge of
community strengths, resources, and service gaps. The foundation of our neighborhood-based model is that it naturally bridges language and cultural barriers regardless of region, and it focuses on community inclusion to support the social and emotional goals of the enrollees. We recognize that a one-size-fits-all approach is not effective to support a person-centered approach.

Magellan Health’s investment in local social service work throughout Florida is illustrated by our pioneering work since the late 1990s in communities statewide. We understand action-oriented partnerships are critical to success. We are intentional and focused in our partnerships with the shared goal of building healthy communities for all citizens. The partnerships, activities and initiatives throughout this response are evidence of our deep commitment to investment in community-based services that play a critical role in improving the health and quality of life for our enrollees in each region we serve. Magellan Complete Care has implemented the IHN in every active region and will implement into all regions as we expand to serve enrollees statewide. Our person-centered, community-based teams work within existing informal neighborhood networks and local public health systems to strengthen and extend their reach. Our local teams help each individual enrollee navigate these systems and supports, facilitating his or her access to community-based resources on the road to recovery and well-being.

CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT PROVIDES DETAILS ON HOW THEIR LOCAL...

The Integrated Health Neighborhood is our customized solution to support the local system of care by bolstering community partnerships, leading meaningful activities and participating in initiatives that supports SMI enrollees at the neighborhood level. Our approach to community partnerships is intentional and process-driven. With the commitment and support of our executive leadership and dedicated regional IHN staff, we develop our annual strategic Magellan Complete Care Systems Transformation Plan, which aligns our goals to improve the health and well-being of our enrollees with the goals of the local systems of care. This plan provides the blueprint for execution by our Integrated Health Neighborhood teams in order to achieve these goals. We will expand this approach into all regions throughout Florida to ensure our approach is consistent and remains a central priority as we enter into regions 1, 3 and 8.

1.1 Connecting with Local Communities through the Community Outreach Specialist Team

Magellan Complete Care has developed a statewide community structure to support the process by which we engage communities and support the local systems of care. We deliberately created internal and external infrastructure to support the IHN concept and position our community engagement model for success.

1.1.a The Foundation: Integrated Health Neighborhood

First we looked inward to build a strong foundational team to carry out our mission to support communities statewide and improve the system of care. As key roles in our Integrated Health Neighborhood structure, the provider support specialists (PSS) and community outreach specialists (COS) work hand in hand with community-based organizations. The PSSs facilitate and support our partnerships with our providers to develop and improve integrated care models. The PSS team consists of licensed behavioral health clinicians or RNs with significant behavioral health experience. The PSSs work together with the COSs to support many of our community-based activities and initiatives.
Our COS team members are master’s level professionals who have embedded themselves into every region we serve to establish partnerships with a multitude of social service agencies, advocacy groups, and stakeholder committees. Our team of community outreach specialists focus on bringing our mission to life in the communities, especially for our enrollees. They are actively engaged in communities statewide by attending steering committees, participating on boards, and collaborating with grass root organizations and social service agencies to help strengthen the local system of care and ensure the needs of our enrollees are considered.

The COS team works to understand the system of care in their localities and looks for opportunities to contribute to meaningful system change. The COSs become intimately familiar with the underpinnings of the neighborhoods in their region, which enables them to identify available resources that can help address social determinants of health and community inclusion.

The COS team works closely with the rest of the Magellan Complete Care IHN team to integrate identified resources and supports and weave in systemic strengths to improve enrollee outcomes and support community inclusion. The COS team works with our care coordination team to identify the unique needs of the enrollees and then develops community connection points to meet those needs.

To ensure our regionally based IHN teams have a support structure to guide their success, our leadership team developed monthly regional IHN meetings. The purpose is to build an organized, productive venue to bring the local team together to focus on collaboration, communication, and coordination on behalf of our enrollees to ensure the highest quality of care. The monthly regional meetings foster strong working relationships among departments as well as enhancing the team’s working knowledge of the community and the resources it affords our enrollees. It also promotes creative thinking and problem-solving at the local level to enhance coordination and help support the system of care in each region. These meetings are held at community agencies so that the IHN teams are truly connected to the neighborhoods they are serving. Additionally each month the community outreach specialist in each region is responsible for inviting a community resource to present for the IHN team. This was allows the team to stay up to date on new resources and apprised of the local system of care landscape in their region.

COMMUNITY ASSESSMENT AND ACTION: The above resources and localized approach allow Magellan Complete Care to bring our mission into the communities and improve the systems of care statewide. In order to intentionally leverage our resources and optimize our impact, Magellan Complete Care established a consistent process by which we launch our efforts into the communities. Our community engagement process is comprised of the following elements: data, research, assessment, outreach and action. Collectively, these are the driving principles that shape our community and systems engagement.

Our COS team synthesizes data and information by performing community health assessments and asset mapping within the neighborhoods they serve. The community health assessments also include key informant interviews, surveys, and listening sessions. All of this is augmented by our local IHN structure. Key elements of our community assessments include a focus on:

> Neighborhoods with high enrollment: A review of service utilization in those areas including high readmission rates, use of outpatient and PCP services
> The identification of providers, stakeholders, resources and other assets located in the target neighborhood
The challenges and barriers of the area
Identifying champion stakeholders crucial in moving the needle
An evaluation of the social determinants of health affecting the area

Next, the COS in each region compiles this information to develop a “Road Map to Recovery” which illustrates the resources, treatment options and assets in neighborhoods throughout the state. Assuming a supportive, “broker role” among the providers, community-based agencies, and community members, the COSs work to connect a comprehensive group of service providers (both clinical and non-clinical) to promote wellness and improve healthcare outcomes through coordination of services and integration of community-based supports. This thorough community analysis provides critical information that helps shape how the COS team and Magellan Complete Care interface with the communities throughout the regions they serve. This research allows our team to recognize the uniqueness of each community, its strengths, and how we can best position our resources to support the local system of care.

Please refer to [General SRC #34, Attachment 1: IHN Overview, Flowchart, and Flyer].
Below is an example of a grassroots community effort that demonstrates the value and product of the above stated process and the impact it has had on a local system of care:

~~Example: Integrated Health Neighborhood: Region 7 – Engaging with the Faith-based Community~~

In Region 7, the Pine Hills neighborhood has as a predominantly African-American community that is plagued by poverty, crime, high dropout rate among school attendees. Pine Hill residents experience a higher than average incidence of chronic health and mental health conditions. Community resources are fragmented and residents feel disconnected. Many residents have turned to their church or their pastor to pray for them in their times of need – this includes through times of physical and mental health challenges. Many churches are now establishing wellness programs to more actively address their communities overall health and wellness.

We partnered with The Worship Center of Orlando and Pastor Frank Thompson, who has participated on committees we attend in in the community. Pastor Frank is our neighborhood champion. In collaboration with other area churches, we recently held a community-wide “Pathway 2 Wholeness Health Extravaganza.” In addition to Magellan Complete Care, vendors included area Federal Qualified Health Clinics (FQHCs), primary care physicians for both adults and children, the Orange County Health Department, the National Alliance for Mental Illness (NAMI) and the Mental Health Association of Central Florida. One of the goals of the event was to help break down stigma related to getting assistance, outside of the church, for overall wellness.

The overall goal of our this neighborhood partnership is to increase the knowledge base of participants on topics related to physical and mental health, break down the stigma related to mental illness and get community organizations/presenters to become more involved in the Pine Hills Community. Based on the success of the event and partnerships, smaller quarterly educational sessions are planned at area Pine Hills churches. Our COS Team partners with the church and Pastor Frank to identify topics and arrange presenters for the subsequent event. We will administer surveys on attitudes and knowledge level related to each topic before and after each session.

1.1 Examples: Partnerships, Activities and Initiatives
We describe in further detail our local community partnerships, activities and initiatives to support the local system of care below.

1.1.a Partnerships
We understand that creating system change requires collaboration with local and statewide entities. Creating parity within the delivery system and strategically leveraging resources to optimize outcomes is not possible without establishing collaborative partnerships. Over the past several years, Magellan Complete Care has fostered solid working relationships with partners who share our values, mission and goals. We seek out partners who are aligned with serving individuals living with serious mental illness and who believe that recovery is possible for all.

1.1.b Department of Children and Families
Since the inception of the specialty health plan, Magellan Complete Care identified the Florida Department of Children and Families (DCF) as a high priority partner to further progress many key initiatives on behalf of SMI enrollees statewide. Magellan Complete Cares joint community partnerships include the following:

> Statewide suicide prevention efforts
> Recovery-oriented system of care (ROSC)
> Florida Assertive Community Treatment (FACT ) Summit

1.1.c Recovery Oriented Systems of Care (ROSC)
President Bush’s New Freedom Commission assessed the nation’s mental health system as, “fragmented and in disarray leading to unnecessary and costly disability, homelessness, school failures and incarceration” and recommended fundamentally transforming service delivery based on a vision of recovery (New Freedom Commission on Mental Health, 2003). Transformation to a ROSC is a proven method to improve care coordination on a statewide, regional, and local level.

DCF is the primary state agency leading the Florida implementation of ROSC. Magellan Complete Care quickly took notice of the value ROSC would bring to system transformation and became a key partner with DCF on the ROSC partnership. We recognized the need to amplify consumer and family voice and participation in our internal decision making processes and as well as guiding our external priorities.
As a first step in Florida’s transformation to ROSC, Magellan Complete Care co-sponsored, along with SAMHSA and the Department of Children and Families, a series of summits in all regions of the state to generate buy-in for a ROSC approach. More than 800 people attended the summits, including system administrators, providers, and individuals living with behavioral health conditions, family members and community stakeholders. The importance of welcoming communities and providers partnering with agencies that offer non-treatment-based community resources and supports was emphasized. A key part of the summits was hearing from those served within the system and their families what was essential to their recovery.

~~Testimonial Regarding a Region 5 Central Florida Behavioral Health Network, from Beth Piecora Consumer and Family Affairs Specialist~~

“Magellan Complete Care has been a great community partner. They are visible within the community and at community stakeholder events and meetings. Unlike the other plans, as I mentioned, they are present and I have been able to develop relationships with Magellan Complete Care staff so that I can reach out to them if I have questions or needs. I know who they are and how to reach them.

It is important to recognize that Magellan Complete Care has been the leader in peer support services in the state from hiring peers at the consumer level to sponsoring trainings throughout the state of Florida to train peers and give them the skills they need to work utilizing their lived experience. This vital service is integral to the recovery oriented system of care that the state of Florida is seeking to develop and with Magellan Complete Care’s help more peers are receiving the help and support they need to do the job. Magellan Complete Care sets a wonderful example for other managed care organizations and providers that are concerned about hiring peers. Their work in this area is helping to develop the standards and processes other organizations need to add peers to their work force.”

1.1.d Florida Assertive Community Treatment (FACT) Summit
Care coordination is a priority effort for both DCF and Magellan. FACT teams are critical to successful community living including for those transitioning from state hospitals. Magellan’s care coordination efforts often involve enrollees who are also on FACT teams.

In May 2017, Magellan co-sponsored a first FACT Summit with DCF, enabling FACT teams in a regions Florida to gather in one room for a day of networking and education. FACT teams learned about how they can be involved in the ROSC transformation, the Magellan Complete Cares care coordination programs, and housing resources presented by the Florida Supportive Housing Coalition. FACT team members expressed appreciation for the opportunity to connect and learn.

1.1.e National Alliance on Mental Illness (NAMI)
Magellan Complete Care has partnered with NAMI a significant amount over the past decade at statewide, regional, and local levels. Over the last several years, we have taken our partnership with NAMI to the next level to become an ally in mental health awareness and movement. Since 2015 Magellan Complete Care and NAMI have collaborated on 22 events statewide, and Magellan Complete Care has provided $61,500.00 in funding for walks, awareness campaigns, events, etc. that bring communities together to combat stigma and empower individuals and families affected by behavioral health disorders.

On a grassroots level, Magellan partnered with NAMI Florida and local affiliates to host a series of listening sessions for families and caregivers and also included other system partners such as:
the Federation of Families, regional systems of care coordinators, managing entities, local DCF, provider organizations, state agencies, faith-based organizations, and other stakeholders. The purpose of the listening sessions was to create a place for stakeholders, community members, and families and care recipients to share their experiences and recommendations for improvement with the healthcare system to bring about positive change for individuals living with SMI. With over 130 community members in attendance, Magellan Complete Care and the other system stakeholders were able to hear firsthand what is needed to improve the delivery system from the people who experience its challenges.

As a result of the listening sessions, Magellan Complete Care was able to take action on this feedback and fund an innovative program in region 7. On November 1st Magellan Complete Care in partnership with NAMI, and other community partners is kicking off an innovative one-stop information service in the lobby of Orange County children’s mental health facilities during family visiting hours. “Friends in the Lobby” provides hope, encouragement, compassion, and information. The concept has proven highly effective in other parts of the country and will be the first of its kind in Florida. NAMI will provide two trained volunteers with lived experience to staff a designated space in the hospital lobby area. Visitors to the hospital will be able to access information on free or low cost community resources such as NAMI Greater Orlando education classes and support groups, Federation of Families programs, Wrap Around Orange, 2-1-1, prescription assistance, housing, mobile crisis and area FQHCs. Having a loved one in the hospital for a behavioral health emergency can be stressful, confusing and traumatic. Friends in the Lobby offers hope, understanding and information to ensure knowledge and connection to needed resources in the community. Magellan’s support in starting this up is critical to enhancing the knowledge and education families and communities need to effectively navigate and access supports, maintain community tenure and achieve recovery.

~~Stakeholder Quote from Linda Briggle, Director of Outpatient Services - Volunteers of America~~

“There are no other plans like you guys. We have a lot of individuals with psychiatric disabilities here at Volunteers of America and sometimes it seems that people have forgotten about them. Magellan Complete Care was able to help us renovate our learning center used to train and teach individuals to do for themselves to become independent in their communities. We are so grateful you are part of our community because other plans do not know how their members are doing outside of the medical offices.”

1.1.f Managing Entities

DCF contracts for behavioral health services through regional systems of care called managing entities (MEs). The MEs do not provide direct services; rather, they allow the department’s funding to be tailored to the specific behavioral health needs in the various regions of the state. Magellan Complete Care has partnered with all seven MEs statewide in an effort to improve coordination of care and work towards integrated models of care. Our PSS and COS teams have attended their quality improvement meetings, provider meetings and have dedicated monthly meetings with the local Magellan Complete Care teams in many parts of the state.

In an effort to improve care coordination, streamline care and prevent duplication of services, our PSSs worked with the local MEs to develop a “DCF/Magellan Complete Care Benefit Cross Walk.” This document provides a level of transparency and insight into both service continuums to help guide and inform the coordination of care process, and it has had a positive effect for enrollees transitioning between funding streams.
1.1. MY LIFE
Magellan Youth Leaders Inspiring Future Empowerment, (MY LIFE) has been leading the way nationally for youth involvement in behavioral health and foster care systems since 2008. It was established in Florida in 2011 with MY LIFE Tallahassee. Through regular meetings and special events, MY LIFE supports youth in reaching their goals and provides opportunities to create positive changes for themselves and their communities. 58 monthly MY LIFE Tallahassee groups have been held with an average of 30 youth attending each one.

MY LIFE’s signature annual event, MyFest, is a free community event designed to entertain and inspire attendees, while sharing valuable resources related to mental health and other challenges facing youth and families. MyFest has been held in Tallahassee for 5 consecutive years and has welcomed over 3500 attendees and 125 exhibitors.

MY LIFE and MyFest Tallahassee events are provided in partnership with the Family Cafe, City of Tallahassee, Department of Juvenile Justice, Vocational Rehabilitation, Department of Children and Families, and numerous other youth-serving organizations.

In 2017 Magellan Complete Care partnered with the Federation of Families of Central Florida to establish MY LIFE groups in Orange, Seminole and Osceola Counties and with Mental Health Association of West Palm to bring MY LIFE to their community. All of these groups meet monthly, and the participation has been tremendous thus far with over 35 youth attending each group in West Palm Beach. Magellan will continue to support MY LIFE activities in these communities, while exploring opportunities with community partners to start new MY LIFE groups in areas in the state.

~~Stakeholder Quote from Lori Fahey President CEO Family Café~~
“Magellan Complete Care has been an exemplary partner in supporting The Family Café’s work with youth and families in Florida. The Family Café exists to provide people with an opportunity for collaboration, advocacy, friendship and empowerment by serving as a facilitator of communication, a space for dialogue and a source of information.

Magellan has invested in that mission by supporting The Family Café’s work to connect people with resources and with each other, through The Annual Family Café, which brings together thousands of Floridians with information and resources at a three-day event each year in Orlando. Magellan has also been a key partner in supporting The Family Café’s efforts to build leadership skills, mentoring, and mental health resiliency among vulnerable youth through the MY LIFE program in Tallahassee.

At every level, The Family Café’s relationship with Magellan has been driven by a shared belief in the importance not only of helping people in the community, but empowering people with the knowledge and confidence they need to transform their communities and their lives.”

1.2 Activities
Magellan Complete Care community activities span a wide range of valuable touch points. We live our mission in the neighborhoods we serve helping people to live healthy, vibrant lives. Below are regional examples of the value and importance of the COSs partnerships within their communities statewide. These partnerships have been critical to addressing the needs of our enrollees from a “whole person” perspective and improving the system of care. Below are a just
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a few examples of how the COS team supports local systems of care in regions throughout the state.

>Region 2: The COS is a board member for Big Bend Mental Health Coalition and is assisting planning and coordinating the monthly meetings and community events.

>Region 4: The COS took a lead position in the Community Health Improvement Process (CHIP) and Mobilizing for Action through Planning and Partnership (MAPP) Steering committee to assist in setting goals and objectives concerning access to care for Volusia County. He also had a leadership position in the System of Care (SOC) committee assisted in developing mission vision and other professional assistance for the SOC grant.

>Regions 5 & 6: The COS is a member of the Pasco Mental Health Foundation and Substance Abuse Ad hoc Committee to assist individuals coming out of jail needing services and medications. They were also a member of the Trauma Informed Care Committee and Behavioral Health Consortium Subcommittee on Transportation to bridge gaps for the most vulnerable in Region 6.

>Region 7: Magellan Complete Care has a partnership with Daily Bread and IMPower, a leading nonprofit mental health and child well-being organization that offers a continuum of care for children and adults focused on addressing mental and behavioral health and child well-being management and med management. Daily Bread is an organization that assists individuals with housing. A COS created a partnership with the organization to have informal marketing events at Daily Bread every month. There was a spike of individuals coming to the Daily Bread with mental health concerns. Our COS connected Daily Bread with IMPower who now offers counseling to individuals and families at Daily Bread. The COS is currently working with Seminole County government to establish a drop-in center for the area, and Magellan Complete Care has signed a letter of support for the center.

>Region 9: The COS took a leadership role to organize the West Palm Beach NAMI walk, a NAMI fundraiser and behavioral health awareness event. Additionally, Magellan Complete Care is a member of Healthier Together Rivera Beach formed to create healthier neighborhood and raise awareness of behavioral health issues and services and strategies for treatment. Finally, we continue to support the Crisis Intervention Team of the Treasure Coast as a member of the Executive Committee, financial contributor, along with providing volunteer and staff training.

>Region 10: The COS is a participant on the Broward County Department of Health Outreach Planning Committee which brings together a multitude of local stakeholders to develop activities and strategies improve health outcomes at various touch points throughout the system of care.
>Region 11: COSs organized a Magellan Complete Care painting day to help the local domestic violence shelter, Lotus House, to raise financial support.

1.3 Initiatives
Magellan Complete Care has developed innovative approaches to support external, community integration and system transformation. Below is an example of how Magellan Complete Care’s COS in region 4 was able to affect enrollee outcomes, community investment and build support for the system of care in Jacksonville:
In February of 2015, The St. Johns Behavioral Health Consort and NAMI began working on developing resources for a drop in center for the St. Augustine area. As an identified thought leader in the community, the Magellan Complete Care COS was invited to be a part of the consort to help bring local providers and government together to support this much needed, grassroots initiative. The COS engaged Stewart Marchmen Act (CMHC), Flagler Hospital, EPIC, Local county government officials and the local Managing Entity- Lutheran Services Florida to move the efforts forward.

The COS provided leadership and technical assistance to help structure the drop in center, develop the services, and help identify funding resources that could collectively support the initial investment to get the center up and running. The search for funding started with a simple online campaign, which quickly gained momentum. Eventually St. John county and the managing entity (DCF) agreed to participate as funding partners to the drop in center committing to contribute significant dollars which would allow the drop in center to move from concept to reality. The St. John’s Drop in Center opened in the summer of 2016 and provides a safe haven for community’s enrollees to engage in social activities, groups, receive peer support services, art, nutrition, and exercise groups. Through developing key community partnerships, understanding the needs of the enrollees in St. John’s County, and his commitment to improving the system of care, the Magellan Complete Care COS was able to enact real change in region 4 that transcends standard healthcare services and will having lasting benefits for the community.

1.4 Supporting Community Reinvestment
1.4.a Magellan Cares Foundation
Magellan Complete Care is focused on the importance of community reinvestment at all levels. At the corporate level, the Magellan Cares Foundation, Inc. was launched in 2015 and is a nonprofit, charitable organization with the mission to improve the health and well-being of the lives and communities we serve.

The Magellan Cares Foundation provided over $600,000 in grants and employee match requests to hundreds of organizations throughout the country whose missions aligns with ours. The Foundation supports many key Florida-specific partners such as: Healthy Start of Palm Beach, Big Bend Homeless Coalition, Camillus House, Community Action Stops Abuse, Children of Inmates, Federation of Families, Habitat for Humanity of Greater Miami, Homeless Coalition of Florida, Mental Health Associations throughout the state, NAMI Broward, National Medical Musical Orchestra, Florida Advocacy Project. The Foundation has paid over $100,000 in disaster relief efforts, including $50,000 to the Volunteer Florida Foundation for Hurricane Irma.

The Magellan Cares Foundation’s key focus areas include the following:

> National or large-scale health access and quality improvement initiatives
> Efforts that help to improve the social supports around a quality healthcare system, such as access to housing, food, clothing, or self-improvement opportunities
> Employee interest in community improvement
> Support to America’s military service members, veterans, and wounded warriors.

1.4.b Donations to Support Community Reinvestment
Magellan maintains a company-wide commitment to reinvest in the communities it serves nationwide by offering the following:
> Volunteer Time Off (VTO)
Magellan Complete Care employees are given the ability to take eight hours of paid VTO. We encourage all employees to identify opportunities in their neighborhood throughout the state to support and contribute to building stronger communities. Our executive leadership team also coordinates group VTO opportunities for Magellan Complete Care employees to participate in to encourage team work among our staff while also giving back. Florida team VTO activities included:

>>> Habitat for Humanity Team Build
>>> We hosted a series of “Community Connection Events” with several homeless organizations statewide. The Community Connection Events consisted of hot meal distribution and new socks for those who participated. Magellan Complete Care had a team of employee volunteers at each event to build touch points in the local communities. Partner organizations that helped make these events possible included:

>>>> Camillus House
>>>> Central Florida Coalition for the Homeless
>>>> Miami Rescue Mission
>>>> Big Bend Homeless Coalition

>>> In the month of November the Magellan Complete Care Jacksonville team will be volunteering at Beaches Recovery Center to host an aromatherapy class for individuals in the residential substance abuse program to support positive coping skills and recovery activities.

>>> In December Magellan Complete Care will host a volunteer event for Children of Inmates that will provide toys, books, games, etc. for the participating children and families.

>Targeted Donations to Support System Transformation- Drop in Centers/Clubhouses
Drop in centers and clubhouses have proven success engaging and empowering individuals living with serious mental illness to connect with the communities and people where they live. Drop in centers and clubhouses are aimed at promoting community inclusion, hope and support for people accessing the services. Given the specialized, SMI population we serve in Florida, Magellan Complete Care targeted these organizations throughout the state to provide a financial gift to help grow, support their business and have a direct positive influence on the enrollees accessing their support.

The COS identified 50 drop-in centers and clubhouses and after meeting with the staff, determined a level of need for the agencies. In total, we donated $92,000 to these drop-in centers and clubhouses. In addition, Magellan Complete Care’s IT staff prepared 40 computers that were obsolete to our operation to donate to these organizations along with 15 computers given to the Achievement Center for Children and Families in Delray Beach recovery process through establishing a meaningful support system.

~~Community Quote from a Region 9 Hilda Navarrete Manager of Drop in Center Welcome House in Okeechobee~~
“Magellan has showed our drop-in center that they are person-centered and community focused especially in our small town of Okeechobee. They have gone above and beyond to help our little community. … It seem that Magellan is everywhere in our community which is a good thing so that everybody know what services are available to them. Magellan is also very peer oriented: they are recently promoting their peer specialist roles and how they play a key factor in people’s recovery and overall health. Mental Health America (MHA) and ITN Productions selected
Magellan as the only managed care company to feature in #B4Stage4, an online program aiming to improve early intervention and combat mental health stigma.”

>Magellan Complete Care Community Event and Sponsorships
Our COS (COS) team continuously identifies opportunities to support community-based organizations and efforts. Funding events and sponsorships to ensure the growth and development of community resources is a core focus of the COS team. Since 2015 we have provided sponsorships for nearly 190 events or community causes totaling approximately $250,000 to Florida specific communities, grassroots entities and resources to build stronger neighborhoods throughout the state.

>Toll-free Hotlines:
In times of need, Magellan maintains our commitment to communities by sharing resources to support the repair, restoration and recovery efforts. In response to recent tragedies in Florida and detrimental weather events, Magellan set up 24-hour toll-free hotlines for individuals, regardless if they were Magellan enrollees, these event included:
>>Hurricane Irma
>>Hurricane Matthew
>>Hurricane Harvey
>>Mass shooting at the Orlando night club
>>Shooting at the Ft. Lauderdale airport
The hotline is staffed by behavioral health professionals offering counseling services and resource materials to help people deal with the feelings of fear, sadness, anger, and hopelessness that may occur related to natural or manmade incidents.

1.5 Magellan Complete Care Partnership Recognition Awards
Magellan Complete Care was recognized for its work educating providers and community stakeholders about the value of peer support.

One of our Magellan Complete Care peer support specialists was awarded Peer Support Specialist of the Year by the Florida Council for Community Mental Health in 2016. She was presented with the award at the annual Florida Behavioral Health Conference for her commitment to serving our enrollees and living a message of recovery and hope. She has worked for Magellan Complete Care for three years and has been able to help many enrollees during that time.

Our Senior Director, Systems of Care, was recognized by the University of South Florida in 2016 and given the University’s Community Partner Award. Our Senior Director was recognized for her efforts to support several USF research projects and ongoing commitment to partnering with the USF team to making meaningful advances in the Mental Health space.

EVALUATION CRITERIA 2:: THE EXTENT TO WHICH THE RESPONDENT HAS SENIOR EXECUTIVE...
Magellan Complete Care’s executive leadership plays an active role within the communities where they live and work. In the past three years, Magellan Complete Care’s senior executive leadership staff have participated on a number of local health and human service related boards, councils, workgroups and commissions throughout the state. We will continue this work in additional regions as we expand to all regions of Florida. Below is a list of the senior executive staff and the organization in which they participate:
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> Senior Director of Account Management: Florida Council for Community Mental Health and  
Florida Association of Health Plans  
> Senior Director, Systems of Care: BRSS TACS (Bringing Recovery Supports to Scale Technical  
Assistance), Florida Council for Community Mental Health, and University of South Florida  
> Chief Operating Officer: Department of Children and Families, Department of Children and  
Families and Department of Corrections, Miami City Serve, and Feed Miami  
> Behavioral Health Medical Director: NAMI, Department of Children and Families, DCF/Suicide  
Prevention Coalition, and Palm Healthcare Foundation  
> Chief Executive Officer: Florida Association of Health Plans, NAMI, and Department of Children  
and Families  
> Director, Recovery and Resiliency Services: NAMI National, Streets Alive, Florida Certification  
Board/Mental Health America, American Psychiatric Association/Substance Abuse and Mental  
Health Services Administration, Department of Children and Families, Department of Children  
and Families, BRSS TACS (Bringing Recovery Supports to Scale Technical Assistance)

In addition to the direct community involvement throughout the state, the CEO also supports the  
Senior Director, Systems of Care who oversees the COS and PSS teams. The COS and PSS  
teams are solely dedicated to fostering relationships with community-based organizations and  
providers and tasked with participating on local committees, boards and workgroups on a daily  
bases in every active region. The work of the COS and PSS teams is reported up to the CEO and  
the entire Magellan Complete Care senior leadership team during monthly field operations update  
calls. The purpose of meeting is to review the community activities from the previous month  
including meetings, events, and partnership opportunities as well as upcoming activities to ensure  
visibility and support for community involvement in all regions. Magellan Complete Care will  
integrate regions 1, 3 and 8 into this process as we expand the health plan statewide.

Magellan Complete Care is a corporate partner of the Florida Council for Community Mental  
Health. Two members of our executive leadership team are regular attendees at quarterly  
meetings. Partnering with the Council has allowed Magellan Complete Care to build and enhance  
our relationships with their members on the Council and develop a comprehensive Integrated  
Health Home program with CMHC Council members who serve our enrollees.

Magellan Complete Care launched the statewide Integrated Health Home (IHH) program with the  
CMHC members of the Florida Council for Community Mental Health to provide integrated,  
enrollee-centric care. This collaborative venture was built on the principles of partnership,  
commitment to community-based care, innovation, and feedback. Over a period of several  
months, Magellan’s corporate VPs and local Florida executive leaders worked with the CMHCs  
to develop the Florida IHH. They collaborated to ensure it was enrollee-focused, recovery-  
oriented and enabled flexibility for the providers to creatively meet enrollees’ needs at the right  
time, right place, and right level.

Not only do our senior executive leadership staff members participate on local health and human  
service related boards, councils, and commissions, but many of our locally based staff also  
participate on community boards, councils and committees. We recognize the importance of being  
active participants within all regions, but more specifically communities that we serve. Moving  
forward, Magellan Complete Care will continue to locate opportunities where our leadership and  
staff can participate on local health and human services boards, councils and/or committees, to  
effect positive change for our enrollees.
CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT HAS PARTNERSHIPS WITH LOCAL AGENCIES THAT FOCUS ON ADDRESSING SOCIAL DETERMINANTS OF HEALTH.

We have learned, as the first SMI specialty plan for AHCA, that addressing the social determinants of health in a focused manner includes engaging non-health care systems as valued partners. We have already developed extensive partnerships throughout Florida with over 4,000 relationships with community-based organizations and we will continue to leverage our established process sited above as we expand into all regions of Florida. Within all active regions, we partner with social support agencies, non-health care system stakeholders, and our health care provider network across their continuum of services and supports.

Magellan Complete Care is committed to addressing social determinants of health as part of our Model of Care. Working together with our community partners, we are uniquely positioned to identify and address these challenges and improve enrollee health outcomes and overall quality of life for enrollees who are living with SMI. Magellan Complete Care understands that each enrollee’s ability to achieve and maintain a healthy and vibrant life is tied to social determinants of health, including housing, poverty, education, and access to transportation and healthy food.

Addressing social determinants of health is key to reducing disparities and health inequality. Our goal is to identify the uniqueness of every enrollee then provide outreach, tools, and interventions to help our enrollees access the services they need and take control of their well-being through partnerships with our providers and community organizations.

Within these communities, we strategically built relationships with housing organizations, employment services like vocational rehabilitation agencies, jail and school systems, as well as the local Departments of Social Services. We engage transportation systems, community development leaders, and the business community. We include advocacy organizations, caregiver, family, and peer support partners. In our experience, these collective partnerships create a broader construct to support our enrollees.

3.1 Community Resource Guide

Our community partnerships have culminated in the development of the Magellan Complete Care Community Resource Guide (CRG) as our customized solution to catalog our regional and county resources and partnerships across the state. The CRG is an online searchable tool, similar to the provider directory that contains services and supports that can be searched by resource type, region, and county. For a walkthrough of the CRG online tool, see [General SRC #34, Attachment 2: Community Resource Guide]. The CRG was developed and is maintained by the COS team using Salesforce and is available on the Magellan Complete Care website for public use. The Community Resource Guide is easily accessible requiring only one click to navigate to the actual search tool function. The CRG has forty different “resource types” identified to address a wide variety of social determinants and other needs in every region and more specifically, county we serve. Magellan Complete Care is currently working on building out these resources for regions 1, 3 and 8 to ensure the same robust neighborhood support services are available statewide.

Through this tool, we facilitate connections between our enrollees and needed services to address their whole health. An overarching concept of our IHN model of care is “everyone can recover with the right supports, and they recover in a community.” The Community Resource Guide contains over 4,000 resources available to enrollees, providers, staff and stakeholders. Examples of the resource types that are available include ALFs, adult GED support, federally qualified health
centers (FQHC), community mental health centers (CMHC), adoption/mother-to-be services, bereavement services, advocacy/peer-run organizations, diet nutrition, domestic violence, early child intervention, employment and training, helplines, government offices, legal assistance, parks and recreations, rent and utility assistance, senior services and thrift stores. Creating awareness of existing resources and then providing the connection for enrollees is critical to support long term recovery and foster community inclusion. The Magellan Complete Care team uses the CRG to make referrals for enrollees in their local communities. Additionally the PSS team conducts provider education on the importance of social determinants and how to access and integrate the CRG into their treatment planning process. Social determinants of health are at the core of how we care for our enrollees.

3.2 Addressing Social Determinants of Health

Below we provide examples from several regions of how our unique community partnerships with local agencies has allowed Magellan Complete Care to effectively address SDOH for enrollees and help to transform the systems of care in regions across the state.

3.2.a Employment:
Magellan Complete Care partnered with the Florida Division of Vocational Rehabilitation to increase employment opportunities through the Magellan Complete Care Apprenticeship Program (MAP). The Division of Vocational Rehabilitation is the key state agency supporting individuals with SMI to find and sustain a meaningful career. It is estimated that 60 percent of Florida vocational rehabilitation (VR) clients have a primary diagnosis of mental illness. We learned through extensive technical assistance with our network providers that hiring peers, individuals with lived experience of SMI, was a priority but that they struggled to identify peers who had the proper training, experience, and certification to sustain employment as a peer specialist. We launched the Magellan Apprenticeship Program with the state office of VR as the primary partner. Together we identified the most appropriate pilot sites throughout the state, created a job profile for peer specialists and provided education to vocational rehabilitation counselors, employment specialists, and vocational rehabilitation clients about mental illness, recovery, and the peer specialist profession. We provided technical assistance to vocational rehabilitation counselors to properly guide their clients including recommendations on trainings. MAP consists of four elements, (1) training, (2) peer mentorship, (3) career assistance, and (4) paid, on the job experience. MAP apprentices have an individualized learning plan to ensure they are trained in evidence-based practices. We partnered with the statewide peer network and the Peer Support Coalition of Florida, to develop a peer mentorship program to ensure each MAP apprentice receives the necessary training to be skilled and prepared as a peer specialist in Florida. Vocational rehabilitation provides career assistance to ensure MAP apprentices have the resources and supports to successfully establish themselves in the workforce. Our first apprentice was a direct referral from vocational rehabilitation and was a demonstration of the collaboration we have with both the state VR office and VR regional offices. We created part-time recovery support navigator apprentice positions in several regions to provide three individuals with SMI, who would otherwise be unemployed or be underemployed, an opportunity to receive paid on-the-job experience as a pathway to a career in the behavioral health field. We will expand the MAP program to all regions statewide.

3.2.b Housing Stability
~~Testimonial from Elizabeth Lynn Community Relations Manager of Orlando Union Rescue Mission, a Region 7 Orlando homeless provider~~
“We know that we can recommend Magellan Complete Care to our guest living here at the Mission and know they will receive quality care and wonderful customer service. This is an organization that truly cares about helping our community and that is evident in the fact that they have invested in the Mission as a whole (through volunteering here and through corporate sponsorship).

3.2.b.1 Magellan Complete Care- Housing Program

The organizations and resources involved in addressing homelessness differ from region to region and often differ between counties within the same region. In 2015, the Magellan Complete Care COS team launched housing programs in all active regions in response to an overwhelming need to address the enrollees’ most basic needs- safe and stable housing. A county specific approach was developed starting with a grassroots focus to understand the housing resources and supports in each community. The COS team conducted boots on the ground research in each county identifying all of the continuums of care (Florida’s statewide housing organizations) and becoming experts in the local housing processes and resources.

Based on the resources in each county, the COS team designed housing flow sheets that became the referral process for the Magellan Complete Care IHN team to navigate the housing resources that will meet the enrollees needs based on the specific nuances in their communities. Each county within each active region has its own unique flow sheet based on the available supports. Magellan Complete Care is currently conducting housing research in regions 1, 3 and 8 to ensure statewide access to housing resources.

Magellan Complete Care has developed numerous memorandums of understanding (MOU) with the Florida Housing Finance Corporation landlords throughout the State of Florida to house our enrollees. The Florida Housing Finance Corporation provides independent apartments located throughout communities for individuals living with disabilities who meet low income status. Our efforts to date have resulted in housing placement for enrollees statewide and improved health outcomes, such as reduction in ER visits and other preventable events. Although this has been a tremendous effort, more housing resources are still needed in order to meet the growing need throughout the state of Florida. We will be continuing to champion this effort within the communities we serve including the regions 1, 3 and 8.

The successes Magellan Complete Care has had to date are a product of leveraging existing resources through strong community collaborations. These connection points within the housing system today will give Magellan Complete Care the opportunity to use the outcomes collected to advocate for additional housing resources in the state to support individuals living with serious mental illness who are in need of safe, affordable housing options. Magellan Complete Care will use this experience and supporting data to lobby for increased resources and educate key people that housing is a healthcare indicator. Below is an enrollee story which illustrates the power and impact that obtaining stable housing can have on our enrollees.

~~Enrollee Story: Joseph (name changed to protect privacy)~~

Our enrollee Joseph is a 59-year-old man who had been chronically homeless for the past three years. Before receiving stable housing, he survived outdoors in parks and behind stores; sleeping on benches to avoid the dampness, dirt, and bugs on the ground. Joseph also used hospitals when he “couldn’t take it anymore.” The emergency room would provide respite, a hot meal, a climate-controlled environment, safety, and a good night’s sleep. He was admitted into a hospital seven times in the last half of 2015. Joseph reported having suicidal ideations as a result of his
homelessness. He expressed feeling worthless and no longer could find meaning in his life. Joseph talked about ending his life and had a specific plan to do so. He did not have any social supports.

This all changed when Joseph’s Magellan Complete Care health guide found a new permanent supported housing project targeting homeless disabled individuals in West Palm Beach. His health guide completed the referral paperwork for the Goodwill Industries program and he was approved within two weeks. Joseph left the hospital and moved into his own apartment on Christmas Eve. Since that time, he has not been hospitalized. Joseph is now independently scheduling and attending his behavioral and physical health appointments. He reported being reluctant to attend appointments in the past due to feeling ashamed of his appearance. Joseph has made friends in the neighborhood and has recently re-established a relationship with his brother. One of his favorite things to do is spend time at the beach which is walking distance from his apartment.

3.2.c Exposure to Crime/Violence

In an effort to ensure the safety of our enrollees and reduce instances of crime and violence, Magellan Complete Care has made law enforcement a key partner in our community outreach efforts. A major part of our community engagement and systemic approach is partnering with the criminal justice system. Individuals living with serious mental illness have a disproportionate rate of involvement in local and state justice and correctional systems. Many individuals living with SMI are inappropriately placed in jail and prison settings when they would be better served in community treatment and rehabilitation programs.

Magellan Complete Care believes and supports crisis intervention training (CIT), which is an internationally supported approach to educate and train law enforcement on how to deescalate and manage crisis situation involving individuals with SMI in a person-centered, sensitive manner to preserve the integrity and safety of the person in need. It is also aimed at reducing unnecessary criminal justice involvement and/or incarceration by using crisis services at community mental health centers to promote treatment and recovery instead of criminalizing a vulnerable population. The following are examples of how Magellan Complete Care has engaged law enforcement, specifically CIT trained officers, in all active regions throughout the state to better partner with the goal of reducing violence in crisis situations and avoiding unnecessary criminal involvement on behalf of our enrollees:

> The COSs (COS) have engaged the CIT programs in their local regions, at the city level, to build partnerships focusing on enrollee safety and reduction of violence.

> The COS manager has been a CIT instructor in region 9 for the officer training sessions and currently sits on the executive committee to influence and progress system change within the law enforcement community.

> The Magellan Complete Care peer support specialists also attend CIT officer trainings in regions throughout the state to share their lived experience with a series mental illness and their personal experiences with law enforcement during crisis situations to build awareness of person first care.

> In region 2, Magellan Complete Care provides the training manuals for CIT on collaboration with NAMI for the 40 hour officer training.
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> In an effort to support, promote and educate the regional Magellan Complete Care IHN teams on the value and importance of CIT for our enrollees, Magellan Complete Care invited local CIT officers to attend and speak at our regional monthly staff meetings. CIT officers spoke to the Magellan Complete Care IHN teams in each region about their role supporting individuals experiencing a mental health crisis, the extensive training they elected to participate in, how to request a CIT trained officer when handling a crisis situation. The officers also educated the Magellan Complete Care team on how they work collaboratively with the local mobile crisis teams within the Community Mental Health Centers.

>> Magellan Complete Care led a panel discussion at the CIT international conference focused the role of peer support services in the law enforcement and the criminal justice system. The panel was facilitated by Magellan Health’s National Senior Director of Recovery and Resiliency Services. Magellan Complete Care invited the peer support specialists from the 19th judicial circuit mental health court and the 11th judicial circuit Criminal Mental Health Jail Diversion Program and one of Magellan Complete Care’s peer support specialists to participate as the panel members. The discussion focused on the importance of lived experience, fair and sensitive treatment during crisis situations to reduce unnecessary violence against individuals experiencing a mental health crisis and the value of leveraging community mental health centers as a solution rather than jail or criminal justice involvement.

3.2.d Health Literacy and Education
The Magellan Complete Care COS team promotes health literacy and wellness in a multitude of ways within local communities throughout all active regions. Our IHN structure is the ideal foundation to engage enrollees into the healthcare process and to educate them about resources and services to help promote wellness. We develop enrollee communication and education materials based on input from focus groups and our Enrollee Advisory Committee. Our local teams, including recovery navigators and family support specialists, help to improve our communications to ensure they are helpful, understandable, and accessible. We review all enrollee materials to ensure consideration of enrollee physical and cognitive abilities, level of literacy, and linguistic proficiency, and to ensure the materials are culturally competent.

One example from region 10 demonstrates provider partnership, creative local solutions and coordination of care. The IHN team in region 10 comprised of a recovery navigator, health guide, COS, and PSS developed a community structure to connect enrollees to preventive care, screenings and education where they typically receive services. Now deemed “community health outreach” events, the goal is to increases community touch points with enrollees through the below process:
>> Target a high volume community mental health center based on claims data.
>> Identify enrollees receiving ongoing services within that CMHC.
>> Coordinate a time for the community mental health center and the Magellan Complete Care health guides (HG) and integrated care case managers (ICCM) to be present at the CMHC to conduct enrollee outreach and education on chronic conditions and review the Community Resource Guide (CRG) to meet address social determinants.
>> Assist enrollees to make any healthcare appointments including preventative care to close gaps in care.
>> Educate enrollees on their plan benefits including Over the Counter, Transportation, Dental and Vision.
>> Refer enrollees to Healthcare Financial, Inc. to pursue SSI benefits.
3.2.e Provider-Led Initiatives:
Dating back to the start of our experience in Florida, CMHCs have been a core partner in our service delivery system. Magellan Complete Care is pivoting our strategy to focus on provider-led initiatives, such as partnering with the Florida Council for Community Mental Health and its CMHC provider enrollees to use additional tools and technology to reach and engage enrollees through the Integrated Health Home (IHH) program. The Council lent critical insights and recommendations based on legislative priorities, shared goals with DCF, and feedback from their enrollees. The Florida Council is a synergistic partner for Magellan Complete Care as an advocate at the state level to enact change and shape the trajectory of the system of care.

Our goal to integrate SDOH into IHH includes the development of provider quality improvement and alternative payment models (APM). Integration of SDOH into provider EHRs would allow for effective data integration, which leads to better informed clinical decision making, tailored services, facilitation of appropriate referrals, coordination of care across community organizations, and facilitation of active panel management approaches that identify and prioritize patients for focused outreach (e.g., intensive care management).

We welcome the opportunity to work collaboratively across MCOs within Florida to effectively move the needle on social determinants. Without standardized tools and measurement, there are significant limitations on the degree to which social determinants of health information that can be aggregated across care settings, limiting its usefulness from policy, health services research, and payer perspectives.

CRITERIA 4: THE EXTENT TO WHICH THE RESPONDENT JOINTLY DEVELOPS AND INCORPORATES...
The Magellan Complete Care field-based teams are affecting communities daily through grassroots and grass-tops partnerships. These partnerships are reflected in every active region and in a multitude of specialty focuses to improve the lives of the enrollees and the overall health of communities throughout the state. The Community Resource Guide includes a comprehensive list of those local resources and supports that will help promote and support recovery. Below are specific examples from different regions of the state to illustrate Magellan Complete Care’s commitment to well-developed grass-tops and grassroots initiatives that have made a great impact.

4. 1 Partnering with Grass-tops Initiatives
4. 1.a Miami-Dade County Jail In-reach Team Project
In region 11, Magellan Complete Care is partnering with Miami-Dade County on the Jail In-Reach Project to facilitate a seamless transition for enrollees coming out of the jail system. The project is a grass-tops initiative led by Judge Steve Liefman, a trailblazer and advocate for individuals living with serious mental illness from a jail system perspective. This is a collaborative effort among Miami Dade Jail, community partners, providers and Magellan Complete Care to improve the assessment, referral, diversion, and care coordination among individuals living with SMI, and possible co-occurring disorders that are reentering the community from the criminal justice system.

>Project partners include:
>>Eleventh Judicial Circuit Criminal Mental Health Project
>>Miami-Dade Corrections and Rehabilitation Department
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>>Jackson Health Systems – Corrections Health Services
>>South Florida Behavioral Health Network.

The proposed project will create a specialized Jail In-Reach Team that will be guided by a shared commitment to cross-system collaboration and division of responsibilities among criminal justice and community partners to:
> Gather and review information to make determinations about eligibility for diversion programs;
> Develop and implement evidence-based transition and reentry plans emphasizing continuity and coordination of care;
> Monitor ongoing linkages to evidence-based treatment and services in the community; and
> Measure outcomes to facilitate performance improvement.

The target population for this program is adults with SMI who are frequent recidivists to the justice and acute care treatment systems. The project has set a goal to screen a minimum of 400 individuals annually using a validated, evidence-based risk and need assessment tools (MHSF-111, TCUDS V, and ORACLE-csn). Those identified to be at moderate to high risk of future recidivism to the justice and/or acute care treatment systems, and who are eligible for community behavioral health services, will receive enhanced transition and reentry supports, as well as linkages to and monitoring of evidence-base treatment and support services in the community.

Anticipated outcomes include increased public safety, decreased demand for services in the criminal justice and acute care treatment systems, and improved access to community-based treatment and recovery support services. As a result, we expect to see proactive identification and more effective transition planning, diversion, and service linkages will result in improved access to treatment and support services in the community, which in turn will result in improved mental health, criminal justice, and public safety outcomes.

~~Quote from Judge Liefman~~
“...I appreciate Magellan Complete Care of Florida's understanding of the unique needs of those with serious mental illnesses. All too often, individuals with serious mental illness find themselves in our criminal justice system, which is unprepared to deal with needs such as comorbid conditions, trauma-informed care and addressing underlying issues to recovery, such as medication adherence. Magellan Complete Care of Florida strongly believes in community-based care, and their outreach is predicated on keeping those who need services as close to their community as possible. I look forward to continuing our work together, particularly as it relates to jail diversion and other similar programs.”

4.1.b Indian River Mental Health Collaborative
In 2015, a grass-tops group of CEOs and CMOs from the healthcare community in Indian River County (region 9) reached out to Magellan Complete Care to be the MCO lead for the “Indian River Mental Health Collaborative.” The CEO and CMOs from two major hospitals, CMHC, FQHC, The Indian River Hospital District and other high level stakeholders came together to address coordination of behavioral health and substance abuse services in their county. Magellan Complete Care was invited to be the managed care expert and thought leader from a national behavioral health perspective. The goals of the groups were to:
> Establish a Community Connections Program to streamline the referral and coordination process, close the gaps in the delivery system and reduce duplication and burden on individuals accessing services through multiple touch points.
>> Establish a specialized network of integrated primary care and behavioral health providers to meet the needs of individuals and families experiencing behavioral health concerns.
>> Develop a behavioral health literacy campaign to reduce stigma and increase access preventative care.
>> Develop an early intervention program for youth and young adults with emerging substance abuse and/or behavioral health indicators.
>> Establish a continuing education and training strategy for professional, paraprofessionals and volunteers.
>> Design a new behavioral health and substance abuse diversion strategy.

The PSS in Region 9 initiated the Magellan Complete Care Provider Partnership Program to assess, evaluate and collaboratively plan integration strategies to support the participating providers in the collaborative. The PSS then presented the finding and recommendations to the collaborative to help shape their goal of creating a specialized integrated provider network. Magellan Complete Care leadership has been a proud partner of this group and actively contributing to its growth and direction. We will continue to provide information, data, and resources to improve the system of care in region 9 alongside the region’s most sought-after executives, medical professionals and system leaders.

4.2 Partnering with Statewide Grassroots Organizations
Grassroots partnerships are at the forefront of our community engagement model. Magellan Complete Care financially and collaboratively supported major grassroots organizations and initiatives during the past several years as evidenced by the examples below. These initiatives are focused on: capacity building, advocacy, training, and support for organizations in Florida, (1) the Peer Support Coalition of Florida, and (2) Youth Mental Health Collaborative (3) Provider Peer Support Excellence Program

4.2.b Peer Support Coalition
The Peer Support Coalition is the statewide network focused on leadership and workforce development for individuals living with mental illness with a mission “to empower peers to lead.”

Magellan Complete Care’s financial support of $149,600 in 2016 and 2017 allowed the organization to hire staff, provide a clearinghouse for employers seeking peer specialists and peer specialists seeking employment, develop a mentorship program, and provide training to over 500 providers and community stakeholders. Several of the trainings involved evidence-based programs.

There were 218 individuals trained in Wellness Recovery Action Plan (WRAP), an evidence-based program for activating wellness for those living with chronic physical and behavioral health conditions. Seventy individuals were trained in Peer Support Whole Health and Resiliency which helps people learn how to make goals related to health dimensions related to social determinants of health. Another 66 individuals were trained in Motivational Interviewing, an evidence-based program for eliciting a change response.

4.2.c Youth Mental Health Collaborative
In 2013, the Mayor of Orange County (Region 7), Teresa Jacobs, convened the Youth Mental Health Commission consisting of stakeholders, community leaders, and consumers to recommend short and long term strategies for improvements for children’s mental health systems of care. The final report recommended complete system redesign due a fragmented and
disjointed system that was almost impossible for parents and families to navigate. These challenges for families and youth had a negative influence on school suspensions and expulsions, psychiatric hospitalizations, suicide rates, child welfare placements, and arrest rates.

An advisory committee of key stakeholders was formed including Magellan Complete Care, DCF, DJJ, United Way, CBC (Child Welfare), the managing entity (ME) for mental health and substance abuse, Orange County Public Schools, NAMI, and the Federation of Families. The advisory committee developed a Youth Mental Health Pilot which will launch 11/1/17.

The pilot will initially serve 25 youth and families (up to 100 over two years). Youth between the ages of 13-16 who have a second psychiatric inpatient admission in a 12-month period will be eligible for pilot services. The pilot workflow supports best practices related to transition in care from inpatient to outpatient services, timely access to clinically appropriate level of care/service and a Family Advocate (peer support) as an integral functions.

Participating providers ascribe to a recovery-oriented system of care framework and are certified as such by the managing network. The pilot seeks to demonstrate that adherence to system of care values, and best practices in coordination of and access to care will decrease the percent of hospital readmissions and increase overall health and wellness for youth and families in Orange County.

The blending and braiding of funding among DCF/ME, CBC, County government, and Medicaid is also a pilot focus, with funding partners providing dedicated unrestricted funds for the two year pilot duration. Collaboration at this level allows the system of care to maximize available funding streams to ensure access to behavioral health services needed by youth and families regardless of coverage.

Magellan supports this community initiative in striving to build a recovery-oriented, accessible and effective system of care aligned with healthcare’s triple aim: quality, consumer satisfaction, and cost of care. As a general partner, Magellan is the only health plan to sign the stakeholder MOU committing to work with this stakeholder group in a collaborative way towards necessary system improvement.

Magellan Complete Care’s innovative apprentice program (noted above) will also be woven into YMH pilot, providing a 20-hour a week, 9-month Magellan employee to be co-located with Federation of Families and function within the YMH pilot as a family advocate. The position will assist and teach families system navigation while interfacing with hospital treatment teams and outpatient providers. The family advocate engages with families within 24 hours of their child’s inpatient admission and stays with them through the transition to outpatient services. This person centered approach recognizes the unique needs and strengths of families and furthers our collective mission to increase access and awareness.

Magellan Complete Care will continue its support and expand the focus to provide expertise and support in areas such as: first episode psychosis, transition aged youth, support for youth and families with DCF involvement, trainings for school-based employees, trauma informed care with a focus on the impact of ACEs (Adverse Childhood Experiences) to address all major needs of the target population and their care givers. As processes and outcomes are established, we also plan to develop similar groups in other areas to combine efforts, effectively position resources and optimize outcomes for youth statewide.
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4.2.d Provider Peer Support Excellence Program
In 2015 Magellan Complete Care launched a grassroots effort in all active regions that we serve
to increase capacity for peer support services. Magellan is a national thought leader in the peer
support, lived experience space. We have seen the value in exponential ways helping to transform
the lives of individuals living with mental illness and building a foundation of hope and recovery
through peer support services.

Magellan Complete Care developed a comprehensive plan of action to support grassroots
organizations and providers to deliver: training, education, funding, technical assistance and
creative solutions to help build a robust peer support work force throughout Florida to bring this
incredibly valuable resource to more enrollees and community members at large. Magellan
Complete Care identified 15 providers across the state interested in growing or expanding their
delivery of peer support services. After meeting with the providers, representatives from the
Department of Children and Families (DCF) and other national subject matter experts, Magellan
Complete Care developed a Peer Support Implementation Plan to guide the participating
organizations to provide direction on several key areas: building a workplace of inclusion,
recovery focused culture, supervision, documentation standards, HR policies and job description,
and much more.

Magellan Complete Care deployed the PSS team to educate the participating organizations on
how to use the plan and overlaid additional technical assistance through the Magellan Complete
Care Recovery and Resiliency Team. We also enhanced the reimbursement rate by more than
half to recognize the value of the service and adequately support the workforce coming into the
profession. Since 2015, Magellan Complete Care has expanded the reach of this initiative to
include nearly 20 organizations. Magellan Complete Care has also funded critical trainings to
support the certification process, WRAP planning and WHAM, throughout the state to impart long-
term, system-wide change.

Evaluation Criteria:

1. The extent to which the respondent provides details on how their local community
   partnerships, activities and initiatives support the local system of care.

2. The extent to which the respondent has senior executive leadership staff who will be
   assigned to the resulting Contract who also participate on local health and human service
   related boards, councils, and commissions.

3. The extent to which the respondent has partnerships with local agencies that focus on
   addressing social determinants of health.

4. The extent to which the respondent jointly develops and incorporates change from
   grassroots and grass-tops provider initiatives.

Score: This section is worth a maximum of 20 raw points with each of the above components
being worth a maximum of 5 points each.
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SRC# 35 – Organization Commitment to Quality (See Section 409.966, Florida Statutes) (Statewide):

The respondent shall describe its organizational commitment to quality improvement, including active involvement by the respondent’s medical and administrative leadership, and document its achievements with two (2) examples of completed quality improvement projects, including description of interim measurement and rapid cycle improvement processes, and a summary of results.

Response:

OVERVIEW
Continuous quality improvement (CQI) across all operations has always been the backbone of Magellan’s services. CQI is reflected in the structure of our organization, systems, and processes for Magellan Complete Care of Florida, which is supported in its quality efforts by active engagement of our senior leadership, including our CEO and CMO, and other executives as well as local quality executives, a robust and well-qualified local quality team, and by our national quality organization. The goal of our quality program is to ensure the provision of consistently excellent healthcare, health information, and service to Magellan enrollees, our provider partners, and AHCA, driving continuous improvement. Magellan’s core values of patient-centered, community-focused, and evidence-based services give clear direction to the Quality Program which touches every functional area of the plan, including healthcare service delivery, service operations with enrollees and providers, case management, disease management, population health, utilization management processes, network composition, compliance and risk management, and information management.

Magellan Complete Care staff obtain input from a broad spectrum of stakeholders, using a plan-do-study-act (PDSA) framework, which is an established and widely used process for continuous improvement. We monitor clinical, outcomes, and administrative quality with metrics derived from multiple data sources to ensure the timely identification of issues, barriers and interventions that require improvement, and to assess the performance of the improvements we have made. We use this model in all QI activities to resolve complex or multifaceted issues in a logical and systemic manner, as well as to engage stakeholders in planning efforts.

Magellan Complete Care’s quality programs have active participation in, and sponsorship by the CEO and top leadership of the organization including the chief medical officer (CMO), who shares joint accountability with the Magellan Complete Care director of quality management (QI Director) for quality outcomes. Quality is everyone’s job at Magellan Complete Care and is integrated in our training, performance monitoring, employee recognition and all day-to-day activities. In fact, as evidence of our commitment, all Magellan Complete Care staff have at least one goal tied to quality in their annual performance assessments. Our experience has shown that supporting CQI and plan-wide quality ownership yields optimal service delivery and enrollee outcomes, leads to systems improvement, and instills a pervasive culture of quality in everything we do.
CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT'S DESCRIPTION DEMONSTRATES THAT THE MEDICAL DIRECTOR...

The goal of our quality program is to ensure the provision of consistently excellent healthcare, health information, and service to Magellan Complete Care enrollees, provider partners, and AHCA. The program, which is an integrated part of all Magellan Complete Care operations, has active participation and sponsorship from the CEO and top leadership of the organization, who share joint accountability with the Magellan Complete Care Director of Quality Management (QI Director) for quality outcomes. The CEO of Magellan Complete Care of Florida is responsible for the Quality Program and for maintaining a culture of quality. The CEO is actively involved in monitoring and reviewing quality outcomes across multiple operational areas. The CMO and QI Director have day-to-day responsibility for implementation and management of the detailed elements of the quality program.

1.1 QI organizational and Program Structure

The structure of Magellan Complete Care’s Quality Program is built on our success operating Medicaid Quality Improvement programs in Virginia, Florida, New York, our partnership with Shared Health, and upon the framework established by NCQA health plan standards. We leverage our integrated analytics platform and our best practice population health capabilities. The QI organizational and program structure are compliant with applicable provisions of 42 C.F.R. § 438, including Subpart D, Quality Assessment and Performance Improvement and NCQA. Magellan Complete Care has full health plan accreditation from NCQA.

1.1 Leadership Commitment and Participation in Quality Activities

The CEO of Magellan Complete Care is responsible for the Quality Program and for maintaining a culture of quality throughout the organization. While the CEO maintains oversight and final decision-making authority, day-to-day responsibilities for implementation and management of the quality program to the Chief Medical Officer and QI Director, who have a Florida-staffed QI Department. Key responsibilities of the QI Department include the development and implementation of quality management and improvement initiatives, accreditation, credentialing, monitoring of outcomes, enrollee safety and critical incidents, appeals and grievances, service operations, and vendor oversight.

Chief Executive Officer Participation: Magellan Complete Care’s chief executive officer (CEO) has accountability for promoting the success of Magellan Complete Care QI goals and efforts by establishing a culture of quality and overseeing quality performance in all key operational areas. The CEO participates in oversight meetings and ensures the QI Program has the resources, equipment and personnel reasonably required to maintain and support QI Program initiatives. As an example of the level of CEO involvement, at the CEO’s direction Magellan Complete Care made two significant investments including the development of an internal member management tool to track proactive outreach to its enrollees to schedule appointments, remind enrollees of their appointments, and confirm appointments were attended. The CEO was actively involved in the design and implementation of the tool and also funded a field-based outreach team, which is a core component of our HEDIS/CHCUP program and has since expanded in scope to a statewide team.

Additional key executive participants in the QI process, and the roles of each are briefly described below:
Medical Director: Magellan Complete Care’s vice president medical director and chief medical officer (CMO) is a Florida-licensed and board certified physician. The CMO is accountable for establishing the Magellan Complete Care Quality Program as well as ensuring that the program is clinically valid and compliant with regulatory and accreditation requirements. The CMO promotes efforts to improve clinical and service quality and monitors quality activity reports so that Magellan Complete Care’s QI program scope is maintained and goals are achieved. The CMO and Magellan Complete Care Quality Director are responsible for oversight of all clinical aspects of the QI Program, the development and coordination of medical integration activities, prevention/wellness activities, and oversight of assigned physician advisors, primarily through day-to-day support of and consultation with clinical staff.

Medical Director Behavioral Health: Magellan Complete Care’s medical director behavioral health (MD-BH) is an appropriately licensed board certified psychiatrist. The MD-BH reports to the CMO and works collaboratively with the Magellan Complete Care Medical Director and CEO. The MD-BH is responsible for the clinical validity of behavioral health care and the oversight of behavioral health quality initiatives. The MD-BH works closely with the medical director, clinical staff, and network providers to enhance coordination of medical and behavioral care and treatment.

Chief Operating Officer: Magellan Complete Care’s chief operating officer (COO) has responsibility for the direction, management, and quality oversight of customer service operations, including telephone access standards, satisfaction survey results, vendor oversight, and enrollee/community outreach.

Quality Director: Magellan Complete Care’s Quality Director reports to the Magellan Health VP quality and works closely with the Magellan Complete Care CEO and CMO. The quality director has the day-to-day authority and responsibility for directing the management and advancement of the QI programs, inclusive of HEDIS and CHCUP.

Vice President Health Services: Magellan Complete Care’s vice president health services reports to the CEO and has responsibility for day-to-day management of clinical operations, including development, coordination and quality oversight of the Health Services Program, which includes medical care management, complex case management, population health and disease management activities, as well as behavioral health recovery and resiliency efforts.

Compliance Officer: Magellan Complete Care’s compliance officer participates in QI planning and initiatives, and reports to the Magellan Complete Care chief compliance officer with direct reporting access to the Magellan Complete Care Board of Directors. The compliance officer works closely with the chief operations officer to oversee the implementation and ongoing operations of the Magellan Complete Care Compliance Program, which is a key component of quality oversight for the plan. The compliance officer is responsible for the development and annual update of the formal Magellan Complete Care Compliance Program, ensures annual compliance training of Magellan Complete Care staff, and serves as the central contact for internal and external customers regarding compliance, security, HIPAA, and the Magellan Special Investigations Unit relating to anti-fraud efforts within the unit. In addition, the compliance officer supports internal and external audits and reporting.

Senior Director Network Management: Magellan Complete Care’s senior director network management reports to the VP network development and works closely with Magellan Complete Care senior leadership. The senior director network management has responsibility for the
direction, management, and quality oversight of network/provider operations, credentialing and re-credentialing of providers and coordination of on-site reviews.

Magellan Complete Care Florida QI Department
Magellan Complete Care has a Florida-staffed QI Department. Key responsibilities of the QI Department include the development and implementation of quality management and improvement initiatives; accreditation; credentialing; monitoring of outcomes; enrollee safety and critical incidents; appeals and grievances; service operations; and vendor oversight.

1.2 Quality Committees and Committee Structure
The Magellan Complete Care Board of Directors has designated the Magellan Complete Care Quality Improvement Committee (QIC) to provide corporate oversight of the QI Program. The QIC also provides direction and coordinates QI Program activities within and between its functional sub-committees. The sub-committees listed below provide direct oversight of quality functions and facilitate rapid process change when opportunities for improvement are identified. The chairs of the sub-committees serve as members of the Quality Improvement Committee and as quality owners of sub-committee communications and deliverables. Members of the QIC include executive representatives from each of the Magellan Complete Care’s departments as well as designated stakeholders.

We established QIC Subcommittees to cover the following areas: (i) Critical Incidents & Risk Management Committee, (ii) Health Services Committee, (iii) Peer Review and Credentialing Committee, (iv) Network Strategy Committee, (v) Vendor Delegation & Oversight Committee, (vi) Member Advisory Committee, (vii) Service Operations Committee, (viii) Compliance Committee, (ix) Care Coordination, (x) Drug Utilization Review Committee, (xi) Population Health Committee, and (xii) Utilization Management Committee. The Magellan Complete Care’s compliance officer manages the Compliance Committee, which is responsible for overseeing adherence to applicable legal, contractual, and policy requirements.

CRITERIA 2: THE ADEQUACY OF THE RESPONDENT’S APPROACH TO INCORPORATING QUALITY IMPROVEMENT ACTIVITIES...
Magellan Complete Care’s commitment to quality does not stop with our quality committee and executives. Quality is ingrained in our organizational culture, and is considered a key responsibility for staff in every department throughout Magellan Complete Care. As evidence of our commitment, all staff annual performance assessments include a quality goal. Our experience has shown that supporting CQI and plan-wide quality ownership yields optimal service delivery and enrollee outcomes, leads to systems improvement, and instills a pervasive culture of quality.

Magellan Complete Care integrates quality into the very fabric of our organization, including such elements as:

>Massive Transformative Purpose (MTP): We strive to infuse MTP into our work every day, making it the responsibility of every team member to drive best performance and quality improvement throughout the organization. We specifically recognize and reward teams that demonstrate excellence in achieving these goals.
QUALITY WEEK: Each year, Magellan Complete Care observes National Healthcare Quality Week with events, trainings, publications, etc. bringing quality to the forefront of the organization’s activities and attention. Each day of the week, we publish articles on different quality topics such as satisfaction and compliance measures; quality and efficiency measures; Fair Hearing process; and patient safety. Staff throughout the organization are encouraged to read and participate in discussion of these areas, with opportunities to win prizes.

SATISFACTION RECOGNITION: Magellan Complete Care regularly recognizes and awards teams and individuals who go above and beyond in delivering quality and satisfaction for our enrollees, providers, and partners.

ONGOING QUALITY TRAINING: All Magellan Complete Care employees receive quality training as part of the employee onboarding process, and at least once annually. In addition, staff receive quarterly training for such areas as grievances, appeals and Fair Hearing, or similar topics.

TOWN HALL MEETINGS: All Magellan Complete Care employees participate in monthly town hall meetings during which we discuss quality initiatives and the importance of quality in various operational areas of the organization. This will often include special presentations on select quality topics, and opportunities for discussion.

Through all of these activities, we emphasize that everyone in the organization has a responsibility for quality in everything they do, embracing a “quality sentiment” as part of all operations.

Our core values of patient-centered, community-focused, and evidence-based services give clear direction to the Quality Program. The Quality Program touches every functional area of the plan, including healthcare service delivery, service operations with enrollees and providers, clinical coordination and support services, core utilization management processes, network composition, compliance and risk management, and information management.

Magellan Complete Care Quality Program staff obtain input from a broad spectrum of stakeholders, using a plan-do-study-act (PDSA) framework. We monitor quality with metrics derived from multiple data sources to ensure the timely identification of barriers and interventions that lead to improvement. We use this model in all QI activities, for all operational areas, to resolve complex or multi-faceted issues in a logical and systemic manner, as well as to engage stakeholders in planning efforts.

Magellan Complete Care’s Quality Improvement Program is designed specifically for our enrollees, tailored to unique sub-populations, and is reflective of regional differences in culture, ethnicity, and health status. Quality activities and program metrics specific to our population are continually captured and reported. Quality activities and metrics are analyzed for regional differences in access to care, cultural and economic disparities, population health indicators, and prevalence of chronic disease and other illness.

The Magellan Complete Care Quality Program focuses on the management of high-quality, safe, innovative, and integrated, evidence-based services. We include a focus on regional needs assessments for pregnant women, children, and particularly vulnerable enrollees. We also focus on outcomes beyond HEDIS to include EPSDT/CHCUP, birth outcomes, and preventable events.
To support these purposes within the QI Program, Magellan Complete Care develops and monitors an Annual Quality and Health Services Work Plan, with specific measurable objectives and activities. The Work Plan is a living document that is actively monitored and adjusted throughout the year by our quality team through the oversight of our multiple quality committees. The Work Plan aligns to our vision, mission, and goals for our enrollees, as well as AHCA’s strategy and goals. Core monitoring metrics, encompassing clinical, operational, population health, and satisfaction indicators are captured in the Work Plan. We set benchmark goals for each metric and assign a quality committee for its ongoing monitoring, consistent with the principles of AHCA’s Quality Strategy.

The Magellan Complete Care Board of Directors has designated the Quality Improvement Committee (QIC) to provide corporate oversight of the Magellan Complete Care QI Program. The QIC also provides direction and coordinates QI Program activities within and among its functional sub-committees.

The sub-committees listed below provide direct oversight of quality functions and facilitate rapid process change when opportunities for improvement are identified. As leaders in their functional areas, they are also responsible for ensuring quality improvement processes flow through their organizations. The chairs of the sub-committees serve as members of the Quality Improvement Committee and as quality owners of sub-committee communications and deliverables.

Members of the QIC include executive representatives from each of the Magellan Complete Care departments, as well as designated stakeholders. Quality monitoring results are presented to quality committees and work groups which provide the structure and mechanism to assure that quality improvement is socialized throughout the organization. The Magellan Complete Care quality committee structure is the more formal structure that includes:

- Quality Improvement Committee (QIC)
- Health Services Committee (HSC)
- Enrollee Services Committee (ESC)
- Peer Review and Credentialing Committee (PRCC)
- Network Strategy Workgroup (NSW)
- Vendor Oversight Committee (VOC)
- Compliance Committee (CC)
- Consumer Advisory Group (CAG)

Each Magellan Complete Care committee monitors the progress of assigned functional areas including performance metrics, stakeholder input to QI projects, and interventions and actions required within each of their respective areas of responsibility. On no less than a quarterly basis, each Magellan Complete Care committee meets to review their monitoring metrics, which are benchmarked to plan-level goals, and tracked and trended over time. Our root cause analyses identify functional areas needing improvement, and QI efforts are implemented to elevate critical performance areas.

Work groups and ad hoc committees are often established by the quality committee structure to meet immediate and high priority needs. These groups are focused on meeting one or more related clinical, quality, or business outcome, and usually require cross-functional representation. They are similar to the more formal quality committee structure in their reliance on data, analytics, measurement, and use of the plan-do-study-act (PDSA) cycle (described in greater detail below).
The HEDIS/CHCUP/EPSDT Executive Steering Committee is one example of this type of purposeful committee. This committee was established in 2016 to actively guide the multiple quality improvement initiatives that were implemented with our enrollees and with our providers to support improved population health outcomes that would be reflected in improved HEDIS and CHCUP/EPSDT rates. Because these initiatives involved every functional area in the plan, this special committee was established to fast-track executive sign-off, ensure prioritization of these initiatives, and to support cross-functional communication and support.

Formal quality committees, purposeful work groups, and ad hoc committees use a variety of reports that present quantitative and qualitative analysis of trends and identify opportunities for improvement, including:

> Quality committee reports for all metrics included in the Quality and Health Services Work Plan, shared no less frequently than quarterly

> HEDIS and CHCUP/EPSDT rate reports, refreshed at least every two months, which ensure ongoing monitoring in addition to the final annual reporting done for NCQA and AHCA

> Program outcome reports, updated monthly, to track the process related metrics associated with QI activities, such as percentage of enrollees reached for a given activity, or number of PCP appointments scheduled

Finally, to reinforce that quality is everyone’s job, every Magellan Complete Care staff member has at least one goal tied to quality outcomes in their annual performance assessments.

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES PROACTIVE PROCESSES AND STRATEGIES...

Magellan Complete Care uses the plan-do-study-act (PDSA) quality improvement framework to proactively identify areas of concern and to solve problems in a logical and systematic manner to ensure that activities meet or exceed identified measures and goals. This framework is reviewed and approved on an annual basis by the Quality Improvement Committee (QIC). The QIC is co-chaired by the chief medical officer and quality director.

Key quality initiatives are documented in Magellan Complete Care’s Quality Program template, which encompasses the PDSA components, and supports effective communication of quality initiatives across Magellan Complete Care to ensure coordination and integration of activities. Both the CMO and the quality director provide expertise and input to the design and implementation of initiatives, and review of program data and decision-making happen in multiple forums, including QIC and work group meetings.

Valid and reliable data are the foundation of measurement and reporting that drive our quality improvement framework and ensure a proactive process and strategy to solve problems before they occur or are exacerbated. Magellan Complete Care staff collect data through multiple mechanisms, including automated reports from the data warehouse, QI core indicator reports, clinical record audits, provider site visits, and complaints and grievances. Data are collected from internal sources such as claims, demographic information, pharmacy and lab results, and electronic medical records if available. In addition, individual enrollee health risk assessment (HRA) and clinical information is collected and utilized as a key data and information component.
We also commission detailed and in-depth studies conducted by Magellan’s Department of Advanced Health Analytics and Solutions. An example, is the study we commissioned this year to assist in driving our HEDIS/EPSDT/CHCUP improvement program. That analysis focused on enrollee’s characteristics associated with adherence to HEDIS measures, understanding the effectiveness of existing interventions, refining those interventions, or developing new interventions and targeting to achieve improved outcomes. The study used multivariate statistical modeling to answer the question of which enrollee characteristics are associated with non-adherence after statistically controlling for other variables. Enrollee characteristics were selected using the industry-standard Anderson’s Model of Health Services Use, which posits that health services use and health practices are driven by: predisposing characteristics (e.g., age, gender); enabling resources/factors (e.g., education, distance to provider); and clinical need (e.g., medical conditions, pain). We used logistical regression to: examine dichotomies; analyze adherence/non-adherence; and determine the characteristics associated for adherence/non-adherence after statistically adjusting for other characteristics. The results of this analysis were instrumental in driving a much more targeted and effective engagement and intervention strategy for closing gaps in care for our enrollees.

We have also made a strong commitment to collecting data on our enrollee and provider outreach efforts related to appointment scheduling to support our Healthcare Effectiveness Data and Information Set (HEDIS) and Child Health Check-Up Program (CHCUP/EPSDT) QI goals. Assisting our enrollees to connect with their assigned primary care providers to receive screenings, lab tests, and other preventive and recommended care, is a Magellan Complete Care-wide operational effort. Magellan Complete Care has invested in the development of a customized application that is designed to track enrollee outreach efforts via phone or home visit, and to document whether an enrollee was reached or not reached (including wrong phone numbers or addresses) and the outcome of successful enrollee connections (appointment scheduled, and confirmation calls on attendance). It allows staff from different functional areas, as well as vendors to view and input data. Similarly, Magellan Complete Care has invested in enhancements to our care management application, TruCare, to ensure enrollee gaps in care are included in individual enrollee care planning, to support integration of multiple enrollee touch-points.

All functional areas of Magellan Complete Care operations, including enrollee services, auditing, provider performance, and clinical processes and outcomes, are appropriate areas for performance improvement. Through the use of the PDSA model, performance expectations are defined; data is captured, trended and analyzed for root causes of below-goal performance; measurable interventions are developed and implemented to improve performance; information is disseminated throughout the organization; and feedback received through internal feedback loops. Consistent application of the PDSA model insures Continuous Quality Improvement (CQI), throughout Magellan Complete Care operations and service delivery. This approach leads to systems evolution and the development of a culture of quality.

Accurate, reliable and frequent reporting support action. As noted earlier in this section, key plan leaders are accountable to lead, participate, and provide quality oversight within the formal committee structure, as well as in ad hoc committee and work groups. When a committee or workgroup identifies an opportunity for improvement, the members determine appropriate action, which may include directing an analysis of the problem including barriers and root causes, and/or developing an Action Plan which may include the development of a QI activity which is supported by our PDSA template.
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Magellan Complete Care maintains a quality management program that promotes objective and systematic monitoring of the quality of medical, behavioral, and psychosocial care and service delivery, with a focus on recovery and resiliency. Achieving these outcomes, while working with individuals who live every day with behavioral health conditions, demands that our Quality department function at a high level and that it be an integrated part of our overall model of care.

As we continue to grow our processes and structures to better support our enrollees and drive continuous improvement in quality, we also look to leverage important partnerships that we have established with best-in-class organizations so we may continue to learn, grow, and innovate in our overall system of enrollee engagement and management. As part of those ongoing efforts, we are partnering with and have engaged Shared Health, a wholly-owned subsidiary of Blue Cross Blue Shield of with 24 years of experience covering 1.3 million members. The organization is fully accredited by NCQA. After a rigorous search for an organization with a tested platform and rigorous results, we engaged Shared Health. With our partnership, we scored strongly in the 2017 desktop review of our Quality Improvement Program processes and documents as a part of the Virginia Department of Medical Assistance Services (DMAS) readiness review process for their CCC Program. Recognizing the strength of this partnership, we are now expanding this partnership to assist in driving similar, superior results for Magellan Complete Care of Florida.

Magellan’s partnership with Shared Health began in 2016, as we partnered with their organization to successfully bid for the managed Medicaid Long Term Services and Supports (LTSS) contract in the Commonwealth of Virginia. Magellan Complete Care of Virginia was awarded that contract and has collaboratively been working with Shared Health for the past year to leverage their Medicaid expertise to build to the systems, frameworks, and strategies to successfully launch their plan as of August 1 of this year. In addition to their collaboration with Magellan Complete Care of Virginia, Shared Health has also joined the Magellan Complete Care team as a consultative partner in developing our population health management framework, as well as focus in other areas.

Their long history serving Medicaid enrollees in the State of Tennessee has led to best-in-class practices to support enrollees in navigating the healthcare system, and in understanding the benefits of regular and ongoing primary care as well as engagement in managed care programs that seek to improve the lives of enrollees. Additionally, Blue Cross Blue Shield of Tennessee has a rich history of working within the communities they serve and conducts more than 500 community events a year to reach their Medicaid population across the state. An important area of focus for Magellan Complete Care in continuing to achieve population health improvements and to improve enrollee engagement and satisfaction is increase our community presence to reach a greater percentage of our enrollees. We believe our partnership with Shared Health will be a significant element in driving the successful expansion of those programs.

By adding Shared Health as an important partner in these efforts, when combined with the deep understanding of our population and the mechanisms that drive successful interventions that we have developed in the several years we have offered this specialty health plan, will yield continued significant improvements in quality, outcomes, and satisfaction for our enrollees.

As the current serious mental illness (SMI) specialty plan, Magellan Complete Care began accepting enrollees who are living with SMI for delivery and management of fully integrated physical health and behavioral health care in July 2014. The plan, which is the first of its kind in

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the country, has been continuously focused on understanding our enrollees and key factors that drive outcomes, enhancing models of engagement to drive improvement, and assessing and refining those models to drive better and better outcomes. The SMI population is consistently plagued by lack of primary and preventive care and treatment of chronic disease in the U.S. and throughout the world. The statistics for individuals with SMI in the U.S. are staggering and well-known. “Patients with serious mental illnesses (SMIs), such as schizophrenia, schizoaffective, bipolar, and recurring depressive disorders suffer disproportionately from medical illness. Their life expectancy is decreased by an average of 25 years, which is equivalent to a loss of nearly 33 percent of their lifespan when compared to non-psychiatrically impaired cohorts. Researchers attribute these increased rates of mortality to a number of factors, including low levels of seeking primary care among this population and health issues related to metabolic syndrome.”

The population of enrollees that came into the health plan at its inception was not previously in a comprehensive physical and behavioral health managed care plan, and as a result, was not as familiar, or comfortable with the concepts of comprehensive integrated care management. This resistance to engagement and compliance is well-known for SMI. Results from one of the few studies actually conducted on SMI utilization of primary care and specialty services, drives the point home. “Data from a community-based sample of individuals with severe mental illness show that over 60 percent of subjects report having difficulty with taking medications, keeping medical appointments, and recognizing symptoms…for individuals with serious mental illness…almost one quarter of visits (24.7 percent) were in the primary care sector while nearly three-quarters were to psychiatrists (71.9 percent)... In contrast…for individuals without serious mental illness, primary care physicians comprised 66 percent of visits, other non-medical specialties comprised 31 percent of visits, and only 3 percent of visits were to psychiatrists.”

Given this historic lack of compliance and access to primary and specialty care, and the heavy burden of chronic disease in this population, Magellan Complete Care has placed strong initial emphasis on initiating engagement; identifying enrollee risks and developing individual and population-wide plans for management; and beginning the process of improving outcomes for our enrollees.

Though some of our quality and outcome metrics may not meet targets, our data clearly shows high performance for many behavioral health focused metrics, and meaningful improvements in nearly all of our reported medical and behavioral health performance metrics, resulting in improved outcomes for our enrollees. Measures for which Magellan Complete Care met or exceeded the 75th percentile nationally include initiation of treatment for AUD/SUD, medication management for people with asthma, adherence to antipsychotic medications, metabolic monitoring for children and adolescents on antipsychotic medications, and cardiovascular monitoring. In addition, we are achieving significantly higher rates of primary care use, reductions in inpatient utilization, ER costs and polypharmacy, and increases in total hospital days avoided.

We are excited about the progress we have made with this difficult to engage enrollee population, in the relatively short period we have been serving them with our fully-integrated model. However, as an organization, we won’t be satisfied until we have demonstrated outcomes for this historically underserved population that exceed best-of-breed results for Medicaid. We believe the continual, data-driven and clinical-based refinement of our model, and our expanded partnership with Shared Health will continue to support us in driving toward that goal.
CRITERIA 4: THE EXTENT TO WHICH THE RESPONDENT PROVIDES TWO EXAMPLES OF COMPLETED QUALITY IMPROVEMENT PROJECTS…

Magellan Complete Care’s first full year of operation in Florida was 2015. As a specialty SMI plan, we expected our population to have low adherence levels to recommended preventive care services based on our behavioral health experience. As noted in the introduction to this section, individuals living with SMI tend to prioritize their severe behavioral health needs, only addressing their physical health needs in an emergent way. Our baseline HEDIS scores for our enrollees reflected this reality, with many of our HEDIS rates for primary and outpatient care falling in the 10th percentile or below, as compared to national Medicaid benchmarks. A selection of key primary care HEDIS measures and CHCUP measures was selected as high priority areas of focus.

We used these baseline data to identify a quality improvement project, and we applied the PDSA Model as shown below:

HEDIS 2016 (services 2015) and CHCUP FFY 2014-2015
> Adults’ Access to Preventive/Ambulatory Health Services (AAP): 75.98 percent, 10th percentile
> Adolescent Well Care (AWC), 23.26 percent, <10th percentile
> Child Health Check Up Participation, 23 percent, AHCA Goal=80 percent
> Child Health Check Up Screening, 21 percent, ACHA Goal=80 percent

~Example 1 - Quality Improvement Project Using PDSA Model~
****Trade secret as defined in Section 812.081, Florida Statutes****

Plan: 

Do: Our internal team began initial enrollee outreach efforts on July 28, 2016. The vendor team began enrollee outreach efforts on Aug. 4, 2016. Both programs ran until the end of the year (2016). We collected real-time outreach outcomes using our HEDIS/CHCUP internally developed application.
Study:

****Trade secret as defined in Section 812.081, Florida Statutes****

>Adults’ Access to Preventive/Ambulatory Health Services (AAP): H2016 - 75.98 percent, H2017 – 77.29 percent
>Adolescent Well Care (AWC), H2016 - 23.26 percent, H2017 – 35.04 percent
>Child Health Check Up Screening, 2015-16 - 25 percent, 2016-17 – 34.66 percent
>Child Health Check Up Participation, 2015-16 - 23 percent, 2016-17 – 27.90 percent

Act:

~Example 2~

Plan: Among Magellan Complete Care enrollees, sickle cell disease accounts for a disproportionate share of preventable hospital admissions, with this disease category being the second highest diagnostic category driving preventable admissions for the plan. Individuals suffering from sickle cell disease also show high rates of preventable readmissions and are often seen to display drug-seeking behavior as sufferers experience significant pain. Sickle cell is the most common heritable disorder in the United States, with costs of care estimated $1.1 billion annually. It is commonly considered an important disease management target among Medicaid populations.

Do: In an effort to achieve improved outcomes for our sickle cell enrollees, Magellan Complete Care created our first specialty care management program built around concepts of fully-integrated case management for a group of enrollees with a specific chronic disease. It is an intensive form of disease management (DM) focused on enrollee education and self-care support for management of their illness. Enrollees are selected into the program based on identification and analysis of their risk and utilization patterns and likelihood of being positively influenced by the program’s education and interventions. The program follows an opt-out model, and an enrollee may decline or dis-enroll from the program at any time. Enrollees who decline or dis-enroll are re-approached after six months and are asked to participate. Enrollees are also provided contact information about the program and are informed that they are able to re-enroll
at any time. When enrollees have completed the program they “graduate” to a lower level of monitoring and management but can be re-enrolled if they later demonstrate rising risk.

The care coordination team works closely with the enrollee using various tools and approaches to manage risk factors such as: gaps in care, changes in health status, social risk factors, crisis and safety risk, over-utilization of the emergency department, lack of compliance with treatment plans, medication non-compliance, need for coordination of services and resources, educational needs, and need to be connected to a provider. Specific interventions include:

>Initial and ongoing sickle cell condition assessment, education, assistance in goal setting, and support for skills development in self-management of the disease
>Interventions that remind the enrollee to participate in: condition self-monitoring activities; health screenings; immunizations
>Self-direction and skill development in the area of independent administering of medication and medication adherence
>Self-direction and skill development of self-management plans and/or relapse prevention plans so individuals can attain personal health goals (e.g., what a person with sickle cell should do when pain is unbearable or crisis occurs)
>Closing identified gaps in care for any applicable HEDIS measure
>Encouragement to participate in the development and ongoing review of the care coordination plan

Additional interventions are identified for each enrollee based on risk level, strengths, and opportunities. A care coordination team member is responsible for following through on each intervention. Each enrollee’s program progress is regularly assessed, in addition to assessment of the individual’s health literacy, skills in self-management, screening for depression, level of confidence, and motivation for making behavior change. Findings from these assessments, as well as information from the enrollee’s provider informs the enrollee’s care plan.

Study: Magellan Complete Care has been very pleased about the results of this program. An early analysis shows that:

>Total average costs were reduced for enrollees who have completed the program, while average costs for enrollees not in the program increased significantly over time. Average total costs for those enrolled in the program were reduced by 41 percent. Pre-intervention costs for those not enrolled in the program were $685.35 dollars, rising to $16,172.52 by the end of the study period.

>The program also seems to have a long-term consequence of reducing total average costs for enrollees who have completed the program. Inpatient utilization decreased by 31 percent for enrollees still completing the program, while those who had completed the program show a 58 percent decrease in utilization.

>Both inpatient and ER utilization (all cause) is reduced for enrollees who completed the program, while it significantly increased for those who did not participate. For enrollees who completed the program, inpatient utilization decreased 58 percent, while for enrollees not participating utilization increased by 1,350 percent. ER utilization for program participants decreased by 29 percent, while it increased by 1,283 percent for non-participants.
>Enrollees who have a high disease burden (3 or more comorbid conditions) are enrolled at more than 2-times the rate than we would expect by chance.

Act: Clearly, the results for this intervention show the benefits of the program. Magellan Complete Care continues to study its outcomes and refine the program where appropriate. The scope of the program, interventions, and other program elements are serving as a foundation for continued expansion, both internally within our ICCM operations, and with the collaborative development of a “Center of Excellence” program with our provider partners. As a result of our analysis of the program and its effects, we are making the following continued refinements and improvements:

>Enrollees who refuse engagement are candidates for, and will be offered participation in other programs such as the (possible) hospital home program, SUD programs, etc.

> The second phase of this program will be the expansion into a “center of excellence” program for sickle cell disease. The first center is already contracted; Broward Memorial Hospital, and a nurse specialist has been assigned from Broward.

> We will expand the center of excellence into other regions as well.

Beyond these initiatives, we believe this intervention has demonstrated the value of this intensive, disease management program for use in other high priority categories affecting preventable events, and quality and outcomes gaps. We have already expanded its use into other categories such as first episode psychosis for adolescents and young adults.

CRITERIA 5: THE EXTENT TO WHICH THE RESPONDENT PROVIDES DATA...
Example 1 above uses the plan-do-study-act (PDSA) framework to describe the specific quality improvement (QI) initiatives we deployed for targeted improvement in primary care measures, using HEDIS and CHCUP measures. The results, as detailed above, and provided here again, demonstrate the efficacy of our interventions, as there were significant improvements made between HEDIS 2016 and 2017.

> Adults’ Access to Preventive/Ambulatory Health Services (AAP): H2016 - 75.98 percent, H2017 – 77.29 percent
> Adolescent Well Care (AWC), H2016 - 23.26 percent, H2017 – 35.04 percent
> Child Health Check Up Screening, 2015-16 - 25 percent, 2016-17 – 34.66 percent
> Child Health Check Up Participation, 2015-16 - 23 percent, 2016-17 – 27.90 percent

The PDSA framework also drove several additional QI activities to drive improved results in multiple areas. Key accomplishments for our overall quality improvement efforts in 2016 include:

****Trade secret as defined in Section 812.081, Florida Statutes****
As a result of these efforts, for HEDIS 2017, Magellan Complete Care met or exceeded the 50th percentile for 10 measures.
Of note, Magellan Complete Care met the 95th percentile in a number of categories which are critical for management of SMI. HEDIS Initiation of Alcohol and Other Drug Dependence Treatment, and Medication Management for People with Asthma measures exceeded the 90th percentile. We met the 75th percentile for three measures which are particularly relevant for our enrollees living with SMI (adherence to antipsychotic medications; metabolic monitoring for children and adolescents on antipsychotics; cardiovascular (CV) monitoring for people living with CV Disease and Schizophrenia); and also for Annual Monitoring for Patients on Persistent Medications. Among the measures where we were below the 50th percentile, eight of our measurement results increased by one benchmark from HEDIS measurement period 2016 to HEDIS measurement period 2017.

Overall, among the 30 measures that can be compared from HEDIS 2016 versus HEDIS 2017, 90 percent (27 of 30) measures have improved. This level of improvement far exceeds that of the top 3 Florida Managed Medicaid plans for HEDIS 2016 versus HEDIS 2017, who on average improved only 53 percent of their measures, using the same list of measures and with an average of less than one percentage point improvement per measure. See [General SRC #35, Attachment 1: HEDIS Improvement 2016-2017].

We do not depend only on annual HEDIS reporting to monitor our progress. Using our certified HEDIS vendor, we also generate in-period HEDIS reports at regular intervals throughout the year. Based on claims and encounter data submitted through June 2017, 29 of 36 (81 percent) HEDIS measures have improved when comparing 1/1 – 6/30/16 versus 1/1 – 6/30/17 performance (see [General SRC #35, Attachment 1: HEDIS Improvement 2016-2017]), suggesting our significant level of improvements will continue this year. Magellan Complete Care places a high importance on improving the health of our enrollees. We have significant resources in enrollee and provider outreach and initiatives, and have the full support and dedication of our senior leadership team in ongoing monitoring and oversight of progress.

Magellan Complete Care’s approach to helping our enrollees, and thus improving our quality measures endorses the University of Southern Florida’s recommendations that enrollees living with SMI require intensive community-based and specialized services. Of note, the USF research indicates that it is unrealistic for a plan that works specifically with enrollees living with SMI to generate similar performance levels relative to Florida-based plans supporting a more traditional Medicaid enrollee population (primarily TANF) or national standards. This is largely due to the fact that these measurements do not recognize the low starting point for engagement and management, and the unique care complexities and management requirements of individuals living with SMI.

CRITERIA 6: THE EXTENT TO WHICH ONE OF THE QUALITY IMPROVEMENT PROJECTS...
As described above, our sickle cell intervention is specifically targeted at reducing preventable events (PPEs), including avoidable admissions, readmissions, and unnecessary ER use. We continue to evaluate its benefits, and refine and expand the program. As noted in our discussion of this example above, the program has successfully demonstrated reductions in preventable events, with a very significant 31 percent reduction in inpatient admissions for enrollees still participating in the program, and an even more significant 58 percent decrease in utilization for those who had already completed and graduated from the program. Similar results were seen for ER utilization, with reductions of 29 percent while we experienced significant increases for
those not participating. This findings are particularly significant given the high incidence of preventable events for our enrollees with sickle cell disease, as reported by AHCA.

Magellan Complete Care shows similar results for other types of programs which we have not profiled here. As an example, enrollees participating in our DM/CC/CM programs, we were able to reduce inpatient admissions by 47 percent for our adult enrollees designated as high-risk by our segmentation and stratification and predictive modeling programs. Moderate and low risk enrollees saw a 37 percent reduction, and we simultaneously increased primary care utilization for all adult groups by 43 percent. Results were similar for our enrollees under the age of 21, with primary care utilization increasing by 41%.

As with all of our quality improvement initiatives and targeted interventions to improve outcomes, we follow the same PDSA framework for each of these programs, starting with detailed statistical analysis of the issue we are looking to assess and address; designing solutions that are targeted and specifically tailored to the results we have identified in those analyses; and finally, rigorously analyzing the results of the intervention to determine its effects and need for enhancement. The results of this approach have been consistently proven by our team, and are actively being applied to new programs and interventions across the organization.

We are applying that same rigor to our efforts to reduce preventable events. As AHCA is aware, assessment of whether an event is preventable is retrospective and risk-adjusted. We have purchased the same technology and are currently evaluating its use as part of our continuous quality monitoring and management processes. As we implement our new 3M Grouper technology, this will allow us to begin analyzing the impact the program has had on PPEs. Although we are currently measuring all-cause events, we are confident that the retrospective evaluation of this utilization will show similar favorable trends.

**Evaluation Criteria:**

1. The extent to which the respondent’s description demonstrates that the medical director has substantial oversight in the assessment and enhancement of quality improvement activities, and the Chief Executive Officer is actively involved in quality management.

2. The adequacy of the respondent’s approach to incorporating quality improvement activities into the culture and operations of the organization.

3. The extent to which the respondent describes proactive processes and strategies that are utilized to recognize and solve problems before they occur or are exacerbated.

4. The extent to which the respondent provides two examples of completed quality improvement projects that incorporated a data-driven quality improvement cycle.

5. The extent to which the respondent provides data on the results of the quality improvement projects that demonstrates the efficacy of the interventions.

6. The extent to which one of the quality improvement projects described by the respondent is related to reducing potentially preventable events or improving birth outcomes.
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Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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SRC# 36 – Health Plan Accreditation (See Section 409.966, Florida Statutes) (Statewide):

The respondent shall specify its current accreditation status by a nationally recognized accrediting body. This shall include the name of the accrediting body, the most recent date of certification, the effective date of the accreditation, the type and/or level of accreditation, and the status of accreditation (i.e., provisional, conditional, etc.). The respondent shall attach documentation that supports this information.

Response:

Accreditation of healthcare organizations promotes quality assurance and consistency. By requiring its participating Medicaid managed care organizations to provide their health plan accreditation status, AHCA has affirmed the importance of independent review and certification.

Accreditation is important to Magellan Complete Care not only because it is a requirement of our contract, but also because external review against nationally-recognized standards and certification by an independent body serves as one of the fundamental elements of our continuous commitment to and ongoing efforts to enhance quality in our business operations and services to those we serve.

Florida MHS, Inc., doing business as Magellan Complete Care, was notified on February 19, 2016, that it received full three-year health plan accreditation from the National Committee for Quality Assurance (NCQA), effective as of February 18, 2016 through February 18, 2019. Please see [General SRC #36, Attachment 1: NCQA Notification and Certificate] for the official NCQA notification correspondence and certificate.

Evaluation Criteria:

1. Evidence that the respondent has:

   (a) Full health plan accreditation by a nationally recognized accrediting body; e.g., full three (3) year accreditation for the National Committee for Quality Assurance (NCQA), full three (3) year accreditation for Utilization Review Accreditation Commission (URAC), or full three (3) year accreditation for Accreditation Association for Ambulatory Health Care, Inc. (AAAHC); or

   (b) Partial/conditional health plan accreditation (e.g., provisional for NCQA, conditional or provisional for URAC, or one (1) year or six (6) months for AAAHC); or

   (c) No health plan accreditation or denied accreditation.

Score: This section is worth a maximum of 5 raw points as outlined below:

   (a) 5 points for full health plan accreditation.
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GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

(b) 3 points for partial/conditional health plan accreditation.

(c) 0 points if health plan accreditation denied or no accreditation.

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